

CALIFORNIA BROKER

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High Limit
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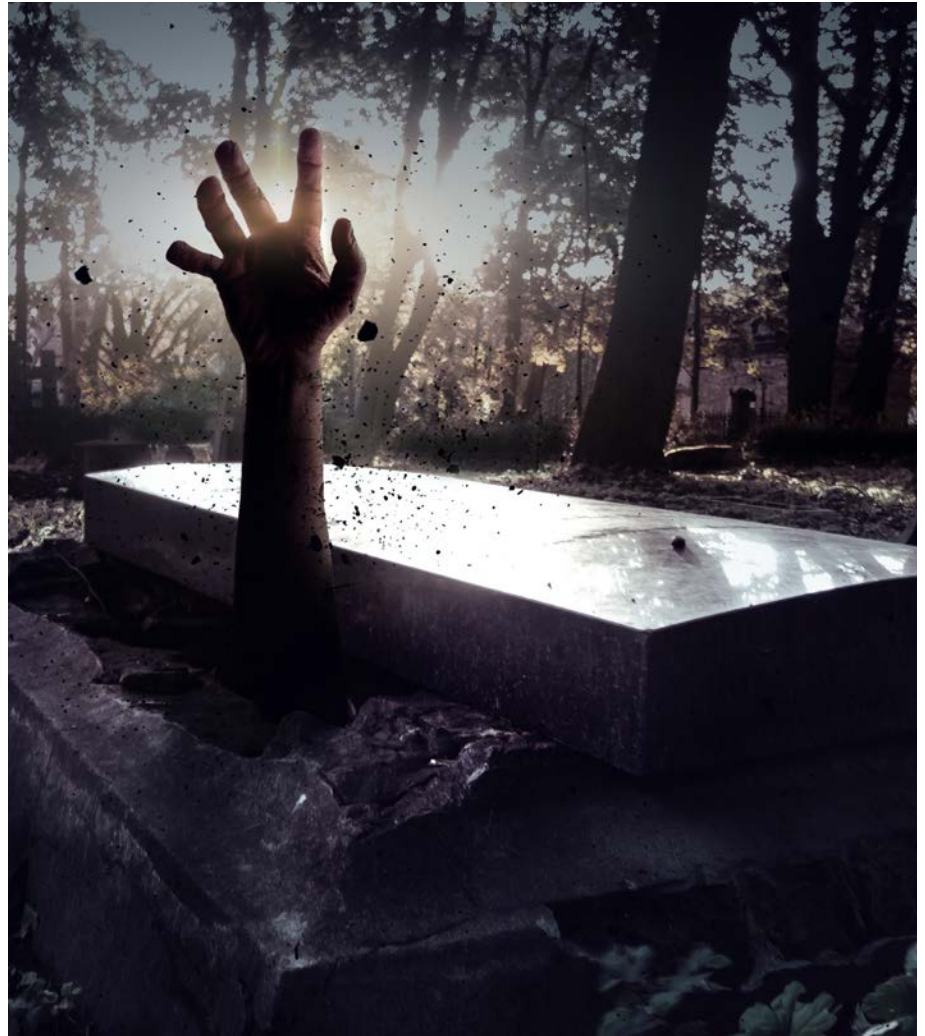
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Insurance Companies Can Help Stop Climate Change

By ROSS HAMMOND

Imagine a world where the same company that you purchase fire insurance from also actively insures and finances rogue teams of arsonists.

Suspend your disbelief for a moment and just imagine that contradiction. No, of course you can't. That would be crazy. Why would a company that would be on the hook to pay out when your house burns down underwrite another activity that would lead to exactly that?

Ironically that's more or less what the insurance industry is doing when it comes to climate change impacts and underwriting fossil fuel expansion.

On the one hand the insurance industry is on the hook for climate change-related payouts. So you would assume they would not want to make the problem any worse. But they are.

You see, the insurance industry plays a significant role in driving climate change by investing their customers' premiums in coal, tar sands and other polluting industries. The top 40 U.S. insurance companies hold over \$450 billion in coal, oil and electric utility stocks. Those investments help finance the extraction of more fossil fuels at a time when the world's sci-

entists are telling us we need a rapid transition to clean, renewable energy. These investments also give fossil fuel companies a veneer of respectability at a time when more and more cities and states are suing them for climate-related damages.

More directly, property and casualty insurers underwrite fossil fuel projects. And we all know that without insurance these projects can't get financing or government approval. Which means insurers are actually a linchpin to the whole fossil fuel system.

But it's not just property and casualty insurers that are helping fuel the climate crisis. Healthcare and life insurers are also unwittingly fueling climate change through their investments in fossil fuel companies. This is particularly bizarre for health insurers given the fact that they have an interest in limiting healthcare costs, not adding to them. Bear in mind that between 2030 and 2050 climate change is expected to cause an additional 250,000 deaths per year according to the World Health Organization.

Surely though these companies must be investing their customers' premiums in fossil fuels because the financial returns are just too good to

pass up, right? Quite the contrary.

Fossil fuel investments have been shown to significantly underperform the market as a whole. As a result, while many institutions have started to divest from fossil fuels because of their role in accelerating climate change, even more have begun divesting to avoid losing their clients' money. In fact leading investors like Jeremy Grantham have shown that it's possible to divest from the entire fossil fuel sector without any material impact on returns whatsoever.

So if these are likely to be bad investments, they are actively driving climate change, and we can ditch them without any impact to our bottom line why would insurers continue to commit customer dollars? That's the question more and more people are asking.

It's clear that citizens and insurance regulators are not going to sit idly by while the industry is asleep at the wheel. A new coalition comprised of major environmental and consumer groups called Insure Our Future was recently launched to pressure the insurance industry to stop making climate change worse. And in the past few years the California Insurance Commissioner has taken an increas-



On the one hand the insurance industry is on the hook for climate change-related payouts. So you would assume they would not want to make the problem any worse. But they are.

ingly active interest in how the fossil fuel investments of insurers doing business in California might impact their ability to pay out claims. In 2016, then Insurance Commissioner Dave Jones mandated that insurance companies doing business in California disclose their fossil fuel holdings. Now, with a few clicks of a mouse, consumers and businesses can find out whether their insurance premiums are being invested in the very fossil fuels driving the climate crisis. Transparency is a first, but critical, step to curbing the problem.

And it's becoming increasingly clear that newly elected insurance commissioner Ricardo Lara is eager to drive further change. As Commissioner Lara put it in his swearing in ceremony, "To the insurance industry—I ask you to

join me in this fight against extreme disasters linked to climate change. We need bold action to ensure our communities adapt and are resilient to this new reality," Lara said. "There is no other industry that has the necessary expertise to ensure that California is prepared to mitigate and reduce risk to our communities and environment. Our planet can't wait. I am ready, and I hope you are too."

Which means the insurance industry has an opportunity. The new insurance commissioner is just that - new. He cares deeply about health care and climate change, and the role that he as the California Insurance Commissioner must take to safeguard the public. But currently no major U.S. insurer has committed to stop underwriting or investing in the problem he is warning

against —fossil fuels that drive climate change. That will have to change—and change soon—if U.S. insurance companies don't want to lose more and more of their business to European insurance companies who are light years ahead of their U.S. peers when it comes to action on climate change. Given the power and size of the California market, what Commissioner Lara does on climate will reverberate throughout the nation and the world. Hopefully the industry stands ready to work with him and stop supporting the very industries that are driving the climate crisis.



Ross Hammond is a senior strategist for Insure Our Future.



Let's Be Clear: Drug Prices Really Aren't Skyrocketing

Adam J. Fein at Drug Channels, a site where he blogs about the prescription drug business, wants the world to know that too many politicians and journalists are repeating the false narrative of “skyrocketing” and “soaring” drug prices. He notes that hot-off-the-presses IQVIA data show that list prices for brand-name drugs grew by less than 6 percent in 2018. Net prices (after rebates and discounts) increased by a mere 1.5 percent. The 2018 figures mark the fourth consecutive year that net drug prices have grown by low-single-digit amounts, writes Fein. So that’s not really so bad, right?

Need Some Health-splaining?

The Council for Affordable Health Coverage (CAHC) and Partnership for Employer-Sponsored Coverage (P4ESC) hosted a crowd of more than 150 health policy influencers recently at the Price of Good Health summit located at the Newseum in Washington, D.C. One great thing that came out of it was a free CAHC whitepaper titled: “Health Cost Primer: Explaining the Medical Cost Trend.” Download it at CAHC.net.



Number of Uninsured Adults Hits Four-Year High

More adults than ever since the Affordable Care Act took effect in 2014 now say they don't have health insurance. About 13.7 percent of U.S. adults went without medical insurance in the fourth quarter of 2018, a new Gallup poll found. An estimated 7 million more adults are without health insurance now versus 2016 when the rate of uninsured dropped to a new low of 10.9 percent.

Voya Financial Launches Suite of HSAs and Spending Accounts

Voya Financial announced the launch of its new suite of Voya Health Savings and Spending Account solutions as optional employee benefits.

The suite of solutions will initially include the following tax-advantaged accounts: a Health Savings Account to be used in combination with high deductible health plans; a Health Flexible Spending Account (Health FSA); a Limited Purpose FSA; a Dependent Care FSA; and a Commuter Benefit Account. Voya's solutions will include several key features:

Easy access to accounts— Employees can access and manage all of their Voya Health Savings and Spending Accounts—when, where and how they need to—through one user-friendly web portal or mobile app.

One debit card to manage all accounts— Account holders only need one debit card to access funds from any of their Voya Health Savings and Spending Accounts to pay qualified expenses.

Employer flexibility— Access one administration portal to review reports and activity on all of their Voya Health Savings and Spending Accounts.

In addition to the savings and spending features of all of the Voya Health Savings and Spending Accounts, HSA account holders with \$2,000 or more in their HSA may choose to actively manage their account and select their investment options within their HSA. More at voya.com.



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

For a complete list of the program rules go to: bit.ly/AgentIncentive2019

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Limelight Gets Big \$

Limelight Health, a quoting, underwriting, and proposal platform for the employee benefits industry, announced it has secured \$33.5 Million in Series C funding. The financing round was led by Principal Life, with participation from AXA Venture Partners, MassMutual Ventures, Aflac Ventures, Transamerica Ventures, Wells Fargo Strategic Capital (a division of Wells Fargo Commercial Capital), LaunchPad Digital Health and Wanxiang America Healthcare Investments. Limelight Health will use the funds for product development, customer acquisition, global expansion and hiring efforts. The company says it will enhance product features to include more automation, enhanced workflow, an underwriter certification program and risk scores based on data sets for better underwriting.

More at limelighthealth.com.

Mason Finance Publishes White Paper

Mason Finance has recently published a free white paper on life settlements for the 65+ crowd. Download the paper at masonfinance.com.

Aflac Recognized for Diversity

Aflac is once again listed on Black Enterprise's prestigious list of the 50 Best Companies for Diversity. This marks the 12th time that Aflac has appeared on this annual list. Aflac's workforce is comprised of 34 percent African-Americans and 45 percent ethnic minorities, while African-Americans make up 12 percent of Aflac's officers, with 27 percent of officers being ethnic minorities. Of Aflac's entire workforce, 67 percent are women.

