

CALIFORNIA BROKER

VOLUME 38, NUMBER 2

SERVING CALIFORNIA'S LIFE/HEALTH PROFESSIONALS FINANCIAL PLANNERS

NOVEMBER 2019



FINANCIAL PLANNING: UNDERSTANDING THE SECURE ACT



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- Small Group Survey 2019
- Vision Benefits
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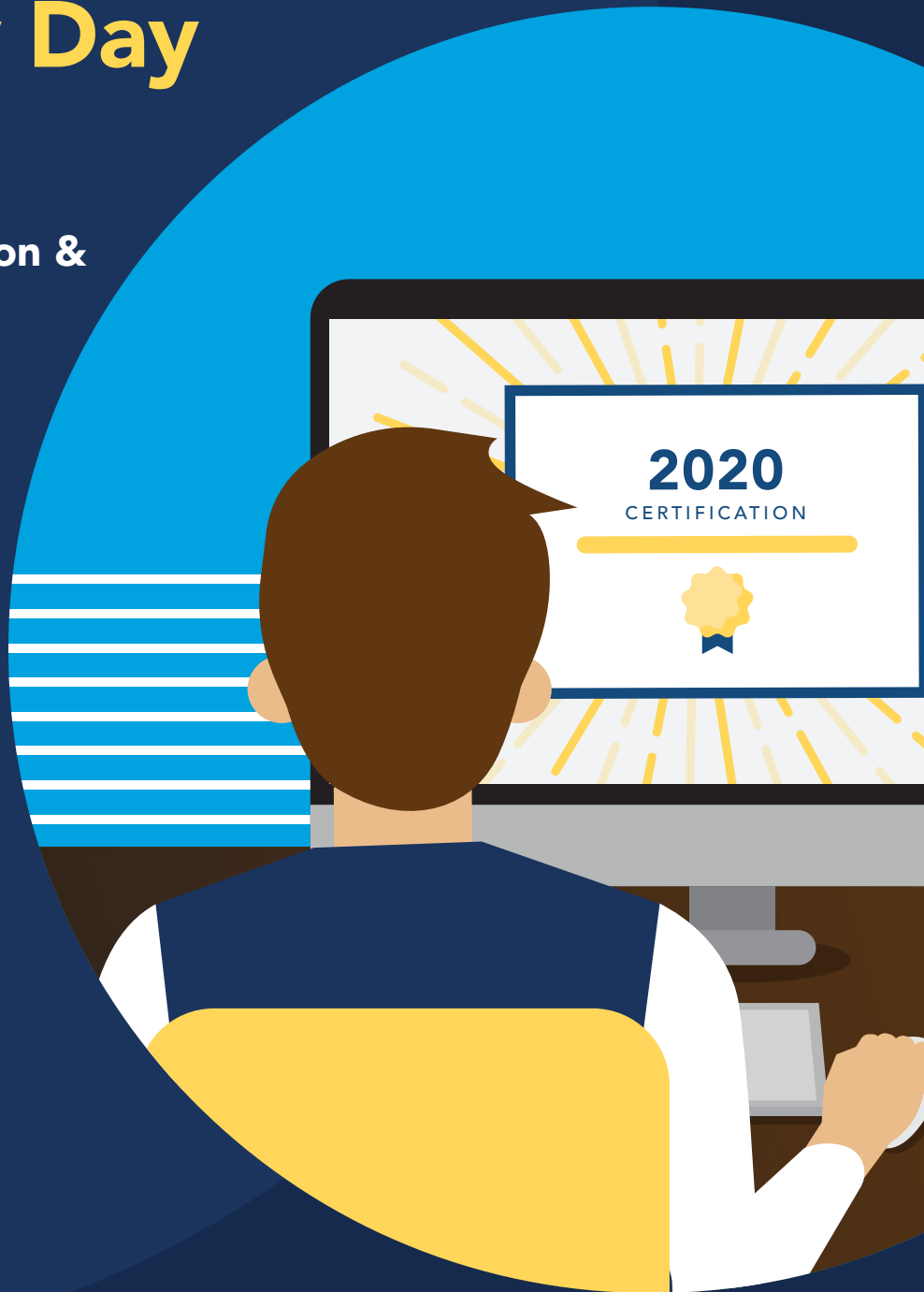
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For a complete list of the program rules go to: rebrand.ly/AgentIncentive2020

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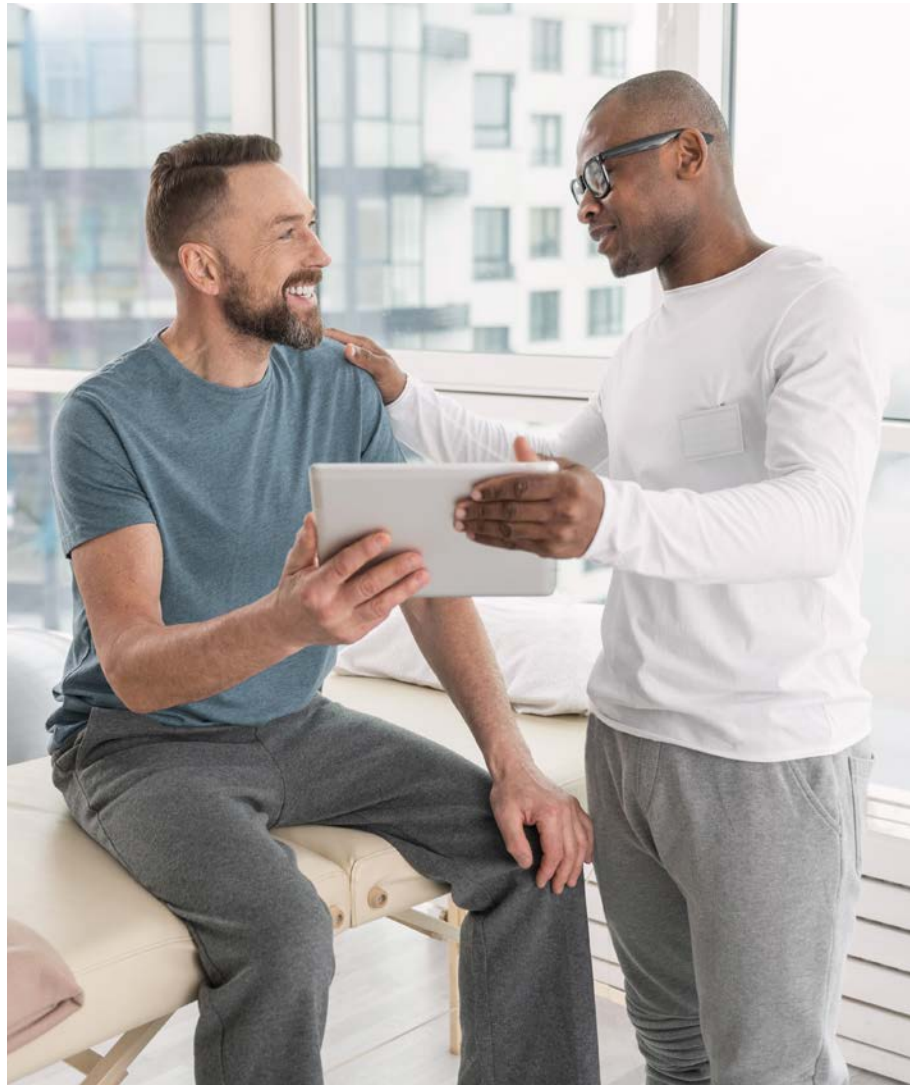
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Mapping 2020 Medicare Changes

By JAGGER ESCH

January 2020 will bring many changes in Medicare that impact current and future Medicare beneficiaries. Top of the list is the retirement of First-Dollar Coverage plans and introduction of a new high deductible plan.

The plan that began as merely a rumor, High Deductible Plan G is now a guarantee. This plan replaces the current High Deductible Plan F. Although, the Supplement High Deductible Plan G (HDG) doesn't have a debuting purchase date on the Medicare market just yet, we anticipate a date soon.

We expect changes in first-dollar coverage plans and a new high deductible plan.

One of the biggest shifts starting in the new year is with the first-dollar coverage plans. These policies will no longer be available to any enrollees eligible for Medicare coverage after January 1, 2020.

While Medicare is getting rid of these plans to newly eligible enrollees after the new year, current members may keep their plans. First-dollar plans are supplement insurance plans that leave the beneficiary with a zero out-of-pocket expense. Future beneficiaries can expect the most change as they lose eligibility for Plans C and F. However, they'll be eligible for other options starting in 2020.

First-dollar coverage plans

The three supplement plans Medicare considers first-dollar are plans C, F and High Deductible Plan F. Due to the Medicare Access and CHIP Reauthorization Act in 2015 (MACRA), any Medigap policy that pays for the Part B deductible will no longer be available to any beneficiary.

Certain members of Congress think beneficiaries abuse their healthcare services because they don't have a financial responsibility to pay for them. With zero out-of-pocket costs, seeing the doctor for any reason has become more convenient and less costly.