According to Black Enterprise, to compile the list, Black Enterprise's editorial research team, in partnership with the Executive Leadership Council, sends surveys to the nation's top 1,000 publicly traded companies to get an in-depth look at the ethnic and gender composition, as well as their programs designed to foster an inclusive working environment. The annual survey focuses on African-Americans but includes other ethnic minority groups as defined by the U.S. Census Bureau. Any information provided by companies on diversity efforts targeted toward women, LGBT, the disabled and veterans is used as secondary, supporting data.

A.M. Best: Health Insurers Doing Well

Who hoo! AM Best says it's maintaining a stable market segment outlook for the U.S. health insurance industry in 2019, citing positive earnings in all major lines of business, growth of industry capital and surplus and reduced near-term regulatory uncertainty. The new Best's Market Segment Report, titled, "Market Segment Outlook: U.S. Health," contends that positive fundamentals continued in 2018 driven by favorable medical cost trend, stable performance of the commercial group market, profitable growth in government programs and sustained improvement in the commercial individual segment. AM Best expects underwriting results to be strong in 2018, though down slightly compared with 2017 (when the industry reported its highest earnings in five years). Best says carriers are pricing closer to medical cost trends in the current year, especially in the individual business where profitability exceeded projections for many carriers in 2017. Strong earnings are expected to contribute to further growth of capital and surplus, which—similar to 2017—outpaced premium growth. Government programs remain the industry's primary source of premium growth, driven by Medicare Advantage and Medicaid managed care. Want to know more? Go to ambest.com to access a copy of the full report.

Walmart and CVS Reunited

Walmart and CVS announced a split in January, but it looks like the two are now reunited for a long-term commitment. CVS Health and Walmart announced the companies have reached a multi-year agreement on terms under which Walmart will continue participating in the CVS Caremark pharmacy benefit management (PBM) commercial and Managed Medicaid retail pharmacy networks. The companies are not disclosing the financial terms of the new contract.

About Medicare Fraud

Walgreens Boots Alliance, Inc. has agreed to pay \$269.2 million to settle U.S. claims that the drugstore chain defrauded Medicare and Medicaid over insulin drugs and a consumer-discount initiative. The two settlements are a result of allegations over improper billing. In the first, Walgreens agreed to pay \$209.2 million to resolve claims it billed Medicare, Medicaid and other programs for hundreds of thousands of insulin pens it distributed to people who didn't need them. In the second, Walgreens said it would pay \$60 million for overbilling Medicaid by not disclosing lower drug prices it offered in a discount program.

DAILY NEWS

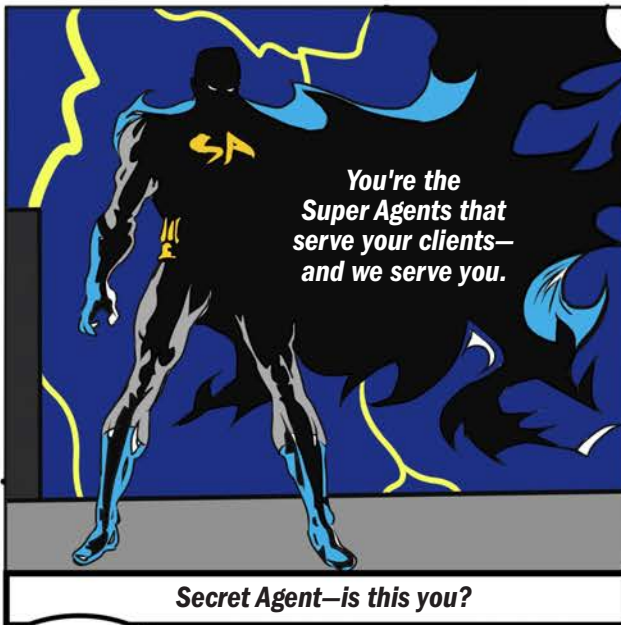
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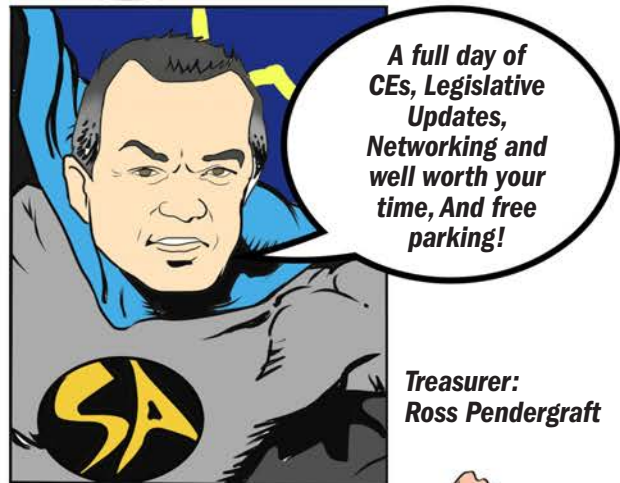
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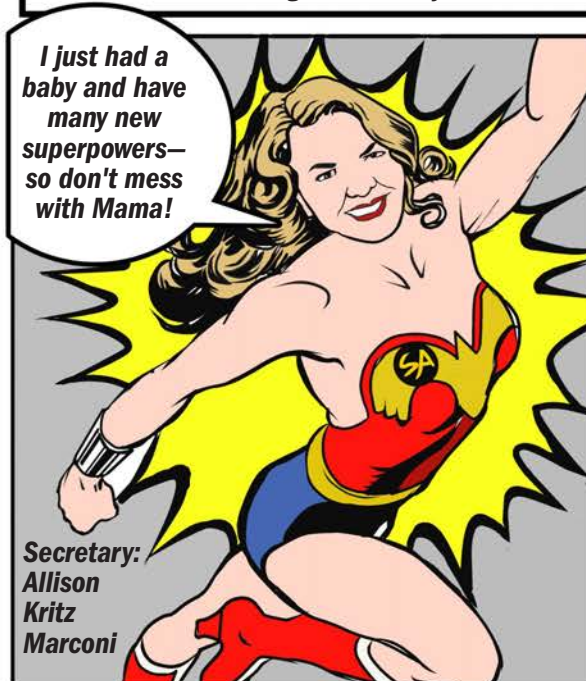
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What's California's Top Medicare Scam?

By KAREN FLETCHER

If you're not already on Medicare, imagine being one of our country's 55 million older adults or younger people with a disability on Medicare. Imagine getting a cup of tea and looking forward to relaxing in your chair, watching a favorite TV program and hoping that darn back ache would just go away! Then, during a commercial break, something catches your eye.

"Medicare covers a remarkable new device that can give seniors freedom from lower back pain," says an ad about back braces. "If you have Medicare, this brace is FREE for you! Call in today, give us your Medicare number and we'll send you your brace. Get ready to feel better and reclaim your youth!"

Wow! While this may sound too good to be true, if I were in pain, on a fixed income and just wanted some hope that I could make my back feel better, this ad would be very enticing. It is, and it works! This ad and many like it are scams, yet thousands, if not millions of Medicare beneficiaries are falling victim to such durable medical equipment (DME) scams each year.

Last year, one of our

Senior Medicare Patrol volunteers saw such a commercial on TV. He happened to be watching a program he had pre-recorded via a digital video recorder (DVR) when the commercial popped up. Because of his work with SMP on fraud prevention, he immediately knew this was one of the scams SMP educates about and watched closely. The end of the commercial had a fine-print disclaimer that ran for just a few seconds – not enough time for anyone to read without freezing the image. Because it was on his DVR, however, our volunteer froze the screen. Here's what it said (company name is made anonymous):

"By calling in, I confirm that this will serve as my signature authority for COMPANY and their customers to call me on my telephone at the number provided. I am aware of my rights to protect my privacy and these rights are waived for the purpose of COMPANY and their customers to call me. I consent to receive information on products not limited to spinal support braces and/or knee braces on this phone call or subsequent phone calls ... I am permitting calls to be

automatically dialed. ... If I am on a do not call list, by opting in, I am waiving this right."

So, this disclaimer says, in effect, that by calling that toll-free number a person is giving the company permission to sell their information to any and all of their customers, and that they and/or their customers can call the person as often as they want for any product they're selling. A person is also agreeing to be the recipient of robocalls, just by calling to find out about the back brace.

This is scary, AND it explains a disturbing trend we're seeing. Namely, that once a beneficiary falls prey to such a DME scam, be it via a TV commercial, or an ad in a newspaper (also often with a very fine print disclaimer), they can find themselves in a vicious loop of receiving unwanted, and at times relentless phone calls, and unwanted durable medical equipment products. One of our SMP clients recently reported receiving over 30 such calls a day. Sometimes beneficiaries are charged for some of these unnecessary products, and Medicare, undoubtedly racks up large bills under the beneficiary's

Medicare number for them.

Here's one recent example that came to our California Senior Medicare Patrol (SMP). In this case, a service coordinator first contacted her local Health Insurance Counseling and Advocacy Program (HICAP), where she worked with Muriel Smalheiser, who is also one of our SMP volunteer liaisons. One of her residents complained to her about receiving numerous unwanted packages from DME companies (10 in total). This service coordinator had been aware of Medicare fraud and scams through some of our SMP presentations for residents, so when she heard this complaint, she immediately suspected fraud and called HICAP/SMP.

With a little investigation, SMP found that this all started when the resident called the number on a TV commercial advertising braces, similar to the commercial mentioned above. The resident received more braces than she had agreed to, and when she refused the additional braces, the DME company told her "it's a package deal and she had take them". These companies aren't taking no as an answer.

In looking at this beneficiary's Medicare Summary Notices, SMP also found that Medicare has already paid thousands of dollars worth of unnecessary braces on this beneficiary's behalf. In total, Medicare paid nine claims from six different DME suppliers, most of whom probably got this beneficiary's Medicare number from the original company she called regarding the TV ad. The delivery of unwanted, unnecessary braces proves how much damage can be done when a Medicare number becomes compromised and when a beneficiary falls victim to this ever-growing DME fraud.

Stopping the fraud cycle

So how do we stop this vicious cycle of fraud? It starts with you. It starts with me. It starts with us all being aware of this problem and knowing what the Medicare rules are. It also takes knowing what the common scams are and sharing this information with our loved ones, clients, colleagues and community and then being vigilant about reporting fraud.

While Medicare does cover medically necessary

durable medical equipment, the key is it must be medically necessary. And a beneficiary's physician makes that determination and must prescribe the equipment for it to be covered by Medicare. Anyone who says they just need your Medicare number and you can have a back brace, knee brace, wheel chair, etc for "FREE" is involved in a scam.

Besides the estimated \$60-90 billion lost to fraud each year, Medicare beneficiaries receiving unwanted and unnecessary durable medical equipment also can have serious consequences on their access to equipment if/when they need it. For example, we've had cases where a beneficiary accepted the offer for a "free" no-frills \$100 wheelchair while the DME company charged Medicare for a \$5,000 electric wheelchair. Later, when the beneficiary actually needed an electric wheelchair, Medicare denied his claim stating he already had one.

How you can help

Our California Senior Medicare Patrol (SMP) is on a mission to put an end to the DME scams and your help is critical. Now

that you know Medicare's coverage policy for DME (needing a doctor's prescription for medical necessity), being aware of the common scams out there will help you be able to spot fraud, and to educate your clients about potential fraud. Even though the scams are constantly morphing, knowing some of them gives you the gist. You'll be able to "smell" fraud if you come across it and help your clients spot it too.

Here are some of the various scams we're seeing in California:

- Beneficiaries disclose personal information to callers offering them braces
- Beneficiaries respond to TV commercials advertising braces to alleviate pain and later receive a low quality brace or no brace at all
- Medicare pays hundreds of dollars for DME that is medically unnecessary and/or DME that isn't rendered.
- Scammers call beneficiaries telling them that a UPS package is waiting for them, and to accept it, they must give their personal information.

We thank you in advance for spreading the word and awareness about

these DME scams. Please join us in urging beneficiaries to guard their Medicare cards and remind them that if they are in need of any DME, they should consult with their doctor first to obtain medical necessity. If you or someone you know comes across DME fraud, report it to our California SMP at 1-855-613-7080. Together we can strengthen the Medicare program, protect beneficiaries and their benefits and put an end to this fraud.



Karen Joy Fletcher, MPH has over 19 years of experience in Medicare training, education and advocacy and has served as CHA's Publications Consultant since 2004. She is the primary researcher, writer and editor of CHA's website content, including CHA's newsletter and blog. She also develops and revises key educational materials, spearheads CHA's social media and chairs the Senior Medicare Patrol Media Team and SMP superheroes skit team. In addition to her work in Medicare advocacy, Karen teaches Earthgym and Qigong at schools, conferences, festivals and retreat centers around the country and abroad, and co-leads Qigong & Wilderness retreat trips in China. She also enjoys ample nature and family time in the Cascadian forests and mountains

Alternative Long-Term

Life is becoming complicated, especially for the long-term care specialist agent. Back in the good old days, agents merely had to compare traditional long-term care policies which were largely similar in structure and comparable in benefits. Not anymore!

By LOUIS BROWNSTONE

Life is becoming complicated, especially for the long-term care specialist agent. Back in the good old days, agents merely had to compare traditional long-term care policies which were largely similar in structure and comparable in benefits. It was easy to spreadsheet different policies and to ascertain which policy would bring the greatest value to the prospect.

Those simple days are gone. Traditional long-term care policies contain some meaningful differences. In addition, a variety of solutions to long-term care needs are available. Hybrid life insurance, linked life insurance, linked annuities, critical illness, short-term care, life settlements, reverse mortgages, etc. It's almost impossible for a single agent or financial planner to acquire all the knowledge necessary to truly understand all of these solutions and to have the ability to accurately compare them and intelligently present them.

Maybe it's best for the agent to limit one's area of expertise so as not to confuse his prospects and himself. One alternative is to pick one favorite traditional long-term care product and one favorite hybrid life insurance product and become a true expert in presenting them. It would seem to be relatively easy to understand the strengths and weaknesses of each. Then the agent could pivot the presentation to which product the pros-

pect would prefer and which product would be the best value for the prospect. Other long-term care solutions would only occasionally be utilized, and would involve obtaining advice from others.

However, the ability to compare different products is not as easy as it sounds.

Let's compare the current favorite traditional long-term care product in California, Mutual of Omaha's Custom Solution, with the current favorite hybrid life insurance product in California, One America's Asset-Care IV. One would expect the Omaha product to contain generally lower premiums, as it contains only one type of benefit versus two in the One America product... life insurance plus long-term care. Of course, the Mutual of Omaha rates could increase over time. The Omaha product also has tax advantages, care coordination, and some special riders, such as shared care. Its main disadvantage is that if you are lucky enough not to have to use it, you lose it. At today's average premium of over \$ 2,500 per year, paying for 30 years plus and then dying could reduce an estate by \$ 75,000 or more.

On the other hand, the One America product contains a death benefit and guaranteed premiums, and its benefit triggers are very similar to the Omaha product. Many prospects do not relish the idea of paying large sums of money with the possibility of no return. This occurs all the time

with fire insurance, automobile insurance, homeowner's insurance, term life insurance, disability insurance, etc. Long-term care insurance seems to be the proverbial straw that broke the camel's back, and "use it or lose it" is a huge not-to-buy factor. Folks may be willing to pay more for the One America product than for the traditional long-term-care product. Of course, that also depends on how much more premium they would have to pay.

There is an additional factor which is less understood but which can make a major difference in determining which is the best value for the prospect. It's gender pricing, especially for single individuals. In long-term care insurance, the female has to pay 50 percent to 70 percent more than the male. Conversely, in life insurance, the female gets to pay about 20 percent less than the male.

Let's take one example, which may or may not be true of other examples. Let's compare the Mutual of Omaha Custom Solution with One America's Asset-Care IV. This example involves 57-year-olds with an initial long-term care benefit of \$4,000 per month for 50 months with 3 percent compound inflation. The Mutual of Omaha long-term care initial benefit limit would be \$200,000. The One America initial long-term care benefit limit would also be \$200,000, including the 25-month extension of benefits rider from a life insurance death benefit of \$100,000.

Care Solutions

Annual Premiums

Female	Male	Couple
Mutual of Omaha		
\$ 3,991	\$ 2,308	\$ 4,412
One America		
\$ 4,143	\$ 4,143	\$ 4,084

Granted, this is not truly an apples and apples comparison, only an attempt to achieve one. But look at the differences! One has to absolutely consider who would be applying. The Mutual of Omaha product contains gender-based pricing, whereas the One America product does not. An agent would have to run premium comparisons in order to properly recommend one product or the other.

For single females, the One America Asset-Care IV policy provides a death benefit of \$100,000 for only \$152 more than the Mutual of Omaha Custom Solution. This small difference might indicate to most that the best value is the One America product.

For single males, the Mutual of Omaha product costs 44 percent less than the One America product. This large premium difference might indicate to most that the best value is the Mutual of Omaha product.

The big surprise for me was in the premium for couples. For couples, the One America Asset-Care IV with its \$100,000 death benefit plus a 25-month extension of benefits for long-term care actually costs 7 percent less than the Mutual of Omaha Custom Solution. A major part of the reason is that the One America death benefit is a second-to-die benefit, which makes

the cost very reasonable because it will normally take longer for the death benefit to pay out.

But there is another major reason which is a part of why it's so difficult to make an apples-to-apples comparison with these two products. In Asset-Care IV, there is no 3 percent compound inflation on the first \$100,000 paid out, as the compound inflation only applies to the extension of benefits rider. The long-term care benefit on the One America product in this example will only be \$4,000/month for the first 25 months. However, the long-term care benefit on the Mutual of Omaha product will inflate to \$8,000/month after 24 years and therefore give a benefit more than \$100,000 larger than the One America product at age 81 for the first 25 months when the policy is most likely to be used.

Once the 25 months has been reached, the long-term care pay out from the two policies will be the same, as both inflation riders inflate the \$4,000 long-term care pay out by 3 percent compound from the effective dates of the policies.

We believe that long-term care benefits longer than 90 days are needed roughly half the time. When long-term care is needed, Custom Solution will give the policyholder more value than Asset-Care IV after paying for 25 months. But if no long-term care benefits are needed, Asset-Care IV will give the policyholder's heirs a death benefit of \$100,000, whereas there would be no benefit from Custom Solution. Unfortunately, the agent is unable to predict whether a long-term care scenario will occur and for how long a period.

What are the conclusions? Maybe the actuaries know what they are doing, and in general, you get what you pay for on an actuarial basis. However, price is a major consideration for prospects in making an insurance decision. For most single males, Custom Solutions would appear to be the obvious choice because the premium is so much lower than Asset-Care IV.

For single females and couples, the relative values of the two products are similar. For them, if life insurance is important in their thinking, they may prefer Asset-Care IV. If they object to the "use it or lose it" feature of long-term care insurance, they may also prefer Asset-Care IV. But if their primary goal is to protect themselves against a long-term care scenario, Custom Solution attains that goal.

The agent's or financial planner's job is first to understand the differences between these two products. Then he or she is in a position to determine which solution fits the needs of the prospect. Then one solution, not two, can be presented, with a good chance of success.



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HEALTH TRENDS

By DAN TRENCHER

THE GREAT 8 FOR THE GOLDEN STATE

It's 2019 and it's no surprise that healthcare continues to face the seemingly uncontainable and unsustainable challenges surrounding cost and access. These challenges have too often contributed to defining care experiences over the last decade. In recent years, consumers have been shouldering more of the spending burden, and this year in the Golden State specifically, healthcare premiums for Covered California plans and those on the individual market will rise 9 percent—more than double our region's rate of inflation.

As employees dig deeper into their pockets and employers weigh options for affordable insurance options, brokers are focusing on plans that offer a streamlined means to secure personalized, integrated care access and resolutions for medical needs. And as the world delves deeper into digital dependency, providers have responded in turn, by creating seamless online healthcare experiences that are both convenient and affordable.

Employers now demand a departure from traditional plan models in favor of solutions that generate an engaged

employee pool that's proactive, healthy, and satisfied. Mindsets are shifting, barriers are falling, and consequently, telehealth options are emerging. Make sure you're well informed about what's ahead as individuals forgo brick and mortar care for fingertip solutions.

1. The front door to healthcare access has gone virtual

When employees first develop an illness or non-emergency health concern, they need a logical first step toward resolution beyond securing an appointment time. In a world of referring physicians, specialists, copays, and waits on hold, consumers need a clear point of entry that's accessible on their terms and provides quality care. A virtual front door that connects them with integrated care providers is a personalized and efficient means to achieve this end.

The ability to count on high quality outcomes is also key. With general medical visits, virtual care remedies a health concern right on the spot; in other cases, the physician can help by providing a specialist recommendation right in the individual's surrounding area, or even offer second opinion

services from a top expert. As part of the full spectrum of mind-body services, physicians also respond to behavioral health needs, directing patients to these services, if needed—all through one access point, again, with proven positive outcomes.

As technology—and our willingness to use it—advances, consumers in 2019 will continue to have growing expectations of using technology for their healthcare needs. And providing a proven, guided front-door experience to your clients' employees may be just what they're looking for.

2. Stakeholders are rethinking non-acute care

Projections indicate that by 2020, chronic diseases will account for almost three-quarters of all deaths worldwide. In California that presents a huge financial burden to employers with the latest studies indicating that over 14 million people in our state are living with at least one chronic condition and more than half of those having multiple chronic conditions. The prevalence of sedentary lifestyles and our dependence on convenience foods are increasing, heightening risks for diabetes, heart disease and obesity. As the Baby Boomers age and our society—as a whole—undergoes major demographic and economic shifts, demand for care services far outpaces the ability to meet them in brick and mortar settings.