To curb this behavior, Congress wants to make all beneficiaries meet a Part B deductible amount. By doing so, they hope to prevent some of the "overuse" of healthcare services. Translation: policies will require all members to first meet the Part B deductible before any coverage be-

gins. Some may argue that this deductible may keep many individuals from getting the healthcare they may need. Many beneficiaries are on a fixed income, and this new policy may be out of their budget. The problem with this is as we all know—avoiding the doctor for a small problem can result in more serious health conditions down the road.

Impact on beneficiaries

Individuals that aren't Medicare "eligible" until after 2020 are those who turn 65 after January 1, 2020. Anyone turning 65 before 2020 may continue to enroll in the first-dollar coverage plans even if they retire after the new year. This also includes enrolling in any new policies.

Unless beneficiaries who turned 65 prior to 2020 are looking to compare coverage, benefits or rates, there's no need to worry about these upcoming changes. Members currently holding a first-dollar coverage policy will be grandfathered into their plans. This means they can keep their plans without needing to make any changes. However, it's likely there will be a rate increase for coverage.

Three 'waiver' states see big impact

In 1990, Massachusetts, Minnesota and Wisconsin received waivers that kept them from mandating the standardized Medigap plans. The waivers were given because they were the only states that already had their own plans in place prior to the 1990 policy.

Now, for the first time in decades, these three waiver states must comply with the changes happening in 2020. This includes eliminating any plans that offer coverage for Medicare's Part B deductible. Although these states continue to have their own supplemental policies regarding supplement coverage, the 2020 MACRA changes will impact them, but not significantly.

The big change will be like the rest of the country: Newly eligible Medicare enrollees can not join any retiring first-dollar plans. Additionally, plans must require all beneficiaries, new and current, to pay a Part B deductible before receiving coverage.

Look for the annual announcement every September-October from the Centers of Medicaid and Medicare Services



(CMS) when the new deductible amount for Part B will be given for the following year. Beneficiaries can use this information to prepare for the next year and budget accordingly.

Alternatives to first-dollar coverage plans

Individuals who become Medicare-eligible AFTER 2020 will still have alternatives to first-dollar policies that may keep costs low. Remember, the difference in these plans and first-dollar plans is the Part B deductible. As of 2019, that deductible is \$185 annually.

One alternative to Plan C is Plan N—known as a cost-sharing plan. Plan N is a good option for individuals wanting to save on any premium costs. However, beneficiaries do incur a co-pay of up to \$20 for doctor visits and up to \$50 for emergency room visits, and may have excess charges applied. Note that some states don't allow excess charges and even when they do, not all healthcare providers charge them.

Beneficiaries who like what current Plan F offers should seek Plan G. These two options are almost identical. The only difference is the deductible requirement for Plan G. As the most comprehensive supplement policy, Plan G covers almost all medical and hospital costs (including excess charges). Plan G is already becoming popular among beneficiaries, due to the great coverage and lower premium cost than retiring Plan F. Plan G is a great choice for people who want the most coverage possible. After meeting the Part B deductible, beneficiaries shouldn't have any further costs for Medicare-covered healthcare services.

Medigap Plan F High Deductible isn't technically a first-dollar policy. However, it's up for retirement in 2020 since it falls under Plan F. Not to worry—Medicare is introducing a High Deductible Plan G to take its place.

Medicare Supplement High Deductible Plan G

No more rumors or uncertainty. Medicare is introducing the

High Deductible Plan G (HDG) in the new year! And it will be available to both current and new beneficiaries. The HDG plan and the High Deductible Plan F (HDF) will likely have the same deductible cost. The big difference between the two will be that the HDG plan requires beneficiaries to meet the Part B deductible before coverage begins.

As of today in 2019, the HDF policy has a deductible amount of \$2,300, while the Part B deductible is an annual \$185. In 2020, the HDG won't offer coverage for the Part B deductible. It's likely this cost will apply to the total plan deductible. There's not much of a difference. The benefit summary for the HDG policy isn't yet available, but we expect beneficiaries will have to meet the deductible requirements before coverage begins.

Medicare supplement high deductible Plan G enrollment

The best policy for a person depends on many factors. For example, location, eligibility and a person's health conditions will weigh greatly on which plan offers the best coverage.

Many seniors favor the standard Plan G choice. Although, for some, the lower premium costs of the upcoming high deductible policy may be a better option. As enrollment for the new plan isn't available to enrollees yet, we expect a date the closer it gets to 2020.

It is important beneficiaries postpone cancelling any coverage until new policies are in place. Otherwise, a lapse in benefits or denial of coverage is possible. Remember to discuss any changes with a licensed, professional Medicare agent before making any decisions.

For those new to Medicare or getting close, looking at different pricing and coverage options is a great way to be proactive. And, of course, remind clients to look at different carriers before choosing coverage. Working with you ensures beneficiaries make the best decision for their healthcare needs.

Jagger Esch is the president & CEO of Elite Insurance Partners.



Victoria Alexander, Editor of Cal Broker magazine, receiving the CAHU Award for “Decades of Exceptionalism and Support” of the industry.

CAHU Awards Include Cal Broker!

The annual convention of the California Association of Health Underwriters (CAHU) took place last month in Costa Mesa. Attendees were treated to some invaluable sessions, with a clear emphasis on humanizing our client relationships. Some of the ones we dropped in on included Stan Israel’s session on long term care issues that Medicare and MediCal don’t address; LISI’s Ken Doyle on helping agents define their “why” and Tony Baffo of Employer Driven Insurance Services presenting on HRAs, HSAs and alternate funding. Alan Katz of NextAgency gave us some ideas about how to make our online communications sizzle and stand out from the crowd. A real favorite, though, was Jan Mesa of Word & Brown discussing leadership (the doctored Back to the Future photos alone made it a hit).

With the theme “Back to Basics: Preparing for the Future,” John Word, III, co-founder of The Word & Brown Companies, gave a rousing keynote in which he reminisced about his days starting out in the industry—including the use of the good ol’ Thomas Guide—and how, despite the changes, leaders in insurance and employee benefits understand one thing: customer service is at the heart of everything. Jessica Word, president of The Word & Brown General Agency, later took the stage and seconded her father’s message that producers must constantly look for ways to increase their value to customers. Do this, and victory shall be yours.

Part of the message from the stage was an appeal for producers to support associations, which work tirelessly for their benefit. And speaking of support...Cal Broker magazine was honored for the work we do informing and educating. Immediate past president Dave Fear, Jr., handed out the award. He noted that Cal Broker was being honored for “decades of exceptionalism and support” of the industry. Thanks, CAHU!



PHOTO CREDIT: RAMON SANDOVAL

Orange County Chapter (OCAHU) cleaned up at CAHU this year!

OCAHU won the most awards, including: Highest Retention 2019; Large Chapter of the Year 2018-2019; Outstanding Chapter Membership Growth 2018-2019; Large Chapter Outstanding Newsletter/Magazine; and past president Ryan Dorigan received the Presidential Citation from Dave Fear, past President of CAHU.

Regional Sr. Sales Executive MaryAnn Trutanich of Kaiser enthusiastically received the Retention Cup on behalf of the Orange County Chapter. Other CAHU accolades went to:

Small Chapter of the Year: Ventura County AHU

Medium Chapter of the Year: Inland Empire AHU

Large Chapter of the Year: Orange County AHU

Outstanding Newsletter (tie): Desert Cities AHU and Orange County AHU

Outstanding Chapter Website: Los Angeles AHU

Membership Growth: Orange County AHU

Membership Retention: Orange County AHU

Robert K. Shepler Memorial Award for Outstanding Individual Recruiter: Jessica Moraitis (Los Angeles AHU)

Executive Board Member of the Year: Brad Davis (Sacramento AHU)

Presidential Citation: Ryan Dorigan (Orange County AHU)

Member of the Year: Deborah Blander (Ventura County AHU)

SIIA 30th Annual National Conference



PHOTO CREDITS: VICTORIA ALEXANDER
 Jeff Kelly of Buckingham Insurance Services with Cal Broker associate publisher Naama O. Pozniak.



Casey Macpherson of RxManage traveled all the way from New Zealand to attend SIIA.



Bill Miller of Drexel led conference attendees in The Star Spangled Banner after the recording failed.



Cal Broker advisory board member Dave Fear, Sr. of Shepler & Fear, has attended SIIA for the last five years.



SIIA newcomer Lanea Riley of Filice came looking for solutions.

SIIA Serious Business in San Francisco

Nearly 2,000 exhibitors, speakers and attendees convened last month at the Marriott Marquis in downtown San Francisco for the 39th annual national conference of the Self Insurance Institute of America (SIIA). The three-day conference was jam-packed with sessions on self insurance, captives, stop-loss, innovative drug solutions, wellness and more. Folks were friendly and down to earth, but overall the tone was quite serious. Those attending included brokers, TPAs, prescription drug benefits managers, speakers from the Rand Corporation, UC Berkeley, several state departments of insurance, Berkshire Hathaway, Blue Cross, United, Unum, Sun Life...the list goes on. The conference keynote happened on Tuesday, October 1.

Notably, "I Will Survive" played as attendees filed in. Later when the recording of Whitney Houston's Star Spangled Banner inexplicably went out mid-song, Bill Miller, CEO of prescription benefit manager Drexel, picked up where Whitney left off. Of course, soon everyone joined him to finish the song. But anyone who does that during a packed conference deserves a special mention.

Another special mention goes to comedian Greg Schwem, who did a great job lightening up the mood of the event. Who knew that there was someone who specialized in making business funny?

What isn't a laughing matter: the fact that going to SIIA represents a considerable time and financial investment. So we asked a couple of attendees what brought them there...

"I love attending the SIIA National conference as everyone—be they brokers, employers, solution providers or vendors—are all there with the common goal of bringing value and innovation to self-insured companies, resulting in an event that has a fantastic energy to it."

Casey Macpherson, RxManage. (rxmanage.com)

"I came to talk to other professionals and learn new strategies. I want a better version of what's available on standard markets."

Lanea Riley, Filice Insurance, San Jose (filice.com)

"This conference is absolutely directed at what my clients need now. Solutions like reference based pricing haven't had as huge of an impact here in California because carriers still dominate here. But coming to a conference like this really gives me a better perspective of what's happening outside of California."

Dave Fear, Sr., Shepler & Fear General Agency (sheplerfear.com)

"The SIIA Conference puts all of the most powerful thinkers under one roof. The creativity and determination to solve problems is worth the price of admission. I've always lived by the motto that you'll never work a day in your life if you love your job. This conference reminds me how much I love my job."

Jeff Kelly, Buckingham Insurance Services, Doylestown, PA (buckinghaminsurance.com)

SIIA's 40th Annual National Conference will be Oct. 11-13, 2020, in Phoenix.

Eye-opening revelations at SIA

By Naama O. Pozniak

The SIA conference was an incredible gathering for those endeavoring to introduce, share and collaborate about the self-insured market,

It was a critical opportunity to gain a deep understanding of self-funding as a cost-saving measure when matched to appropriate businesses. Self-funding concepts are not easy to explain, yet are super necessary for our conversation with each and every employer. No health care plan is a one size-fits-all solution. It is critical to develop a clear understanding of the mechanisms of self-funding and make sure our clients know what they are purchasing. There are many choices and many experts in the field who can help us deliver this option competently to the market.

Conversation tips for each and every employer:

- Compare self-funded options with the fully insured plans which cover the majority of California employers
- Determine how science, transparency, quality and education can apply to achieve further cost savings
- Introduce the network solution, medical management, Direct Primary Care, Claims administration, PBM RX Solutions, Disease management, wellness, etc.

As a strong believer in self-healing and the potential of the mind over body journey, it was mind-blowing for me to learn where the fully insured dollar goes. The session about CANCER revealed that it is one of the top causes driving our healthcare costs to rise:

- 45 million Americans spend \$300 billion annually on healthcare, almost one third of which is spent on cancer care.

• The direct cost for hospital care for cancer is higher than the proportion of direct costs on hospital care for all diseases.

• While breast cancer represents only 15% of cancer claims, the total cost is nearly three times that of the next closest cancer condition. Those costs, like all cancer treatment costs, are rising.

• From 2015 to 2018, claims costs for injectable drugs rose 10%, with cancer medications leading the way.

• In 2018, injectable drugs used in the treatment of cancer made up 71% of the top 20 high-cost injectable drugs list. Some injectables generate high costs because they are frequently prescribed, even if their average cost is relatively low. The FDA approves these, for use on label or off label.

Part of the increase is tied to an evolution in treatment and solutions. For example: use of Keytruda has seen rapid expansion. Keytruda is not a chemotherapy or radiation—it helps the immune system to attack cancer cells and is being used for both blood and solid organ tumors. But Keytruda costs \$113,300, on average per patient.

I personally believe there is a better way! When treating cancer, we could benefit from looking at the healing process holistically. While drugs like Keytruda may make a difference, gene therapy is a huge discipline to explore. My understanding of this approach is that it allows practitioners to examine cancer cells and find more ways to treat the specific cell discovered.

The take away for me is: when thinking about our employer clients, we have an obligation to look for opportunities to root out waste that also drives up treatment costs for conditions like cancer. More importantly, placing an emphasis on wellness versus disease management can have a significant effect on costs.

MORE NEWS

LAAHU Small Group Carrier Panel Attracts 100+

By Linda Lalande

The LAAHU Carrier panel on Oct. 17 at the Skirball attracted more than 100 insurance professionals. “We are all doing important work by helping millions of Californians get health care,” opened Brian Sullivan, Market VP, Humana. “Even during busy open enrollment season, over a hundred of you showed up. That shows real commitment to your clients.”

The meeting started with a legislative update by DeDe Kennedy-Simington,

president of BenAssist, who conveyed LAAHU’s commitment to lobbying for the industry (see <https://www.cahu.org/our-issues>).

Giving back was a theme carried forward with an update on the mentoring program, which encourages members to hire interns and attract new recruits into the industry. Attendance to the upcoming holiday party Dec. 17 was also encouraged. Proceeds from the party will support Camp Ronald McDonald, a program for kids with a devastating health diagnosis. Last year LAAHU sent 150 kids to camp.

For the panel, representatives from eight carriers shared updates and 2020 offerings. In the fold were Kristen Berthiaume of CHOICE Administrators, Ernie Bernal of Health Net, Amy Dalton of Unit-

edHealthcare, Mike Ciciarelli of Anthem, Michael Lujan of Oscar Health, Shad Johnson of Blue Shield, Chris Patton of Kaiser and Dan Tyler of Covered California. Alan Katz, CEO, Take 44, served as moderator, supported by LAAHU leaders Sullivan and Scott Gilbert.

Katz began by saying “We are thrilled so many carriers are still in California!” eliciting a hearty laugh from the audience. Each got to share what they wanted brokers to know. The focus for all was on partnerships—with a compassionate personal touch. The stated mission of helping Californians lead healthier lives received heart-felt agreement by all assembled.

For more information: www.LAAHU.org. Email Info@LAAHU.org or call 800-676-1628.

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What Might Make Californians Insecure About the SECURE Act

(And What To Do About It)

By MORGAN CHRISTEN

Earlier this year the U.S. House of Representatives passed the SECURE Act, which will modify some of the current laws that govern retirement plans. SECURE is the acronym for Setting Every Community Up for Retirement Enhancement. Overall, the legislation makes it easier for Americans to save money for retirement and contribute to their IRAs longer, while possibly creating new tax credits for small businesses that establish 401k plans for their employees. Given that one quarter of Americans have no retirement savings whatsoever—and 13% of those workers are 60 or older - additional incentives should be considered of critical importance.

One of the provisions of the SECURE act is extending the Required Minimum Distribution age out to 72 years old from 70 ½. Allowing individuals who are still working to delay distributions for an extra year-and-a-half while allowing continued contributions could benefit one's portfolio significantly. While this is a positive aspect of the legislation, it probably won't have a huge net effect for individuals currently saving for retirement and building their IRAs.

A lesser-known provision, however, could have a dramatic negative impact and will significantly affect rules for

non-spousal beneficiaries inheriting retirement plans. This impact deals with a beneficiary's ability under the current law to "stretch" an inherited IRA. It is generally recommended for the non-spouse beneficiary to take distributions over their lifetime (per IRA Required Minimum Distribution Tables)—commonly referred to as a "Stretch-IRA." The value of this for a beneficiary is they potentially can also stretch out the taxes due over a long period of time.

The pending legislation would simply scrap this widely used strategy. Based on what we know about the SECURE act, beneficiaries would need to deplete the inherited retirement assets in just ten years. Since Congress passed the legislation overwhelmingly and in bi-partisan fashion, this dismantling of the Stretch-IRA appears to be a fait accompli.

The requirement to take the funds out over a shorter time period could greatly spike annual taxable income compared with taking distributions over a beneficiary's lifetime. While the Senate's version of the bill (RESA 2019) contains exclusions to provide some tax relief, it remains entirely unclear if those provisions will become part of the final law.

The implications for California residents could be particularly significant. Home to beaches, deserts, moun-

tains, our state also boasts some of the highest tax rates in the nation. The rates in California range from 1% to 12.3% with a 1% surcharge for those with incomes over \$1 Million. And that top marginal income tax rate of 13.3% is the highest in the country.

According to the Census ACS 1-year survey, the median household income in 2017 was \$71,805. For a 50 year-old taxpayer earning that median income, and who just inherited a \$400,000 IRA, under the SECURE Act they would now need to take \$40,000 (assumes no growth over the term of distribution) out per year for ten years. If that taxpayer is married filing jointly, their income would jump from the California median \$71,805 to \$111,805, while their state tax bracket would shift from 6% to 9.30%.

Likewise, a high-earning California resident in the same scenario would be adding these distributions to their annual income. If that additional income takes them to the top bracket, they could see roughly a 50% tax rate (37% Fed and 13% CA State).

When we start looking at available strategies to mitigate the higher tax impacts of this legislation, it becomes clear that pre-planning is essential. For individuals with large IRA balances, it could be time to spend more of their IRA's and retirement accounts, as it is not a great asset to leave to heirs.

(CONTINUED ON PAGE 27)

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SMALL GROUP SURVEY

2019

COMPILED BY THORA MADDEN

1. What are the most important trends in the small group market?

**Brent Goode,
VP of Broker Solutions and
Public Sector Aflac:**

Many small businesses are already aware of traditional supplemental insurance offerings. A growing trend for small-business owners and HR managers is more than benefits: It is the need to balance many responsibilities, from payroll to compliance to employee relations. They are looking for not only a benefits provider, but also benefits enrollment and administration support.