Non-acute and chronic conditions management requires immediate attention and a model that supports organized collaboration among providers. The industry is primed for a shift in how it identifies and treats those most at-risk, especially when we consider the rise of co-morbid conditions in tandem with chronic or complex diagnoses. Virtual care will fill this gap, helping consumers navigate services to leverage both telehealth and brick and mortar care services right when they need them.

3. Satisfaction and success go hand-in-hand

By providing virtual care benefits plans, California brokers and employers will generate significant improvements in user satisfaction. In the era of value-based care, it's critical that care not only be successful and efficient, but that it's perceived that way by both consumers and providers. The decades-long season of healthcare discontent can finally evolve into something positive—as consumers are able to navigate the care they need easily and on their terms, benefits design and accessibility will drive major improvements along the entire care continuum.

Furthermore, technology has delivered on the modern expectation for “here and now” service delivery through consumers' mobile phones. Through grocery delivery, to ride sharing, and now healthcare, people expect convenient solutions to everyday problems. As virtual care grows, we'll see an uptick in satisfaction levels in 2019 for healthier, more productive employees.

4. No compromising for consumers

It's no surprise that savvy consumers seek the best of both worlds. In healthcare, that means household health-

care decision-makers will demand both convenience and high-quality. In turn, employers and brokers won't accept higher costs, but instead, will seek higher efficiencies. No compromises!

To summarize recent research from Deloitte, people want healthcare access when, where, and how it best suits them, driving behavior and services selection.

Especially as Californians' household demographics models shift, multigenerational and multi-earner decision-makers will require an integrated, virtual care resource to maintain health and wellness support. Women, especially, who often juggle roles of employee, mom, and household “chief medical officer,” prefer sensible, seamless access to care that saves time. By offering quick resolutions to common problems and a sensible access point for more complex issues, virtual care enables true partnership with caring physicians whereby their clients' requirements aren't sacrificed.

5. Behavioral health becomes better integrated

Thankfully, the veil of stigma and misinformation surrounding mental illness and behavioral health continues to lift. As we progress, it's critical that behavioral services expand to more seamlessly integrate into employees' healthcare plans. Despite nearly 70 percent of people with behavioral health problems also having a physical comorbidity, mind-body conditions are typically managed separately.

In 2019 and beyond, mental and behavioral health conditions will be managed with better outcomes through greater coordination in virtual care. Often, patients are unsure if their symptoms warrant treatment, or are unclear about what method may be best for their needs. During general telehealth visits, physicians can help individuals acknowledge and identify challenges, guiding them to secure services and further optimize the productivity and accessibility of behavioral health providers.

While some employers and brokers lean on employee assistance programs (EAPs) to meet specific individual's needs, these services typically handle an event in isolation and in a reactive, as opposed to proactive, way. Conversely, virtual behavioral health services, through an integrated provider, enable relationship building and extended treatment—with medications when appropriate—between a patient and clinician or psychiatrist. By investing in this more proactive relationship model, healthier, happier employees will generate more productive output for employers.

6. Barriers fall; virtual care momentum progresses

Virtual care has moved past the point of inevitability. As technology dependence has fueled user trends toward on-demand consumption of services, additional developments from regulatory and economic entities have aligned to ensure virtual care's success.

Under proposed rules implementing the Bipartisan Budget Act of 2018, the Centers for Medicare & Medicaid Services (CMS) will broaden the ability for Medicare Advantage plans to include telehealth as part of their bids for the

2020 plan year. Certainly this will drive broader adoption of virtual care services and further spread to impact decision-making by commercial payers in the coming years. Likewise, state parity laws around reimbursement of telehealth services are shifting positively for virtual care's expansion as a central point for integrated care delivery. As we look to the future, employers can expect the influence of virtual care to grow and for payment models to evolve to support it.

7. AI will fulfill role as augmented intelligence

The promise of AI in healthcare is significant. It's even more promising when we look at AI as augmented intelligence; combining the power of technology with the brightest minds in healthcare.

Through AI's ability to mine disease, and condition-specific research, physicians can access important clinical data to make informed recommendations. One study has found that it would take a physician 29 hours each workday to keep current on the latest medical literature! Another recent publication determined that it takes an average of 17 years for new evidence-based findings to reach clinical practice.

Thankfully AI offers the ability to search, organize and consolidate medical literature at a volume and speed that no doctor could manually match. AI enables medical care to become an individualized, knowledge-rich pursuit to achieve better outcomes through the development of condition- and disease-specific solutions that are both applied personally and supported clinically.

8. As access increases, costs will go down

Facts: Employers and consumers have been faced with rising insurance and medical costs, while physicians remain overworked and unable to meet demand. The consequences: patients defer both routine and specialist care, leading to the development of worsening conditions and more invasive treatments. Nearly 40 percent of Americans report skipping a recommended test or treatment, and 44 percent

say they didn't seek care for a sickness or injury in the last year because of cost.

The New Year demands a new care philosophy: let's help employees gain affordable, timely access to all their care needs. Partnership with a full-service virtual care provider delivers this. As the high-cost of specialty medications and treatments continues to plague healthcare, the system at large must invest technologies that are proven to assure that a patient has the accurate diagnoses and subsequently the right treatment plan, minimizing unproductive care episodes and avoiding the spiraling of exorbitant costs and claims.

A centralized conception

As we quickly approach our next decade, healthcare decision-makers are considering the most effective means to integrate and streamline care episodes. California brokers, in particular, evaluate virtual benefits options on their ability to generate efficacious outcomes in a manner that leads to better outcomes.

An integrated virtual care solution enables engagement of today's evolving consumers, and complete collaboration among care team members to address multifaceted medical concerns. Remember: healthier individuals are happier, and consequently, better, employees. The year 2019 may be the one where the stars finally align for both employers and employees to experience increased satisfaction in their health plan offerings with virtual care leading the way.

As senior vice president of product & corporate strategy for Teladoc Health, Dan Trencher oversees the development and execution of new growth opportunities and products for the company, leading business initiatives that deliver compelling user experiences and transforms how people access quality care. He ensures that Teladoc Health delivers innovative commercial products, leading long-term road mapping, market analysis, product development and management, and project execution.

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TRANSITIONS ACADEMY DEBUTS FUTURISTIC LENSES AND MORE

By VICTORIA ALEXANDER

It was all "light years ahead" at this year's Transitions Academy.

Cal Broker was among the more than 900 invited guests from North and South America to attend the 23rd annual Transitions Academy. This year's event was held at the JW Marriott Grande Lakes in Orlando, Florida. The theme "Light Years Ahead" was, indeed, appropriate. Chrystal Barranger, president Essilor Photochromics and Transitions Optical, stressed innovation as the company brings higher-tech lenses and more light management solutions to wearers in 2019 and beyond. Among the key announcements:

Better photochromic lenses

Transitions debuted the Signature GEN 8 photochromic lenses, the result of over five years of product research and development. Main benefit: the lenses transition at a fraction of the time of previous generations of lenses. Light sensitivity and light stress may be underappreciated factors in a healthy lifestyle, according to some research.

Contacts that work like photochromic lenses

This was the showstopper unveil. Transitions, in partnership with Johnson & Johnson Vision, debuted Acuvue Oasys photochromic contact lenses.

The new lenses are light-sensitive, vision-correcting contacts that contain filters that sense the amount of light entering the eye and darken or lighten accordingly. Acuvue Oasys, which have been in the works for over a decade, received FDA clearance in April. TIME magazine named them one of the best inventions of 2018.

Updated educational website for employers and employees

Vision benefits education can be easy if you get people to healthysight-workingforyou.org. The newly updated website provides a range of educational resources and quantitative tools to reinforce the value of enrolling in premium vision plans.

What else? Well, we tracked down a number of attendees to ask a few burning questions about issues that matter to our readers. Here's what we learned...

CB: What's different today in the vision benefits world?

"I've worked in vision benefits for 22 years," said VSP's Melody Healy. "Right now, the cost of health care and how to cut costs dominates all benefits conversations. The good news, though, is that vision benefits can be the bright spot in this conversation. You can offer a plan that has more coverage and is still af-

fordable. People can use their benefits and walk out of the eye doctor with a better pair of glasses. It's something tangible that most people immediately recognize as improving their lives." By the way, keep an eye on VSP. Healy says the company is expanding product offerings, especially for groups under 1,000.

CB: What's your biggest concern with patients and vision benefits?

"My biggest concern right now is that patients need more education about doctor-dispensed eye wear," said Dr. Eric White. Many patients erroneously believe they can see an eye doctor for their prescription and then order the very same glasses they might get from a doctor online or from Costco. "They don't realize that the cheaper products aren't just cheaper. They're inferior," said Dr. White. Lorie White said she spends a fair amount of time just chasing down a patient's vision benefits. "It would be great if patients knew more about their vision benefits, or even knew if they had them. But, then again, I've gotten good at finding the benefits and letting them know what their coverage is." Lorie said she's found it helps to frame the benefit correctly, though. "I show them how much they would pay if they didn't have vision benefits versus how much they are paying with benefits. It makes them truly appreciate their coverage."



Melody Healy, Chief Operating Officer, VSP Vision Care.



Brokers Dan Pennington and Bill Schulte attended on behalf of Anthem.



Dwight Ellis, sales executive, USI Insurance Services.



Eric White, OD, and Lorie White of Complete Family Vision Care, San Diego, California.



San Jose, California, eye doc William To spoke on a morning panel. Find Dr. To on Instagram @TheTravelingOD



Transitions key account managers Jacob Mann and Jonathan Ormsby with Drew Smith, director of North American channels.

CB: What did you learn by coming to Transitions Academy?

When you're talking about population health management, vision can become a bigger component, said broker Dan Pennington. "There's a real conversation to be had. Vision is an economical benefit, but we need to ask: What can we do with vision to bring down medical costs?" Pennington said vision providers can see certain aspects of the health of members before other health care providers might. Diabetes, high cholesterol and other disorders can be identified early in an eye exam. "So we need to think about building in programs to incentivize employees to get their eye exams. When you frame the vision conversation this way, suddenly vision becomes a key leg of the benefits stool." In other words, the vision conversation can become a really important four minutes.

Bill Schulte, another broker, was impressed that photochromic lens technology has come so far and that light management has been linked to employee productivity, health and stress. "There are now lenses that work well and change quickly so this gives people the ability to easily filter and screen harmful light," he said. Again, more to talk about during those four minutes of the vision benefits convo!

CB: How can doctors improve the vision benefits picture?

"I'm always surprised that eye doctors don't recognize a need to have a relationship with benefits providers. Like anything else, a relationship with good communication makes everyone happier," said Dr. William To. He keeps in contact with benefits companies so he can understand changes in reimbursement and how to communicate benefits very quickly to his patients. He admitted, however, that since he's practicing in Silicon Valley many of his patients are privy to extremely rich eyewear plans. "Some of my patients have plans with all the bells and whistles—including premium lenses and three pairs of glasses every year," said Dr. To.

CB: What's the biggest obstacle for brokers who want their clients to embrace rich vision benefits?