With Aflac, small businesses receive full-service enrollment support, including unique educational tools that help employees determine the benefits that best fit their needs and personalized communications strategies for each business partner based on location, worksite type and communications capabilities. From brochures, email templates and videos to in-person presentations, we offer customizable resources that help meet each business' ideal communications strategy. Our digital platform streamlines the enrollment and administrative processes for employees and benefits managers alike at no extra cost.

**Todd Mason, territory manager, California
South Coast, Colonial Life:**

We still find that many small businesses are confused by healthcare regulations and are continuously besieged by rising health care costs. As a result, employers are transitioning to higher deductible plans and are shifting a greater share of the costs to employees. And many of the smallest groups, primarily those with under 50 employees, are not able to offer health benefits at all. In addition, small businesses rarely can afford a

The most important trend in the small group market is expanding the availability of benefits, especially non-traditional, ancillary benefits that complement core benefits.

—Jessica Moser

benefits consultant to assist in navigating their challenges and this makes offering supplemental so important.

Joseph Stefano,
Divisional VP, Western U.S.,
The Guardian Life Insurance Company of America:

One of the most important trends impacting the small group market (Guardian defines as firms with fewer than 50 employees) is that more than seven in 10 workers in small firms rely on their employer as their household's primary source of health, life insurance, disability insurance and retirement savings.

A convergence of market forces are prompting small firms to rethink the role of benefits in their companies. Attracting and retaining talent (particularly millennials), controlling costs and maintaining compliance are among their top benefits priorities. In response, many are addressing workforce health, leveraging technology, and outsourcing administrative rolls to improve the employee experience and increase efficiency.

All that said, small businesses are "cautiously optimistic" about their firm's growth. The Guardian Life Insurance Company of America® (Guardian) found that more than 60% of firms anticipate revenue growth in the next five years and nearly half (47%) expect to create new jobs and launch new products and services.

As a result, staffing is a top business challenge according to Guardian's "Small Business, Big Benefits" Workplace Benefits Study, with 37% of respondents saying it's a top hurdle for small business owners/leaders (second highest after sales/revenue growth). The issue many small firms run into however, is that the gap between large and small employers in terms of benefits offered—and the level of employer contribution—making it difficult for small businesses to compete for talent.

How small businesses utilize their benefits is also shifting, with 45% of small firms increasing their spending on HR Technology since 2015.

Chris Patton, Senior Director of Strategic Business Development and Retention, Small Group, Kaiser :

Small groups are leveraging Employee Benefits more than ever to recruit and retain employees. The labor pool is extraordinarily tight as a result of a generally strong economy and the resulting historically low unemployment rate.

Employers are rounding out incentive programs with benefits and are sensitive to not only price but value for the dollar. Younger employees place an emphasis on the entire compensation arrangement and look at the entire offering inclusive of the richness of non-monetary compensation.

Jessica Moser, SVP and segment head, Small & Specialty Business, MetLife Group Benefits:

The most important trend in the small group market is expanding the availability of benefits, especially non-traditional, ancillary benefits that complement core benefits. Today's workforce looks to their workplace as the center of their financial life, and so employees demand a more customized benefits experience. This means employees want what makes the most sense for them. Variability, such as tiered pricing, is key for important benefits such as dental, vision, life and disability, but also in benefits that are considered voluntary or ancillary, such as legal plans, hospital indemnity, and even pet insurance. Research, including MetLife's 17th annual Employee Benefit Trends Study, shows that a customized benefits plan increases employee loyalty, and that customization is highly valued. In fact, employees want a greater variety of benefits to be available, even if they have to pay for some of those benefits themselves.

Tim Rhatigan, SVP of Small Business, UnitedHealthcare of California:

Employers are increasingly looking for ways to help provide their workforces with access to a more personalized, convenient, and simplified care experience. By using technology, pro-consumer benefit designs and more modern care models, health plans and care providers are collaborating to help achieve the triple aim of better care, better health and lower costs.

Emerging technologies, such as telemedicine and connected devices, can help remove barriers to care and make treatments more convenient, cost-effective and data-driven. Meanwhile, the growing use of wearables—combined with the strategic use of incentives—is proving effective in motivating people to take charge of their health.

Another key trend is the transition away from fee-for-service payment models to a value-based care approach. Value-based care models can foster increased accountability for quality and cost, such as shared savings pro-

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“Today’s HR technology and growth of voluntary benefits is making ancillary benefits more attainable and manageable for small groups than in the past.” —Joseph Stefano

grams and performance-based contracts, and reward health care providers for effectively managing people’s health. For instance, UnitedHealthcare has developed more than 1,000 accountable care organizations (ACOs). We have seen that the most effective ACOs perform better than non-ACOs on 87% of the most common quality measures, including reducing hospital admissions by up to 17% and costs by up to 12%.

Developing a health care system focused on quality – and using technology and incentives to help encourage healthier habits – can drive important improvements in how health plans and care providers collaborate to support people on their journeys toward health.

2. Are certain ancillary benefits more suited to small groups?

Brent Goode:

Many small businesses want to support their employees by offering a variety of benefits but are understandably concerned about widening their benefits packages without a plan to mitigate costs. With supplemental benefits, employers can decide how much to contribute to employee policies, if at all. Aflac’s brokers and agents counsel small groups, helping them navigate the nuances of health care changes in the U.S. and decide what benefits make sense to offer their workforce.

Popular benefits among small groups tend to be dental, vision, short-term disability and life insurance. These can be key contributors to employee happiness and retention. In addition, insurers like Aflac often include access to value-added services that complement supplemental coverage, such as financial and legal support, telemedicine, wellness programs, and health advocacy and bill negotiation services. These provide value from the first day and can be a differentiator in hiring and retention efforts for small groups.

Todd Mason:

Many employees at small businesses, just like large businesses, are the sole breadwinners for their family. With growing numbers of America’s workers living paycheck-to-paycheck, they need the base coverage of life insurance, disability insurance and accident insurance to protect their income if they are unable to work. Another

key benefit that employees expect to be offered, and a benefit that helps protect the entire family, is dental. Our launch of a new dental product and the value-adds we are able to offer has been tremendously successful for small employers.

Joseph Stefano:

Today’s HR technology and growth of voluntary benefits is making ancillary benefits more attainable and manageable for small groups than in the past. We see tremendous opportunity among small groups to offer supplemental health benefits, like accident insurance or critical insurance, to help increase their workforce’s financial security. The advantage of offering voluntary benefits is that the cost of these benefits is largely picked up by the employee, while at the same time, allows for small groups to offer robust employee benefits packages.

While some small businesses struggle to offer a fruitful supplemental benefits package, Guardian’s study found that as of 2018, 38% of small businesses offered accident insurance (up 15% points from 2015), 25% offered critical illness insurance (up 14% points from 2015) and 21% offered hospital indemnity insurance (up 24% points from 2015). Offering these supplemental benefits can help employees fill the gaps and attract potential employees for small firms.

Our research also supports the desire employees have in mental health/substance abuse rehab benefits, which employers may have via their Employee Assistance Program. Our data shows 22% of workers want benefits to support mental health/substance abuse, which we anticipate will continue to be of interest in the years to come. Finally, in the past five years more small businesses have established flexible work schedules, remote work policies, paid leave and wellness programs to improve workforce health and help employees balance their work demands and personal responsibilities. Our study confirmed that nearly 1 in 4 small firms offer wellness programs (mainly health risk assessments, weight loss programs, gym membership discounts); and 1 in 3 allow for flexible schedules and telecommuting.

Chris Patton:

More and more the benefits package is considered as a whole for smaller employers in the enrollment season. Dental, Chiropractic, acupuncture and even pet insurance



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A THOUSAND MILES
BEGINS WITH THE RIGHT
HEALTH INSURANCE.**

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With growing numbers of America's workers living paycheck-to-paycheck, they need the base coverage of life insurance, disability insurance and accident insurance to protect their income if they are unable to work.

—Todd Mason

are seeing greater emphasis in today's market. Small employers are often looking to bundled offerings for administrative ease which makes medical offered with dental attractive.

Jessica Moser:

As employers struggle with increasing healthcare costs, employees are squeezed to pay higher deductibles and co-pays. With more and more small businesses instituting high deductible health plans to combat those rising costs, their employees may find themselves responsible for thousands of dollars in medical costs before their health insurance kicks in. For this reason, supplemental health policies are no longer just for larger employers. Small employers can differentiate and provide value to their employees by offering ancillary benefits as well. For a relatively low cost per paycheck, employees can have more peace of mind that they won't be overly financially burdened if they face a significant covered event. Policies that are considered supplemental health, like Accident, Critical Illness and Hospital insurance are designed to be easy to use, and we foresee significant growth in these types of benefits.

Tim Rhatigan:

Dental and vision are the two most popular ancillary—also known as specialty—benefits. In fact, 77% of people said having vision and dental coverage options is important to them during open enrollment, according to a recent UnitedHealthcare survey.

Many people select these two benefits because they expect that they, or their family members, will use them regularly. There is also growing evidence of a link between dental and eye health to overall health, as well as to an array of chronic medical conditions. Having these benefits can help prevent disease before it starts and, if necessary, improve the prevention or management of certain chronic conditions.

Some employers are rounding out their benefits options by adding other specialty plans, including accident, critical illness, disability and hearing. Offering these plans as part of an employee's menu of benefit options maximizes the effectiveness of a company's health care dollars, while helping build a culture of health and providing families with additional coverage.

3. What are the keys to being a successful broker to small groups?

Brent Goode:

The first key to being successful in reaching the small group market is to know its vastness: small businesses make up 99.9% of all U.S. companies, according to the Small Business Administration. It is both humbling and encouraging to know that there is no shortage of opportunity available today.

Keeping benefits simple and easy are key. Small business owners have many responsibilities, so a complicated benefits process with multiple carriers is likely unattractive. More favorable to them are brokers who can bundle an array of offerings and provide white-glove service. However, that does not mean sacrificing customization. Brokers can create more value by making it easy to offer flexible benefits options as well as scheduling personalized consultations to ensure the needs of their diverse workforce are met. For instance, many of Aflac's insurance policies can be customized to include benefit riders, helping employers determine the level of protection and coverage options for specific conditions.

Todd Mason:

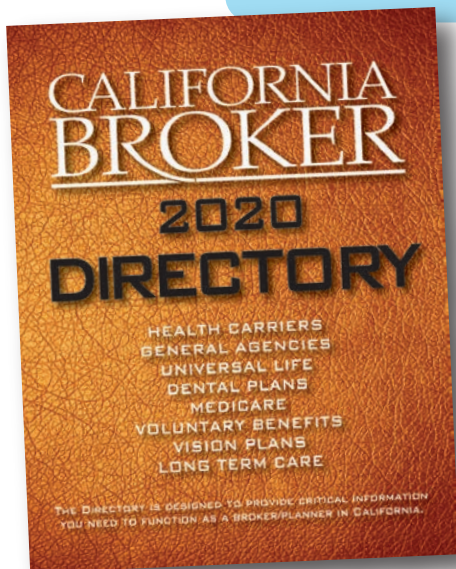
A broker should consider choosing a voluntary benefit company that offers its own enrollers to support major medical enrollment while educating employees on voluntary benefits. Some brokers are losing income opportunities with changes to major medical offerings. But they have a chance for significant supplemental income just by making the introduction to the employer.

At many small businesses, one or two people often fill the roles of business owner, day-to-day manager, HR director and benefit specialist. There is often a need to overcome an objection for something that sounds time-consuming or complicated. For example, some decision-makers are concerned that it takes a lot of effort to add a payroll slot for voluntary benefit deductions. But the small effort that goes into creating the slot can more than pay for itself when the decision-maker realizes the pre-tax savings that can be experienced through voluntary benefits and the variety of value-added services a benefit company can offer.

Brokers can create value by offering no-cost or low-cost digital enrollment for all benefits. They can combine that

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Brokers can create more value by making it easy to offer flexible benefits options as well as scheduling personalized consultations to ensure the needs of their diverse workforce are met.

—Brent Goode

with voluntary benefits to create benefit customization, which employees are looking for. This customization is especially important now with the most-diverse workforce we've ever seen, including five generations.

Joseph Stefano:

Successful brokers understand the dynamics of running and growing a small business. They take on the role of an advisor to help navigate employers through the employee benefits landscape. This includes the ability to talk to employers about their employee population and employee needs that may not be covered by employer-paid benefits, and then educate them about the range of new benefits available on a voluntary basis. While small employers might not be able to offer the benefits a large firm does, it's important to offer employees the best benefits that fit within a company's financial means. Personalization is key, there's no "one size fits all."

In addition, encouraging small group clients to switch to digital can also lead to success. Employees live in a digital world where they have access to everything they want in the palm of their hands. Bringing that same concept into the workplace with the digitalization of benefits can go a long way with employees, particularly because they want their benefits to be easier to access and understand. One thing that is helping small firms, especially start-ups, to deliver an enhanced employee experience, is the increased use of cloud-based software and digitalizing various aspects of the HR and benefits functions. In fact, our study found 52% of small businesses have digitalized most of their benefits processes.

Chris Patton:

The broker role is ever changing but there are certain fundamental elements that remained relatively stable. Brokers are a fundamental element of distribution in many markets and particularly in California. They play a vital role in the relationship between the insurer and the customer. Successful brokers understand their role as a bridge between all parties. The customer is obviously important but the relationship between the broker and the insurer is also critical. When it really counts, having a relationship with the carrier at various levels works well for both the broker and the insured. Issues that arise can be handled using a common language based on a partnership that has the

customers best interest at the center.

If I could offer any advice to brokers getting started: Look to the insurer as your business partner. Getting to know the people that can help when things are not working right will help to expedite getting a member what they need. Developing your business relationships on both sides of the transaction will pay off in loyal customers by having a team in your corner when you are called on to help fix a problem.

Jessica Moser:

Especially for small businesses, brokers are more than a conduit to insurance carriers. Brokers are trusted partners that can guide smaller businesses, and often save business owners time and money—not just in navigating the healthcare maze, but in putting together a comprehensive benefits program that can help make them an employer of choice. Additionally, brokers can provide a great service in helping employers effectively communicate those benefits to employees.

Brokers specialize in helping businesses to manage risk, and the brokers that work with and understand small businesses know that also includes the risk of losing key employees to larger competitors who may have bigger recruiting and benefits budgets. So brokers who present well-designed benefits plans, starting with healthcare, and building onto that with ancillary benefits, can address those business problems around retention and become the relied-upon benefits counselor that small employers need.

Another key that the best small business brokers recognize is how critical communication is. If a small business owner—who may not have an HR department and therefore does much of their own benefits work—can look to their broker for advice in communicating the benefits, that broker will, in all likelihood, be successful. There is a wide gap between what employers think about the effectiveness of benefits communication, and what employees believe, as shown in the MetLife Employee Benefit Trends Study. The risk in this is that even the most well thought out benefits plan may be purchased, funded and implemented by an employer, but then not embraced by employees because they don't understand what they're being offered. Working with their carriers, successful brokers provide communications tools for their clients.

The goal is to make the health insurance buying process as simple as possible, and listening remains the most effective sales technique.

–Tim Rhatigan

Tim Rhatigan:

Successful brokers are mindful to what's coming next and are able to adapt to a fast-changing and fluid marketplace.

The continued creation of clinically integrated networks has prompted the need for brokers to articulate to clients the benefits of these new collaborations between health plans, care providers and pharmacies. Helping employers better understand and take advantage of these new models of health care provides a more personalized experience, improved outcomes, and lower costs for their employees.

4. Are there certain sales techniques that are most effective with small group?

Brent Goode:

Some of the best sales advice out there is foundational but profound: Listen to the customer. If a broker goes in only to make a sale, they may not find as much success as they would in providing benefits solutions tailored to the client's needs. There is no one-size-fits-all approach because every business is unique with its own needs.

The success of any business often depends on its ability to provide a service-oriented experience. With more than 60 years in the business, Aflac arms its producers with an array of marketing and educational materials designed to help build awareness, greater understanding and increased participation in benefits programs. We also offer the technology tools that simplify benefits administration and meet the expectations of today's digital-savvy workers. For example, Aflac's innovative One Day Pay initiative and MyAflac app help ensure that employees can submit and receive payment for eligible claims quickly.

Many small businesses like to support local businesses and participate as a member of their community. To help them create a local brand, we encourage our brokers and agents to get involved in their community. Aflac's CSR-in-a-Box toolkit provides brokers and agents with a number of resources that make it easier to get involved in their community and share their stories of doing good beyond their core business. This not only allows them to make an impact, but also to increase their network and build trust and a positive reputation within their community.

Todd Mason:

We find brokers can use the following four opportunities to engage small employers around benefits:

- Enrollment digitization
- Benefit customization
- Cost and time saving approaches (like increased pre-tax participation)
- Offering a program incentive to enhance the benefits plan and participation.
- Robust product offerings to meet the needs of all employees.

We find that education is the biggest hurdle to overcome with small groups. Many small business owners don't realize that voluntary benefits can be available at a workplace with just three employees. There is a misconception that employees don't want, don't need, or can't afford voluntary benefits. But when our counselors are able to sit down with employees, who are feeling the added pressure of healthcare costs on their wallets, we find that many are willing to spend a few dollars to protect their incomes, their lifestyles, and their families with financial protection products.

Joseph Stefano:

A broker's role as an advisor/consultant now requires that they be knowledgeable in benefits technology, benefits communications, and absence management due to the increase in paid leave laws. This is a result of the evolving benefits landscape, which is requiring brokers to blend traditional sales techniques and become more well-versed in an array of products and services than ever before.

For example, Guardian's Benefits Technology study showed 2 in 5 employers have not spoken to their benefits broker about their benefits technology needs. With benefits technology becoming an integral component of a benefits strategy, a strong understanding of the platforms available to small groups is essential in today's market. Platforms fueled by application programming interface are helping HR teams save hours of manual work, improve the accuracy of a plan set-up and provide small employers with a user-friendly enrollment experience.

Meanwhile, with benefits communications, research continues to show that very few employees and employers understand the basics/importance of employee ben-

The broker's role is to help navigate through the market offerings to find the right balance of elements...to accommodate the diverse needs of the small business owner and their employees.