"I think that employees need to know more about their vision plans. For example, many people don't realize that Anthem plans cover photochromic lenses completely for kids," said Dwight Ellis of USI Insurance Services. "But I also think that the people in charge of benefits need to be educated about some of the changes in eyewear. If there are products out there that offer more quality and impact health or well-being, they need to understand why these products

are important and what they are paying for. If I could get this across to them in a quick, simple demo that would help me sell the benefit."

CB: Once the public is made aware of Oasys, insurance agents and brokers will certainly be fielding calls about the coverage for these lenses. What do we know right now?

"For now, the Oasys lenses are covered the same as any Acuvue contacts," said Transitions Optical's Drew Smith.

CB: Does a company like Transitions have single payer concerns?

Everyone is watching the issue, said Jonathan Ormsby of Transitions, but realistically it might not impact a company like Transitions as much as providers, insurers and benefits folks. "What we offer could still be accessible. Premium lenses aren't in the same cost league as, for example, a medical treatment that wouldn't be possible without good insurance coverage." Still, employees want rich vision coverage (including premium lenses). Time and again benefits pros say that when employees are given options between vision plans with less coverage or more, they opt for the higher benefits. "They are willing to pay more for coverage of premium products because they see the value right away," said Ormsby.

BRAIN EXERCISES THAT HELP YOU REMEMBER WHERE YOU PUT YOUR CAR KEYS

Unfortunately, the older we get changes do take place in our aging brain. Our memory slowly begins to decline beginning at age 40.

By **RON STOCK**

Daily and vigorous exercise of your brain is one of the best medicines you can give yourself to slow the onset of dementia or, worse, Alzheimer's disease. Do you ever forget where you filed an important customer policy or where you put your car keys? Do you then ask yourself, "Geez, am I getting dementia or, worse, Alzheimer's?" The answer is you are probably not getting dementia, as only 3 percent of the population ages 65-74 become afflicted with dementia, but that number jumps to 47 percent for those over the age of 85.

Unfortunately, the older we get changes do take place in our aging brain. Our memory slowly begins to decline beginning at age 40; a 75-year-old takes up to four times longer to process information than a 20-year-old. As we age, our intelligence is a little slower solving problems. Yes, we sometimes forget where we put the car keys!

But there are also some early indications to worse problems: increasing forgetfulness, like more than once a week

forgetting where the car keys are or forgetting to take your daily blood pressure or cholesterol pill. Or, asked what you had for breakfast, you cannot recall you had eggs and bacon. Difficulty in following a conversation, making correct change or remembering how to drive home from a familiar place—a park, a hardware store or a favorite restaurant—are also signs that you should exercise your medical benefits and make an appointment with a neurologist.

Dementia and Alzheimer's are chronic diseases with no cure, but their progression can slow through healthy living. What can you do to help delay memory issues, including dementia and Alzheimer's? Doctors will suggest eating healthy, plenty of vegetables and fruit, lots of broccoli. Maintain an active social life and stay stress-free (impossible during Open Enrollment and up against a quota!). Also get plenty of exercise for your body and your brain.

John E. Morley, MD, director of St. Louis University's Division of Geriatric Medicine, recommends 10 brain exercises to delay dementia and Alzheimer's.





What can you do to help delay memory issues, including dementia and Alzheimer's? Doctors will suggest eating healthy, plenty of vegetables and fruit, lots of broccoli. Maintain an active social life and stay stress-free.

1. Test your recall. Make a list—of grocery items, things to do, or anything else that comes to mind—and memorize it. An hour or so later, see how many you can recall. Make the list as challenging as possible for better mental stimulation.

2. Let the music play. Learn to play a musical instrument or join a choir. Studies show that learning something new and complex over a more extended period is ideal for the aging mind.

3. Do the math in your head. Figure out problems without the aid of pencil, paper, or computer; you can make this more difficult—and athletic—by walking at the same time.

4. Take a cooking class. Learn how to cook a new cuisine. Cooking uses many of your senses: smell, touch, sight, and taste, which all involve different parts of the brain.

5. Learn a foreign language. Speaking and hearing foreign languages stimulate your brain. What's more, a rich vocabulary reduces the risk for cognitive decline.

6. Create word pictures. Visualize the spelling of a word in your head, then try and think of any other words that begin (or end) with the same two letters.

7. Draw a map from memory. After returning home from visiting a new place, try to draw a map of the area; repeat this exercise each time you visit a new location.

8. Challenge your taste buds. When eating, identify individual ingredients in your meal, including subtle herbs and spices.

9. Refine your hand-eye abilities. Take up a new hobby that involves fine-motor skills, such as knitting, drawing, painting, assembling a puzzle, etc.

10. Learn a new sport. Start doing an athletic exercise that utilizes both mind and body, such as yoga, golf or tennis.

Insurance agents who play golf, you could knock out several of these brain exercises while stealing an afternoon on the links! While you are exercising (golf), guess the ingredients in the hoagie sandwich (taste buds) from the fairway shop. Look at your scorecard and mentally add up everyone's score (math). Picture the layout and yardage on the holes you shot birdie (mental map). Count in Spanish from your recently acquired Berlitz program (language) the money exchanging hands for lost Nassau bet.

See, it's not hard to exercise your brain! Why not start today?



Ron Stock, president of Beta Benefits, FMO Medicare Health Plans, with over 25 years in Medicare, also conducts broker education unit (CEU) classes, "How to Start Your Own Agency" and "5 Must-Do's for Selling Your Agency." Beta Benefits also offers Nippylinks (nippylinks.com), a mobile app for phone and tablet, with the broker's UserID and Passwords embedded for quick access to providers' broker portal. Questions? Contact ron@betabenefits.com or Beta Benefits' sales and marketing manager Bronson Lee, Bronson@betabenefits.com.

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2019 FAST FORWARD: FOUR PAYMENT TECHNOLOGY PREDICTIONS SHAPING CROSS-INDUSTRY CHANGE

By DAVE YOHE

Increasingly digitized channels will start to have a serious impact on commercial payments. Consumers are used to paying bills and purchases with their credit card online, over the phone and even directly from their mobile device.

The payments world continues to evolve and is going through critical and disruptive changes. A failure to embrace this disruption could lead to lost time, money and, potentially, customers. Here are four industries which have traditionally been slow to react to payment innovation. Take heart, I expect to see progress over the next 12 months.

Payments are currently in a period of transition from the traditional to the digital. Witness a recent Capgemini report on consumer payment demand in 2019 which describes the payments industry as rapidly transforming from an infrastructure of cards and terminals to a system dominated by mobile devices such as smart watches, phones and even IoT-enabled cars!

Healthcare goes mobile—and text

Healthcare payments continue to be a hotly watched area for revenue cycle managers and C-level industry

executives. Providers and patients alike must adjust to high-deductible insurance plans, value-based care price transparency and public health-care programs such as Medicare and Medicaid.

For providers, payment priorities are set to shift through 2019. A Q4 2018 study by BillingTree revealed that providers are focusing on improving the patient payment experience with technology. While agent-assisted and online payments currently dominate the revenue cycle management process, text-based notification and billing is now the fastest growing channel being explored.

More than a quarter of all providers plan to adopt text notifications for bill payment/notification in the next 12 months. This number more than doubled from the previous year's survey, indicating this is a fast emerging channel. Expect this to continue into 2019 with text-based payments gaining wider adoption as an immediate, convenient and compliant option which suits both providers and patients.

B2B stops pushing paper

As we move into 2019, increasingly digitized channels will start to have a serious impact on commercial payments. Consumers are used to paying bills and purchases with their credit card online, over the phone and even directly from their mobile device. Yet the B2B payment sector continues to drag its feet when it comes to payment channel innovation. The benefits are clear—quick handling of multiple payments, increased security and integration with existing business management and accounting software.

But, recent Mastercard research shows that over one-third of businesses plan to decrease their use of paper checks in the future, with more than 40 percent saying they are too slow and require too much manual paper work. Watch this space as we move through 2019, as more businesses ditch paper and realize the efficiency benefits of moving to ePayables.



Omnichannel goes from afterthought to first-thought for CUs

Although many people are aware that credit unions often offer preferred loan and credit card rates than banks—and boast lower/fewer fees—there are still many myths surrounding membership. With confusion concerning eligibility, technology, and payment services, many people who could benefit from membership are often reluctant to take the first step.

In order to allay these concerns and appeal to a younger customer base with huge potential, credit unions must prioritize the member experience. We are starting to see credit unions focus more on their service offerings, realizing that providing a wide selection of payment options can improve member service. Technology is moving from afterthought to first-thought. The ability for members to make payments or check their account anytime from their mobile device or any computer terminal is a benefit which they will sincerely appreciate.

ARM must deal with convenience fee confusion

Omnichannel expectations are becoming key to driving revenue in accounts receivables management (ARM). But simply offering a wide range of payment methods doesn't mean a company has found the Holy Grail. Just because a customer chooses to receive a notification of an out-

standing bill via email doesn't mean they plan to settle the bill online. It may be more convenient to pay over the phone or to even negotiate a payment plan with an agent. This means the consumer must be able to move freely between 'channels' and payment methods—those who innovate here in 2019 will stride ahead of less prepared competitors.

Less of a technology trend and more of an industry-wide debate is the continued confusion around no-fee to biller models and convenience fees. Respondents to the BillingTree ARM study were split more than ever before in their attitude towards convenience fees. This shows no signs of abating in 2019. It's up to the card issuers to enforce a change to clear up the confusion once and for all.

2019—a decisive year

The next 12 months is a critical time for healthcare providers, B2B payments, credit unions and ARM organizations. Those who react quickest may hit the perfect trifecta: faster payments, happier customers and increased revenue.



Dave Yohe is vice president of marketing for BillingTree.

AN ESSENTIAL GUIDE TO DISABILITY

*Let's cut to the chase...
There are many reasons why I think agents should sell disability*

By LARRY SCHNEIDER

- H**ERE ARE MY TOP REASONS:
- 1.** It is a great door opener that places you above your competition
 - 2.** There's very little competition
 - 3.** First year commissions (50 percent) and renewals (10 percent) are outstanding
 - 4.** Persistency
 - 5.** No need to re-quote every year, rates are guaranteed
 - 6.** To avoid being sued when a disability occurs and your client asks "Why didn't you recommend this type of coverage to me?"

Disability In a Nutshell

Could you continue to pay your personal daily living expenses (food, rent etc.) if you were unable to work for any length of time because of a disabling injury or sickness? Do you know how much money would still be coming in each month and from what source should you become disabled?

For someone between the ages of 35 and 65, chances of being unable to work for 90 days or more because of a disability are between 35 and 50 percent.

Some people can rely on disability benefits from their employers and/or the government, but for a great many workers, income stops when work stops! Disability income protection insurance is designed to replace lost income when that happens.

Disability income insurance can provide your clients with a tax-free guaran-

teed income should they become sick/injured, whether it be as a result of an on or off-the-job disability. It helps to protect a family from financial catastrophe by providing income to help meet daily expenses and can come in two forms as follows:

A variety of employer-paid (group disability) and government-sponsored programs, generally cost-free (taxable) to the worker.

Private policies, paid for by the individual, which protects income when there is no other applicable coverage, or when available programs do not adequately meet needs.