—Chris Patton

efits, particularly supplemental health benefits. Benefits communications that break down the basics of the product, uses real life examples, avoids industry jargon, and includes decision support tools can go a long way with potential clients, especially with small businesses.

Finally, paid leave laws are continuing to gain traction across the country. In California, we see tremendous interest in absence management services and products that can help a small group employer navigate the laws and remain compliant. The broker doesn't have to be the expert or own the solution, but they have to raise the issues to protect their clients from potential liability – otherwise, another broker can more easily displace them (e.g., “you mean your broker hasn't talked to you about the new changes to California's paid family leave law?”).

While this may sound like a lot, these are great opportunities for brokers to better serve the needs of their small business clients and show they are a trusted partner.

Chris Patton:

The cost of health insurance is second only to payroll in the world of the small business owner. Selling the lowest cost offering in a market is a dated strategy. Employers are looking for value and that value is evidenced by employee satisfaction. Lowest cost may seem like a sound fiscal strategy on the surface but disgruntled employees are extremely costly particularly in a tight labor market. Low cost in an ACA environment is primarily achieved by cost sharing with the employee in the form of premium, out of pocket cost and access. There is no magic plan in today's environment that is high quality, low out of pocket cost and robust access for sale at a shockingly discounted rate. The broker's role is to help navigate through the market offerings to find the right balance of elements associated with a reputable plan to accommodate the diverse needs of the small business owner and their employees.

The sales strategy that works is the one that communicates the reality of the benefits market to the employer and helps them tailor a plan that meets the ongoing needs of their company.

Jessica Moser:

Essentially, people want to buy from someone they believe understands the issues they face, and what they

are trying to accomplish. Right now, small business owners are facing incredibly challenging competition for workers in this era of low unemployment. Often their salary packages don't compare to larger employers. And, in many cases, as they are living on razor thin margins; cost is the first, second and third consideration in benefits decisions. On top of that, the owner is generally doing much of the work in choosing and implementing the benefits package.

So, savvy brokers work with their clients to offer the programs that meet those challenges. It is critical that brokers make it easy for small business owners to access benefits, and to ensure that those simple benefits are competitive and compelling for their employees. Offering bundled, tiered benefits packages provides them with a variety of options, but as they are curated packages, the choices are not overwhelming. And, adding voluntary benefits to those packages can allow small businesses to compete with the richer packages of larger employers, at little or no cost to them.

This need to combine cost, ease and choice is why MetLife is developing a digitized quote to claim solution: it significantly simplifies the experience, enabling brokers to easily quote, sell and administer ancillary benefits for their small business clients in the way that they want, integrating to the systems already in use if they so choose. If the broker keeps the client's needs in focus as the driving force to define and communicate a solution, they will be well positioned for success.

Tim Rhatigan:

The goal is to make the health insurance buying process as simple as possible, and listening remains the most effective sales technique. By becoming better listeners and understanding the needs of a particular employer and its employees, we can better align those needs with available technologies and new care models.

Understanding and balancing the needs of an employer with the needs of the employees is the key. Brokers can increasingly add value by recommending the right products that provide the appropriate type of access to care. By listening and understanding the needs of each employer, brokers can help promote a personalized health care experience and help maximize the value of the medical and ancillary benefits.

(SECURE ACT CONTINUED FROM PAGE 14)

Current law allows certain non-retirement assets to receive a step-up in basis. Assume you bought a house many years ago for \$300,000 and it is now worth \$1 million. Your heirs would inherit the house at the basis value upon your date of death, representing a step-up in value and potentially avoiding capital gains on the \$700,000 of appreciation. For this reason, non-retirement assets tend to be more tax efficient.

Roth IRA and Roth IRA conversions are also a great estate-planning tool, as the distributions for these assets are not taxable. Consider gradually converting your traditional IRA to a Roth IRA. You will owe taxes upon conversion, but if you expect rates to be higher in the future, you and your heirs could benefit.

Additionally, sending your annual distribution directly to a charity is a great way to give, and sidestep current income taxes. While you will not receive a charitable deduction, you will not realize the income. You could also leave your traditional IRA to a charitable remainder trust. The trust would pay income to your beneficiaries for their life or a certain amount of time. Once the beneficiary dies the charity will receive the remaining assets.

For insurance brokers, one solution would be to use the income from the IRA to purchase life insurance that will provide a tax-free death benefit which can replace

California - Married Filing Jointly	
Tax Bracket	Tax Rate
\$0.00+	1%
\$61,538.00+	6%
\$85,422.00+	8%
\$16,446.00+	2%
\$38,990.00+	4%
\$107,960.00+	9.30%
\$551,476.00+	10.30%
\$661,768.00+	11.30%
\$1,000,000.00+	12.30%
\$1,074,996.00+	13.30%

the spent asset. Taxes and income needs certainly should be reviewed before adopting such a plan, but for those that do not need the income, this may be a viable solution.

To put in perspective how this will affect America's aging population, one needs only to consider the very significant amount of wealth in this country. According to WealthX, a global research and insight organization, by the year 2030, more than \$15 trillion in wealth will be transitioned from one generation to the next. Some \$8.8 trillion of this generational wealth-shift will occur within the United States. While still relatively young on average, as California's population ages in the next ten years, many more households will be impacted to a significant degree. It's not too early to have a plan in place.

Morgan Christen is CEO and Chief Investment Officer of Spinnaker Investment Group, and has more than 26 years of professional experience offering clients full service independent wealth and investment management services. Christen has earned the Chartered Financial Analyst (CFA), Certified Financial Planner (CFP®) and Certified Divorce Financial Analyst (CDFA®) designations, and served as a board member of the CFA Society of Orange County. He has a Bachelor of Science degree in Business Finance from the University of Southern California, and an MBA from Pepperdine University.

While still relatively young on average, as California's population ages in the next ten years, many more households will be impacted by the SECURE Act to a significant degree.

HOW EFFICIENT IS YOUR BENEFITS ADMINISTRATION PROCESS?

By **MELISSA ANCKERSEN**

For most HR departments and organizations, the path to a successful enrollment season seems like an uphill battle, no matter how much preparation goes into it. With open enrollment season here, HR teams have spent immeasurable time preparing their benefits administration strategy to handle the obstacles that so often derail a smooth enrollment period. But it's not for nothing.

On average, employee benefits account for 31.7% of total compensation costs, and this places intense pressure on HR teams to determine the best approach to benefits administration. Preparing docs, confirming changes, making corrections—depending on your company's size, even the more clerical tasks associated with benefits could take the whole year to prepare. So how do you know for sure that all this work ensures your administration process is future-proofed and ready?

The best way to answer this question is by holding a magnifying glass up to your administration processes and seeing where the roadblocks and inefficiencies exist. For instance, are you checking that your benefits administration strategy educates employees on all benefits questions, helps them elect smarter benefits, and keeps their benefits organized in one place?

To help you augment your benefits administration processes, we'll discuss some of the most common inefficiencies that plague HR teams and the administration tools that can

solve for them. By leveraging benefits administration tools and solutions (or outsourcing your benefits administration altogether—see www.hodgesmace.com/benefits-outsourcing/), you can update and even automate steps in your existing administration, which can alleviate HR stress so your team can stay focused on what's important.

Common inefficiencies

When HR departments seek to improve their benefits administration strategy, outside factors such as rising healthcare costs and trends in employee benefits can end up clouding the clear, actionable steps that need to be taken. But when you hone in on specific inefficiencies that lie within your own administration processes, it's easier to find a way forward and improve your overall administration strategy.

Some of the most common inefficiencies that employers encounter can be broken up into two categories:

Educating employees about benefits

Employee education is a salient issue that pervades the entire HR community. In fact, one recent study showed that four out of every five employees end up enrolling in the wrong health plan. (According to a research article by Eric Johnson et al: Can Consumers Make Affordable Care Affordable? The Value of Choice Architecture.)

Another study found that 41% of surveyed employees say



the open enrollment process at their company is “extremely confusing.” (www.shrm.org: Employees Dazed and Confused by Benefit Choices). This situation arises when employee questions are left unanswered, benefit comparison data is missing, or your benefits administration process is generally faulty. The bottom line is that benefits administration processes are often ripe with opportunities to increase employee education around benefits, enabling your staff to appreciate the value of benefits and ultimately make better benefits decisions.

What inefficiencies to solve for:

- Elevate employee education on different benefits plans
- Answer common employee benefits questions
- Provide plan comparison documents
- Keep benefits information in a centralized location

The other common benefits administration issue stems from a lack of centralization. Many problems are solved by having one place that’s easily accessible by employees and embodies a single, integrated system for HR departments. Employers can spend less HR resources administering benefits and ultimately help control costs by having a dedicated place to track benefit declines and elections, consolidate data into a single centralized system, and use electronic submissions to make their open enrollment choices. If your com

pany suffers from a fragmented benefits system, it might be time to look for a more centralized benefits delivery platform.