Group Disability

Most employers allow some short-term sick leave. These might last anywhere from a few days to six months, depending on company policy and



Add up all of the benefits a client is entitled to plus their savings. If the total approaches the required income needs after taxes, you can assume they have enough to cover their expenses while recuperating from a disability.

length of employment.

No law exists that require employers to offer group long term disability coverage. However, approximately half the medium and larger sized companies offer coverage for at least five years. Typical plans cover 60 percent of salary and are fully paid by the employer. As a result, benefits are taxable, thereby reducing the benefit amount. Individuals should check with their company benefits office to see if they are covered, for how long and what the benefit amount offsets might be (reductions from other disability programs, including workman's compensation, social security etc.)

What About Social Security Benefits?

Most workers participate in these benefits and besides providing retirement benefits this government program also provides benefits for a covered disability. Salary, prior income and number years worked, determine how much anyone might receive. Good to know:

People are only eligible for disability benefits after they've been disabled for 5 months and only if the disability is expected to last at least 12 months. These benefits might be reduced by other programs and eligibility is based on the inability to perform ANY gainful employment, not just the duties of the job the person was doing at the time of disability (and thus a 72 percent denial rate). These benefits can also be taxed.

Eligibility For other Disability Income Benefits

There may be other potential sources of income, should someone become disabled, for example...Workers com-

penensation (only for on-the-job injuries), Veterans Administration pension benefits, civil service, black lung for miners, union benefits, automobile, private disability coverage, Medicaid ,etc.

How Much Coverage Is Enough?

Add up all of the benefits a client is entitled to plus their savings. If the total approaches the required income needs after taxes, you can assume they have enough to cover their expenses while recuperating from a disability. If not and they are eligible, they will want to consider buying individual disability insurance to make up the difference. A special note for the self employed...Purchasing your own coverage can be particularly important, not only will you not receive benefits from a group plan, but your entire business may suffer as well.

Essential Knowledge

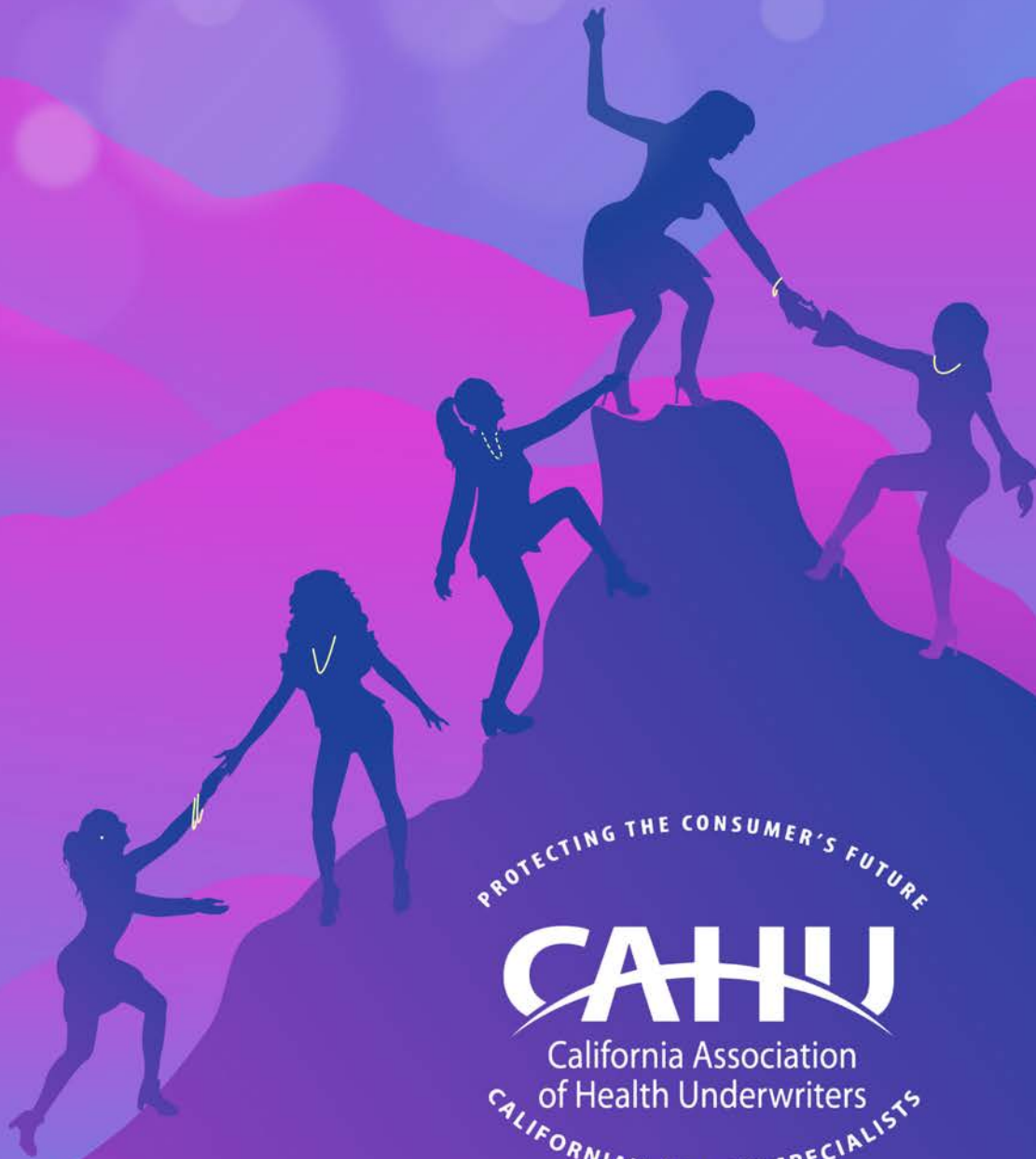
Selecting the amount and duration of disability insurance benefits is only the first step. You want to make sure coverage won't be canceled so you must ask about the policy's renewability and rate increase provisions. Disability insurance policies have three different types of renewal guarantees: 1) non-cancelable and guaranteed renewable policies, give you the right to continue coverage without threat of cancellation, wording changes or rate increases upon timely payment of premium. 2) guaranteed renewable only policies, only takes away the threat of being cancelled, but allows the carrier to increase rates. 3) Least expensive of all, optionally or conditionally renewable policies (no guarantees). These only renew the policy for a set period of time, usually just one year and rates can be

increased. Most all types of policies include a waiver of premium, which means after the deductible has been satisfied (usually 90 days) a disabled person doesn't have to make payments and if and when they return to work, back payments are forgiven. There are a few other options that are available that take care of other circumstances. Protecting one's "own occupation" which should be the basis for satisfying the definition of total disability (this governs how your disability is viewed for claims purposes) is also very important.

In general, premiums paid by an individual means the benefits are tax free. If an employer pays all or some of the premium, then all or some of the benefits are taxable. When you buy an individual policy, buy one that covers for both accident and sickness. In fact, as one gets older, it is more likely that a disability will result from a sickness than from an accident.

Larry Schneider is a disability specialist with over 45 years of exclusively specializing in disability insurance with over 50 published articles. He is the owner of Disability Insurance Resource Center. He can be reached at: info@di-resource-center.com, For more information on his company and his CV, his website is: www.di-resource-center.com. Toll free number is: 800-551-6211 Schneider is also an expert witness consultant for claims which have been inappropriately denied and a national resource for hard-to-place applicants as well as a brokerage for standard cases. Schneider was instrumental in rewriting the American College's DI manual. He's one of the founding members of the International Disability Insurance Society and has published an Encyclopedia of Disability Insurance manual.

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THE SALESPERSON ISN'T DEAD BUT NEEDS TO RISE TO THE OCCASION

By JOE NAVARRO

Have you heard that the salesperson is dead in 2019? Don't buy it. Here are some stats that prove this statement dead wrong and offers insights that speak to the challenges and opportunities that lie ahead this year. According to a 2018 PwC survey:

- Consumers would pay up to 16 percent more for better customer experience.
- 75 percent of consumers around the world desire more human interaction.

In addition, when it surveyed 4,000 U.S. internet users 13 and older, PwC found that more than 8 in 10 respondents said that as technology improves, they will want to interact with a real person. Yes, you read that right: a real person.

To take it further, U.S. internet us-

ers were less inclined than other countries to think that once technology becomes even more advanced, we won't need humans for great customer experiences, according to the survey.

Is "great customer experiences" your primary goal for growing your business? If not, 2019 is the perfect year to make it your goal. That's because consumers—yep, I'm talking millennials—not only want to interact with real people like you, but they also desire a better customer experience.

When asked about their "secret sauce" (why people buy from you), it's quite common for most brokers to respond with, "We deliver good customer service." Which may be true. But the differentiator today is when you can say, "My agency is known for great customer experiences online and in person." That is how you can win BIG in the New Year—particularly

with the newest generation of buyers.

How can you provide great customer service? There are many things you can do, but here are the ringers:

- Great salespeople communicate well from emails to in-person conversations. They are clear, concise and speak with the customer "voice."
- Great salespeople listen to people and welcome feedback. They listen to learn what they can do to create a better experience.
- Great salespeople are humble. They realize it is not about them and they are willing to sacrifice their time, energy and resources to make sure their clients succeed.

Another key thing you can do: Aim to better define the customer journey when you're working with prospective or existing clients. Put yourself and your team in their shoes. If the experience doesn't truly differentiate you from others, if the experience is

If the experience doesn't truly differentiate you from others, if the experience is not exceptional, go back to the drawing board to talk about how you can get there.

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not exceptional, go back to the drawing board to talk about how you can get there.

Three Kinds of Consumers

When looking at today's consumer, Accenture's study, "The Voice of the Customer: Identifying Disruptive Opportunities in Insurance Distribution," found three distinct consumer personas. Each is differentiated by its members' attitudes toward competitive pricing and low cost, and their level of interest in high-quality, responsive service. According to Accenture, they are:

- Nomads—A highly digitally active group, ready for a new model of delivery
- Hunters—Searching for the best deal on price
- Quality Seekers—Loyal to insurers that deliver on brand integrity and service excellence

You have the ability to influence how all these different personalities think about and purchase insurance. And that should be done in a way in which you have a positive impact on a client's experience.

Insurtech For The Disrupters

Though consumers are looking for interactions with real people, it would behoove us to keep in mind that technology will play a key role in how consumers interact online with you and insurance companies.

Let's go back to 2018 for a bit. We all heard a lot about technology. Key words making the rounds included blockchain, artificial intelligence, data mining—and, in our industry, insurtech. McKinsey & Company called insurtech "the threat that inspires."

What is insurtech?

McKinsey says, "Insurtechs are technology-led companies that enter the insurance sector, taking advantage of new technologies to provide coverage to a more digitally savvy customer base." Another definition from Investopedia says, "Insurtech refers to the use of technology innovations designed to squeeze out savings and efficiency from the current insurance model."

When insurtech was first coined a couple of years ago, some people called it a disrupter and thought it could eliminate the need for agents and brokers. But focusing on the New Year, I believe "technology disruption" will create an insurance industry that is even more robust and attractive to a new buyer, revitalizing processes and responding to the needs of a more tech-savvy consumer.

So for clients who may prefer less interaction with people and more with technology, optimize your business in such a way that you can cater to their needs as well. If you haven't already, implement technology in your business processes in order to provide a better consumer experience.

Five Business Drivers for This Year

Here's the takeaway. You should set out to do these five things this year:

1. Urgently evaluate all aspects of your agency. Who are you, what do you do and how do you do it? Clearly define your secret sauce for all to know, from employees and clients to product partners.
2. Define, differentiate and deploy your great customer experience.
3. Prioritize the delivery of fast, seamless and personalized service.
4. Be authentic. Genuine relationships trump technology.
5. Personalize the tech "disruption" of your agency.

The New Buyer is the Millennial

The new buyer is changing. They will be different and they will impact how you sell insurance in a dramatic fashion.

If you haven't figured it out by now, "they" are millennials and they are now the largest generation in the workforce. They come with new buying attitudes, perceptions and demands on the buying process. Almost half of them currently work in business and professional services, while one-third are in financial services, according to a new Paychex survey on small business.

Being the largest generation they will also soon be the decision maker on what broker they will use when it comes to the purchase of health insurance for the company they work with.

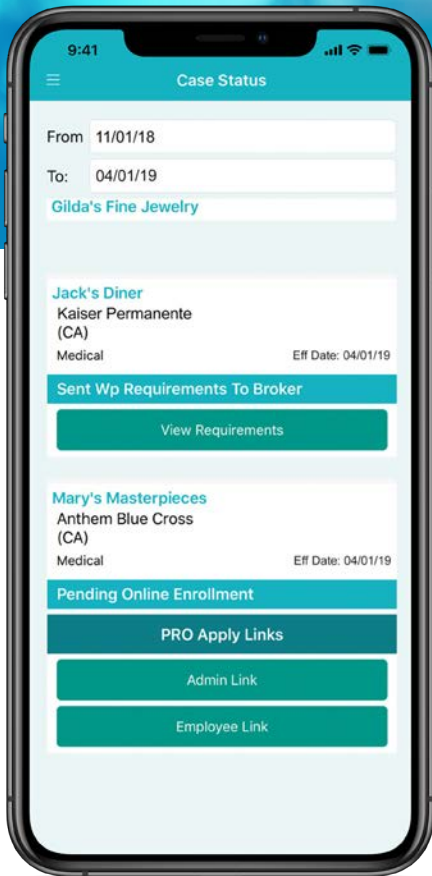
Which, in closing, I encourage you to think about: Are you millennial ready?



Joe Navarro has a long-standing history of serving the needs of agents in the health insurance industry. In his role at Warner Pacific he is the director of broker development, working with brokers/agencies on growing their business in a new market. Past president of LAAHU and recipient of the Paladin Award, LAAHU's most prestigious honor, Joe currently serves on the Board of Directors for the Ventura County Association of Health Underwriters.

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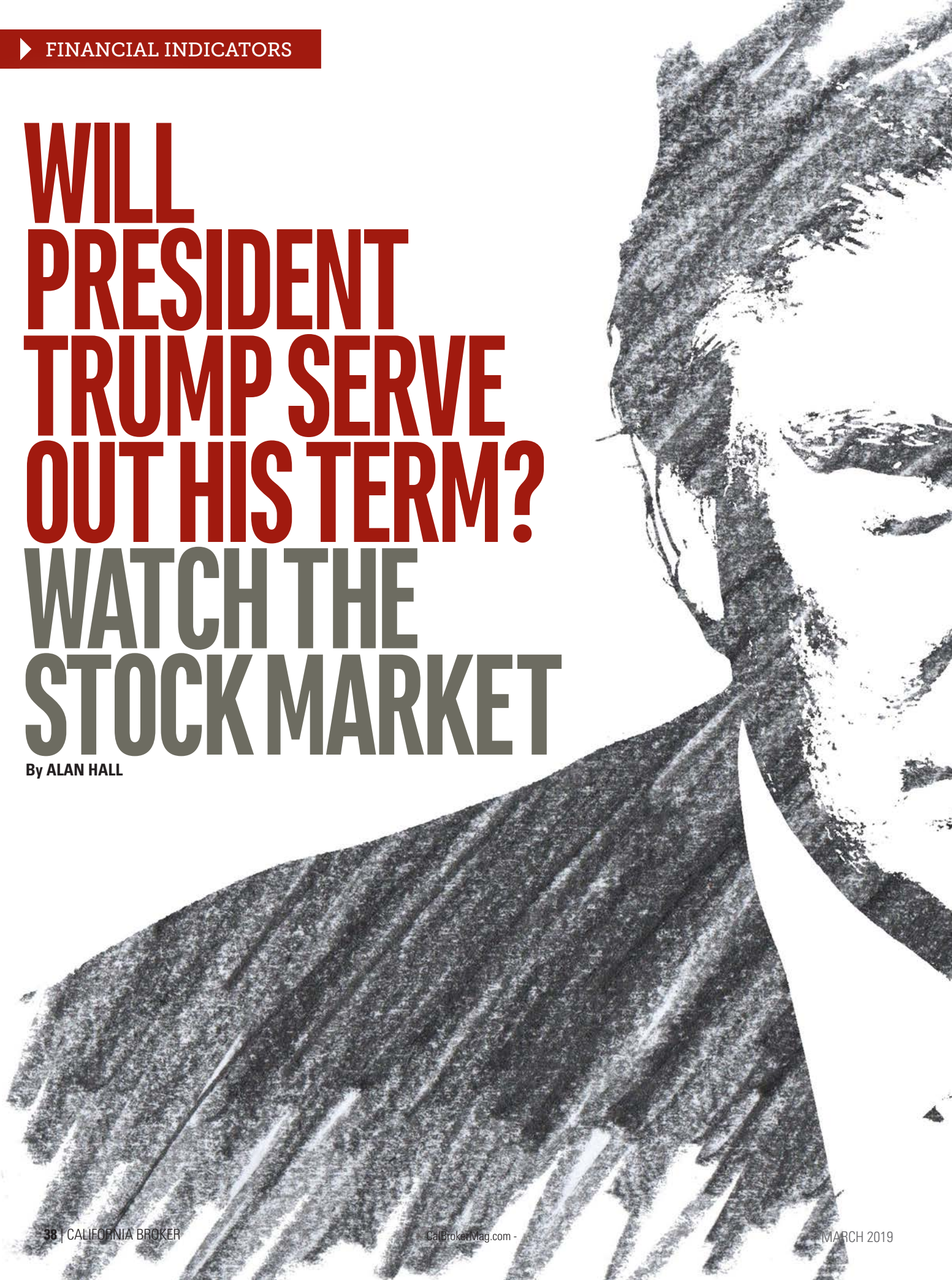



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WILL PRESIDENT TRUMP SERVE OUT HIS TERM? WATCH THE STOCK MARKET

By ALAN HALL





Those who want President Trump to stay in office should hope the stock market rises, and those who want him ousted should hope it crashes.

Why? History shows that the stock market is a useful indicator of people's attitudes toward the president. Socionomic theory proposes that society's overall mood regulates both stock prices and the public's perceptions of its leaders. Positive social mood makes society feel optimistic, nudge up stock prices and give leaders credit for these good feelings. Negative social mood makes society feel pessimistic, sell stocks and blame leaders for their bad feelings.

These tendencies are evident in presidential re-election outcomes. Presidents Hoover and Carter, for example, lost bids for re-election during trends toward negative social mood as reflected by declining stock prices. In fact, the stock market is a better re-election indicator than inflation, unemployment and GDP growth combined, as my colleagues at the Socionomics Institute demonstrated in a 2012 paper.

Social mood's influence is also evident in the results of U.S. presidential impeachments and near-impeachments. Twice in history, the U.S. House of Representatives has voted to impeach a president. In both cases, social mood was trending positively, as reflected by rising stock prices, and in both cases the Senate voted for acquittal.

Figure 1

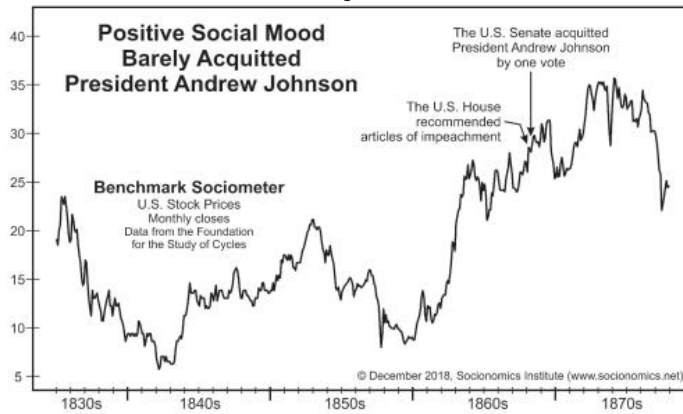


Figure 1 illustrates the timing of the first presidential impeachment. On March 2, 1868, the House of Representatives formally agreed to 11 articles of impeachment against President Andrew Johnson. The Senate took three separate votes, and each fell one vote short of the two-thirds majority necessary to remove Johnson from office. The Senate acquitted Johnson on May 26, 1868, during a stock rally that added to the 250 percent increase since October 1857.

Figure 2

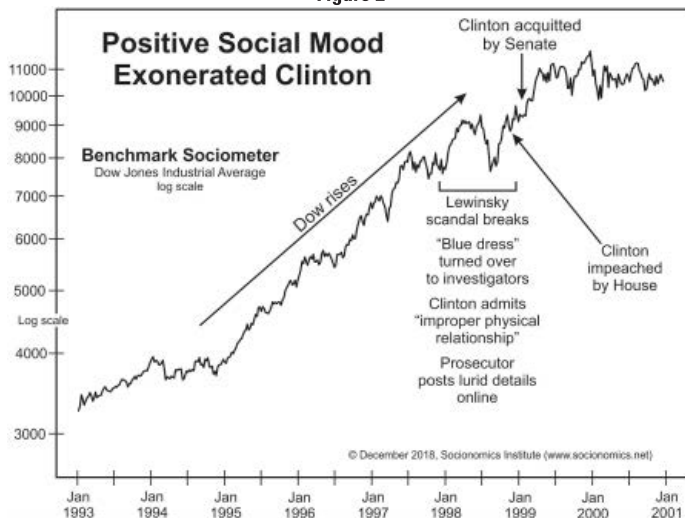
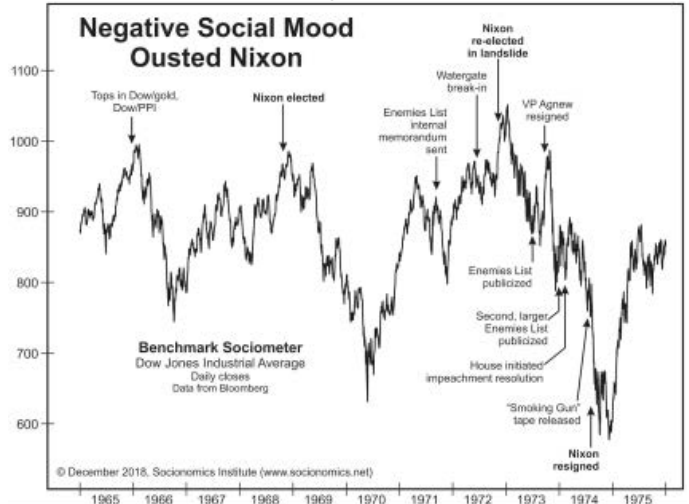


Figure 2 shows that a substantial trend toward positive social mood preceded President Bill Clinton's impeachment in the House and subsequent acquittal in the Senate. Note that some of the most serious events in the Monica Lewinsky scandal coincided with the largest downturn in the Dow during Clinton's presidency. Yet, as the Dow recovered, so did Clinton's approval ratings. And despite a \$70-million prosecution of Clinton's related perjury and obstruction of justice charges, the Senate acquitted the president as positive social mood lifted the Dow, Dow/gold and Dow/PPI to important peaks.