Other functionalities to consider:

- Collecting census data from different systems
- Tracking declines and elections
- Confirming and processing plan changes
- Manually setting up benefit plans every year
- Overcoming benefit admin inefficiencies

If your benefits administration process is experiencing problems with any of the above inefficiencies, you’re not alone. Seek turn-key benefits administration solutions that simplify and automate the common inefficiencies encountered by HR teams every enrollment season. By tackling some of the most common employee education issues and automating administrative HR functions, you will streamline the entire enrollment process and better leverage your investment in employee benefits.

Melissa Anckersen joined Hodges-Mace as senior vice president of Technology Services in November 2014. Prior to Hodges-Mace, she served as the SVP of Technology Services at SmartBen, a cloud-based technology company in the benefit administration and exchange market. As senior leader managing all customer life cycle functions, Melissa was responsible for implementation of data services, service teams, account management and technology services.

BECOME AN ENROLLMENT HERO

Using Technology, Targeted Communications and Smart Personalization

By MICHAEL ESTEP

The digital age of benefits has arrived. Employees now look to their employers to provide an enrollment experience that mirrors their daily consumer habits. With companies exposed to more human capital management technology than ever before, employers are adopting HR technology to meet the needs of their employees who seek a more personalized and easier-to-navigate interaction with their employee benefits. This is especially relevant during annual enrollment periods when the employees' experience can directly impact overall satisfaction with a company. For example, a recent Guardian study found that 75% of employees who had a very positive enrollment experience were more likely to stay with their current employer for at least five years compared to those with a negative enrollment experience.

To meet the needs of today's workforce, many employers are allocating more of their budget to benefits technology, and they are turning to their brokers for insights and guidance. Brokers now play a key role in advising clients on the use of benefits technology, which requires them to stay up-to-date on the latest offerings, as well as counseling employers on how to personalize their benefit offerings.

Digital technology consultant

Today's workforce wants an employee benefits 'shopping' experience that mirrors how they make online purchases, and employers are responding. According to the Fifth Annual Guardian Workplace Benefits Study, Game-Changer: The Digitalization of Employee Benefits Delivery, more than 40% of all employers say expanding their use of technology will be among their top benefits strategies in the next five years. This

has led a majority of employers to increase their spending on benefits-related technology, with about 50% of businesses anticipating further increases in the next three years.

While the rapid expansion of benefits technology allows employers to meet their employees' needs, it can also lead to confusion about which vendors and capabilities are the best fit for a company. There is a tremendous opportunity for brokers to not only talk to their existing and potential clients about the value of benefits technology but to establish themselves as a trusted professional on the topic. Employers that use their broker more strategically tend to place a greater emphasis on improving employee well-being and incorporate more technology solutions.

Smart personalization and relevant communications can lead to 'noiseless' enrollment

While competitive pay certainly still influences an employee's decision to join and stay with a company, Guardian's "What Employees Want" study reports that 70% of respondents say they're more likely to be loyal to a company that offers employee benefits that are personalized to their needs. Employers are responding by providing their employees with tailored benefits that include a suite of voluntary benefits, student loan debt support and mental health benefits, among others. The study also found that employees are looking for an omni-channel approach to benefits communications through expert advice, digital support on mobile apps, decisioning tools, one-on-one expert guidance and short educational videos.

Providing employees with mobile tools and personalized advice has helped many companies experience a "noiseless enrollment," meaning a significant reduction in employee

Editor's note: Due to a printer error, this article did not appear in its entirety in the October issue of Cal Broker.

We've reprinted this month so readers wouldn't miss out!



questions about the enrollment process and their benefits options. It's no secret that benefits are complex, so the majority of questions from employees are driven by not fully understanding what benefits are available to them and how they can help bridge financial gaps. In fact, recent surveys indicate most employees do not fully understand the benefits offered to them. The average score on Guardian's 2019 Employee Benefits I.Q. Quiz was 68%. Among millennials, scores were lowest, with 1 in 4 failing the quiz.

Simplified communications

Poor understanding of their benefits can become overwhelming for many and lead to frustration and confusion during open enrollment. In a recent Guardian study, when asked what would help the most when learning about and enrolling in their company's employee benefits, workers' top suggestions were:

- Less insurance jargon and simpler explanations about how their benefits work and what needs they address
- Personalized information and recommendations tailored for their specific age, life stage, lifestyle or financial situation
- Access to expert guidance, such as an adviser or benefits specialist, to answer questions and validate decisions during the employee benefits selection process
- Online support including tools, navigation, and interactive media to more effectively educate and engage employees throughout the enrollment process.

At Guardian, we took these market insights and created highly tailored tools designed to make enrollment easier to understand and empower employees to make informed benefit choices. We deliver these resources to brokers, who

work directly with their clients on the best way to make these available to their workforce during open enrollment. These tools are designed to unburden the broker from developing tailored communications and provide employees with recommended voluntary benefits that best fit their individual needs. A data-driven pre-enrollment analysis helps identify the best benefit recommendations based on each individual's personal needs. These recommendations are delivered via real-time chat, email, etc., so by the time an employee is able to make their enrollment selections, they feel educated about their options.

Job satisfaction = loyalty

Listening to and addressing employee needs helps drive greater job satisfaction. When an employee is satisfied with their job, they are likely to stay at a company longer. These are exciting times in our industry. With new technology options and an abundance of consumer data and insights, brokers have a wealth of information to be the "enrollment hero" their clients need. Annual enrollment has become an important aspect to an employee's overall satisfaction with their company, and it can be one of the factors in determining if they want to stay long-term or seek employment elsewhere.

The enrollment experience can be a vital opportunity for brokers to partner with their clients to help employees make important, informed decisions that could improve employee morale and impact their immediate and long-term future with the company.

Michael Estep is vice president group products and worksite leader at The Guardian Life Insurance Company of America.

A LOOK AT SMALL GROUP BENEFITS

By BRUCE JUGAN

Kaizer continues to lead the field in the California small group market by consistently offering the lowest rates through a comprehensive health care delivery system where the doctors, hospitals and insurance company act as one entity. Another reason Kaiser is an industry leader is that they seek input from stake-holders and implement the best ideas— something we can all emulate! To that end, I was fortunate to be included in a round table discussion earlier this year with key brokers and the senior leadership of Kaiser Permanente's small group sales and account management team.

We learned that as a result of last year's key broker meetings, Kaiser added durable medical equipment (DME) as a benefit to all small group plans. Other responsive changes include an ambitious administrative system overhaul: Kaiser is working diligently to improve their computer systems so that small group employers (1-100 employees) and brokers will be able to better manage their accounts online.

The revised system will enable brokers and employers to add and terminate employees from coverage, view invoices, and manage other administrative tasks. Kaiser has invested a great deal of staff time and resources to improve their system. One result should be an easier-to-understand—and shorter—monthly invoice.

Risk adjustment payments increase the cost of care

Another aspect of the market we would do well to un-

derstand is risk adjustment payments mandated by the government.

While Kaiser is committed to keeping rates low, they do so with a financial burden: payments they must make to their competitors. According to a report on "permanent risk adjustment transfers" from the Centers for Medicare and Medicaid Services (CMS), Kaiser is the largest payer of "risk adjustment payments," which the Affordable Care Act (ACA) requires.

As the report describes, "The Patient Protection and Affordable Care Act established a permanent risk adjustment program (in section 1343), one of three premium stabilization programs, to provide payments to health insurance issuers that cover higher-cost and higher-risk populations to more evenly spread the financial risk borne by issuers and help stabilize premiums."

(Source: Centers for Medicare and Medicaid Services, Summary Report on Permanent Risk Adjustment Transfers for the 2017 Benefit Year, page 7.)

The payments are intended to more evenly spread the financial risk borne by one insurance company that may have enrolled higher-risk/sicker individuals. In theory, the insurance companies with healthier members pay insurance companies with sicker members. The problem is that the formula to calculate risk seems to favor high-cost insurance plans. Simply put, in California, the HMO plans pay the PPO plans.

In the CMS report, Table 3 Issuer-Specific Information shows that the top California health insurance companies paid

or received the following amounts in the small group market in the 2017 plan year:

- Anthem Blue Cross of California RECEIVED \$199 million
- Blue Shield of California RECEIVED \$136 million
- Kaiser Permanente PAID \$312 million

Other insurance companies also paid risk adjustment payments, but none paid more than Kaiser. Even actuaries—the people who developed the risk adjustment formula—recognize that the formula is flawed. According to this article in *The Actuary Magazine*:

The risk adjustment transfer formula does not account for plans that have more advanced approaches to care management or more progressive value-based contracting methods that help drive premiums lower in a market. The transfer formula penalizes plans with lower premiums and rewards those with higher premiums in relation to the statewide average premium. Unfortunately, low cost insurers working to keep the marketplace affordable for individuals are being hit with the formula imbalance. Similarly, the inclusion of administrative costs (e.g., non-claims costs) into the calculation further exacerbates the issue for highly efficient plans with low administrative costs.

(Source: The Actuary Magazine, Transfer Problems: Exploring the imbalance in the ACA's risk adjustment transfer formula.)

The sad irony of the risk adjustment payments is that, according to this Brookings Institution report, Kaiser's comprehensive health care delivery system actually offers higher quality care at a lower cost than the PPO/fee-for-service plans, such as Anthem and Blue Shield. As this report says:

There is no financial gain for driving up high volume and high intensity services in the emergency department or hospital, nor would there be gain to Kaiser Foundation Hospitals by having "insured" patients admitted to its facilities. The Permanente Medical Group's (doctors) share in the hospital budget variance through Kaiser Foundation Health Plan (the insurance company), so it is in their best interest to see that care is delivered in the most appropriate clinical setting.