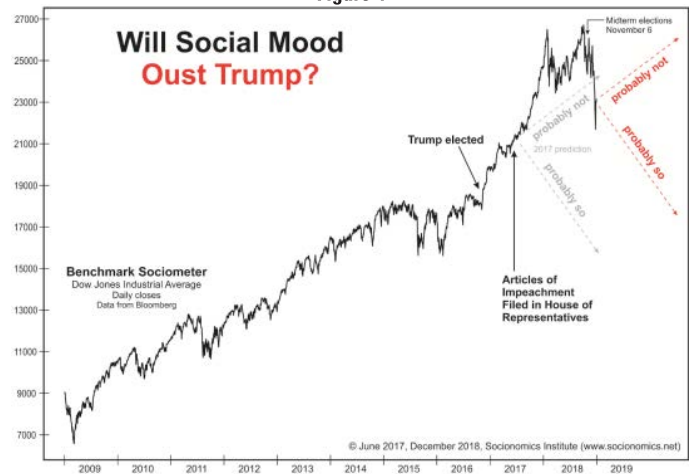
President Richard Nixon's near-impeachment and resignation from office serves as a textbook case of how social mood influences the fortunes of public figures. Figure 3 shows the Dow Jones Industrial Average surrounding his time in office. The soon-to-be-infamous Watergate break-in occurred toward the end of a strong 67 percent rally in the Dow from May 1970-January 1973. That trend toward positive mood helped

Figure 3



Nixon win re-election in a landslide. But as mood trended toward the negative, the public's view of its leader darkened, its appetite for scandal increased, the investigation accelerated, and Nixon's fortunes changed. With almost certain impeachment looming, Nixon became the first president to resign from

Figure 4



office on August 9, 1974.

What does this history tell us about the probability that President Trump will serve a full term in office? We considered this question in the June 2017 issue of The Socionomist. Figure 4 is a chart from that issue, updated to the present. It depicts the trend of social mood as reflected by the Dow. We left the gray arrows showing our 2017 analysis in place, and we added red arrows to indicate the possibilities going forward. In July 2017, Congressman Brad Sherman formally introduced an article of impeachment against the president in the House of Representatives. Yet as the market rose during 2017, President Trump—despite low approval ratings, tremendous staff turnover, unrelenting criticism from the political left and numerous indictments and charges of Trump associates in the ongoing Mueller investigation—did not face an impeachment vote. After the stock market peaked on January 26, 2018, however, the tone changed, and even some on the political right became more critical of the president.

We don't know what the Mueller investigation will ultimately reveal, but for Trump, the facts may not matter as much as the social mood.

Since the October 3 stock market peak, disapproval of the president has grown steadily louder and more strident. At the same time, the Mueller investigation has implicated more and more of the president's inner circle in illegal activities. The Democrats won control of the House in the 2018 midterms. A November 26 Gallup poll revealed Trump's disapproval rating had hit an all-time high. On December 10, Fox News's senior judicial analyst Andrew Napolitano said Trump could be charged with "three separate crimes and could be indicted while serving as president." By December 17, the Mueller investigation had issued more than 100 criminal counts and charged 34 people, 10 of whom have been found guilty. That same day, Wired published its list of "All 17 (Known) Trump and Russia Investigations" and said, "it's increasingly clear that, as 2018 winds down, Donald Trump faces a legal assault unlike anything previously seen by any president."

In the weeks since the Trump Foundation agreed to dissolve, and Secretary of Defense James Mattis and diplo-

mat Brett McGurk have resigned. On December 24, Time reported, "National Christmas Tree to Stay Dark During Holiday Due to Government Shutdown," and several news organizations ran stories with versions of The Atlantic's headline, "President Trump's Nightmare Before Christmas," as the stock market plunged. Of course, stalwart supporters of the president remain. Yet the number of oppositional voices is rising. A December 19 NBC News/Wall Street Journal poll found that 41 percent of Americans favor impeachment hearings.

We don't know what the Mueller investigation will ultimately reveal, but for Trump, the facts may not matter as much as the social mood. Fasten your seatbelt and keep your eyes on stock market indexes, our best reflection of the trend of social mood.

Alan Hall is a senior analyst at the Socionomics Institute and a writer for The Socionomist.

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HOW TO EVALUATE A

BY ROBERT C. LAWTON

Savvy clients will annually review the services they receive and what they are charged

Recently my dad passed away. To help my mom gain an understanding of her financial situation, I needed to learn about the financial advisor they were working with.

My parents came from a generation where it was considered rude to discuss money (and politics and religion). Good parents didn't burden their children with the stress associated with money, even if those children had grown children of their own.

When I was young, anything related to money was discussed in hushed tones. As a result, when Dad said that we didn't have any money, I believed him and thought we would be out on the street the next day. Only much later did I learn that some people feel they don't have any money unless they have \$100,000 liquid (this was not, regrettably, ever my dad's situation).

So I needed to evaluate my mom's financial advisor, hired by my dad, and the services that he was contracted to provide.

I am sharing the process I went through with the awareness that others might conduct a similar evaluation of you. In fact, I often tell people they should do such a review every year. Typically this is best done after the year concludes. I know that 2018's evaluation might have been a bit different from most because of the significant volatility we experienced in the markets.

I should mention that I run a Registered Investment Advisory (RIA) firm that has more than a half-billion dollars under contract, so I can assure you that I touched all bases during my review, an outline of which appears below.

Clients should know exactly what they are paying

My mom wondered what I would be asking her financial advisor. I said I would start by asking what he is charging and what services he is providing.

Mom said: "You can't ask him that, it would be rude. He might be offended."

Savvy clients, especially younger clients, will not feel this way. Most advisors (brokers especially) have transitioned from a transaction based service model to one that is consultative. It would be unusual now to charge only on someone's account activity (buying and selling of investments). So it is likely clients are being billed an annual percentage fee that varies based upon the amount of assets they have.

A couple thoughts here. Most advisors have a fee schedule that declines as assets increase. For example, 1 percent (or 100 basis points) on the first million and .50 percent (or 50 basis points) on anything above that. Unfortunately, most investors use multiple advisors and end up paying much more for advice than they need to, since they are always stuck in the meaty part of the fee schedule.

For example, if someone has \$1 mil-

lion with Advisor A and her spouse has \$1 million with Advisor B, they are paying \$20,000 per year in advisor fees (using the fee schedule above). However, if the couple used the same advisor, they could save \$5,000 per year. The easiest way for many couples to increase their portfolio returns is to place all of their investable assets with the same advisor. Worth pointing out to clients.

I talk to many investors who feel that paying 1 percent per year is too much when they have no trading activity. They complain that their advisor isn't doing anything for them but collecting a fee.

If you have a client who feels that way, recommend she place her assets with a discount broker (Schwab, for example) and hire you at an hourly rate each year to review her portfolio and make recommendations. In some cases this will make sense and save you the client's resentment.

Discuss fee transparency

Some advisors receive payments from mutual fund families, insurance companies and other financial institutions. As a result, it may take a little work for clients to determine exactly how much you earn from working with them.

The most sophisticated will ask you whether you receive any revenue in addition to the fees that the client pays to you. The most sophisticated will also

FINANCIAL ADVISOR

understand that it's best to work with advisors whose only source of revenue are the fees you pay them.

Understand your investment costs

Most of us invest in mutual funds. If these funds comprise the majority of the portfolio, clients will need to determine whether they are using the cheapest share classes available for each fund.

They may do their research or just ask you. Generally the institutional or "I" share classes are the least expensive. If your clients aren't in the lowest-cost share class for each of their funds, tell them why.

Be prepared for clients to ask about Fidelity, Schwab and Vanguard since they've been aggressively lowering their investment minimums and expense ratios on their index funds. For some clients it could be that a fund from one of these firms can be a less costly alternative to achieving their investment objectives.

Provide a list of your services

Once you have an understanding of what you are paying and how it is charged (quarterly, annually, deducted from assets, etc.), you need to understand what that is buying you.

Most advisors will conduct at least an annual, in-person review with their clients and provide continual portfolio monitoring services. More frequent reviews are possible (quarterly is the

most frequent you can get) but are dependent upon the amount you have with that advisor. If you have \$100,000 with your advisor, you aren't going to get quarterly reviews.

The more money you have with an advisor, the more services you can expect to access. Tax preparation, estate planning services, legal advice and document preparation are just some of the services that you could expect your advisor to either coordinate or deliver if you have a significant sum of investable assets with that advisor.

Advisor backgrounds are easy to check

Studies have shown that investment advisors who have been sued in the past are more likely to be sued in the future. Be aware that clients can check the background of their advisors using BrokerCheck.

BrokerCheck is a free service provided by the Financial Industry Regulatory Authority (FINRA), a financial industry regulatory agency under the direction of the Securities and Exchange Commission (SEC). Advisors are not notified when someone uses BrokerCheck.

Make sure you are giving leading-edge advice

Clients should hear about new ideas that may affect their investment portfolio from you and not from somewhere else.

If they are reading about something that they believe directly affects their investment strategy, or they hear from friends that their advisor is recommending something that appears to relate to their investment portfolio, and they haven't heard the same thing from you, that's a concern.

Clients check the marketplace

After clients have developed an understanding of what they can expect to receive from their advisor and what they will be paying, they may make a couple calls to other advisors to see how you compare.

They'll be satisfied if your fees and services are in the same ballpark with those of the other advisors they are checking. So make sure that's the case.



Robert C. Lawton, AIF, CRPS is the founder and President of Lawton Retirement Plan Consultants, LLC. Mr. Lawton is an award-winning 401(k) investment adviser with over 30 years of experience. He

has consulted with many Fortune 500 companies, including: Aon Hewitt, Apple, AT&T, First Interstate Bank, Florida Power & Light, General Dynamics, Houghton Mifflin Harcourt, IBM, John Deere, Mazda Motor Corporation, Northwestern Mutual, Northern Trust Company, Trek Bikes, Tribune Company, Underwriters Labs and many others. Mr. Lawton may be contacted at (414) 828-4015 or bob@lawtonrpc.com.

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