(Source: Center for Health Policy at The Brookings Institution, Kaiser Permanente – California: A Model for Integrated Care for the Ill and Injured, page 5.)

The fee-for-service medical care delivery model encourages more testing, treatment and medical services because each medical provider in the system is rewarded for doing MORE services—not for offering high quality care. Accordingly, the risk adjustment payments seem to reward high-cost, inefficient medical care and weigh heavily on Kaiser when they set their rates. Policy makers should re-evaluate these payments.

Kaiser's needs to better tell its story

The brokers and Kaiser reps agreed that many people have a skewed view of the services Kaiser offers. Kaiser's integrat-

ed care includes doctors, hospitals and the insurance company. As such, when something goes wrong people don't simply blame the doctor or the hospital. They blame Kaiser. No other insurance company has this burden.

In fact, as the above referenced Brookings Institution article describes, the medical outcomes at Kaiser are significantly better and at a lower cost than other health care delivery systems. It would be wise if Kaiser developed some marketing material that cites third party analysis of their system.

Suggestion for a new plan design

Another idea mentioned at the meeting would be for Kaiser to create a medical plan that uses Kaiser doctors and facilities but also pays for services of out-of-network providers. Years ago, Kaiser offered a "Point of Service" (POS) plan which covered services out of the Kaiser system. Now, Kaiser only offers a very high-priced PPO plan which doesn't offer access to Kaiser.

The executives told us about the Added Choice Point-of-Service Plan that they are testing in Georgia. If successful, Kaiser may expand this plan design in other states and hopefully bring it to California.

Personal take-aways

Kaiser has done a lot of work to improve itself and offers real value. In the course of our meeting I heard the executives describe Kaiser's work in precise and clear terms—evidence that they have given a great deal of thought to their processes.

For example, a national priority is to make Kaiser "easy to buy, sell and keep." Another executive said that Kaiser seeks to "perform, grow and lead." Again, this demonstrates that Kaiser spends time examining itself and seeking to improve.

Finally, as business people, we all seek to improve our processes so that we can offer our clients exceptional service. Accordingly, I was impressed with the clear and concise description of the broker workflow broken down into three areas by a Kaiser executive: "new business, maintenance, and renewals."

While this may seem obvious to many; I found it very insightful—and I've been in the business for 25 years.

Editor's Note: This article is adapted from an article that originally appeared on BenefitsCafe.com



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THE TRUTH BEHIND ONLINE VISION TESTS

Don't Overlook Vision Benefits

By STEVEN EISS

In today's fast-paced world, we need to be more efficient than ever to get things done. Certain technology advancements have been a game-changer to achieve this—from grocery delivery, to streaming services, smart homes and subscription boxes. When it comes to our health, though, that can be a different story. While it's easy to fall into the convenience trap, there is still no substitute for meeting with a healthcare professional in-person. Case in point: online vision screenings.

According to research from Transitions Optical and the American Optometric Association (AOA), there is a lack of understanding about—and need for education on—the importance of comprehensive eye exams. The 2019 Transitions Employee Perceptions of Vision Benefits survey (conducted by Wakefield Research on behalf of Transitions Optical) indicated that half of employees think that online vision screenings that provide a prescription are a suitable replacement for in-office eye exams. The truth is, this is not the case.

As online vision screenings become part of the vision benefits conversation, it is imperative that employees, employers and providers understand the difference between an online vision screening and an in-person, comprehensive eye exam with an eye doctor.

Understanding the Difference

Usually, an online eye test measures the sharpness of your vision, as well as imperfections that cause blurred vision. While this is helpful to see your best, it's missing a big factor: assessing the health of your eyes. According to the AOA, online vision tests often give misleading information. They can delay essential, sight-saving treatment—meaning they are not a substitute for an in-person, comprehensive eye exam by an eye doctor.

Regular, comprehensive eye exams with an eye care professional are the best way to preserve vision and assess eye health. Not only do they measure for vision sharpness and imperfections that cause blurred vision, but they also measure a plethora of other essential items. The American Academy of Ophthalmology® (AAO) notes that these exams include looking at the pupils, side vision, eye movement and pressure; looking at the front part of the eye to check for cataract and any cornea scratches; and finally, dilating eye drops to examine the retina and optic nerve for signs of damage (see aao.org). Not only this, but comprehensive, dilated eye exams can uncover problems even before symptoms occur—and can even provide early detection of serious health issues, like diabetes.

Periodic eye and vision examinations are an important part of preventive

health care. Many eye and vision problems have no obvious signs or symptoms, so many may not even know that a problem exists. Early diagnosis and treatment of eye and vision problems can help prevent vision loss.

According to HealthySightWorkingforYou.org, common eye diseases that can be detected through a regular eye exam include:

- **Cataracts:** The leading cause of blindness; this occurs when the lens of the eye becomes cloudy
- **Glaucoma:** Increased pressure within the eyeball and the second-leading cause of blindness
- **Age-Related Macular Degeneration:** Painlessly destroys sharp, central vision

More serious and costly health conditions that can be detected by a comprehensive eye exam include:

- **Diabetes:** Can lead to problems in the eye, such as diabetic retinopathy, cataract, glaucoma and age-related macular degeneration
- **Hypertension:** Also known as high blood pressure, hypertension impacts the eye as well as the body. Without treatment, it can lead to bleeding in the eye, blurred vision, or even blindness.

As mentioned, half of employees from the survey believe that online vision screenings that provide a prescription are a suitable replacement for in-



office eye exams. Millennials were the most likely to agree (57 percent)—compared to half of Gen Z, Gen X and 36 percent of Boomers.

What employees want

Tips for education

The misunderstanding of the difference between an in-person eye exam with an eyecare professional and an online vision screening emphasizes the importance of education.

Provide up-to-date eye health information

Three in four employees say that their eye doctor is their source for information about eye health (71 percent). The second-largest source? Their vision plan provider. One in three employees indicated that is where they get eye health information, so it's important that vision plans are providing the most accurate information about online vision screenings.

Stay consistent with ongoing education

When open enrollment comes around, this is a great time to discuss benefit options—but it typically only comes once a year. Discussing the importance of routine eye care year-round can help remind employees about how a comprehensive eye exam with an eye

doctor is their best bet to not only see well, but also to stay well. The AOA doctor locator at www.aoa.org also has an easily searchable database of doctors to provide employees with.

Offer a comprehensive vision benefits package

Low in cost, vision benefits offer a high return-on-investment for employers. Vision benefits can help to save on medical costs, boost employee productivity, and can even help to attract and retain top talent.

According to inc.com, 44% of Gen Z employees (who are ages 18-24 and expected to comprise one-fifth of the workforce by 2021) said that whether a company offers vision benefits has been an important factor in their decision to accept a job.

When selecting eyewear, an overwhelming 94 percent of employees say that premium lens options are important to them—making vision plans that cover these a key differentiator for employers. Employees say the most desired premium lens options include:

- Scratch-resistant lenses: 73%
- Anti-reflective or no-glare coatings: 71%
- Photochromic lenses, like Transitions® Light Intelligent Lenses™: 43%
- Blue light protection: 35%

Health over convenience

Technology is essential these days in getting more done. But when it comes to eye health, and overall health, there is no replacement for an in-person, comprehensive exam with an eye doctor. Without this, the employee is at risk of missing out on early detection of potentially sight or even life-threatening conditions. You can help employers eliminate a step for their employees by providing education on eye health, and the importance of offering a comprehensive vision benefits package.

To help elevate the importance of comprehensive eye exams and quality eyewear available through vision benefits, Transitions Optical offers a variety of employee and employer focused tools and education. These can be accessed, free of charge, at HealthySight-WorkingforYou.org.

Steven Eiss, OD, Third Party Committee Chair, American Optometric Association, is a graduate of Muhlenberg College and the Pennsylvania College of Optometry. He is an active member of the Pennsylvania Optometric Association, where he is currently serving on the board of directors as a trustee. He is also active in the American Optometric Association and the Bucks-Mont Optometric Society, where he has held the office of president and treasurer. Dr. Eiss was named the Optometrist of the Year by the Pennsylvania Optometric Association in 2010.



WOONG MILLENNIALS WITH A WELLNESS PROGRAM

By JAKE LEWELLEN

The consistently low unemployment rates in California and across the U.S. make attracting and retaining the best talent a challenge. In fact, “ghosting” recruiters and hiring managers is becoming more prevalent. When prospective employees get multiple job offers, they may abruptly stop all communications with recruiters during the hiring process and seemingly disappear like a ghost.

To stand out with and engage prospective employees, corporations are enhancing their benefits and perks—including wellness programs.

Attracting millennial team members

As the largest generation in the workforce, millennials or Generation Y (born 1981 to 1996) are a focus for many employers. However, millennials are in a life stage that requires them to be always open to new opportunities and make quick career decisions. Being raised during a time of major corporate layoffs, many millennials view loyalty to their employer in terms of months instead of years.

Gallup says millennial turnover costs the U.S. economy \$30.5 billion annually. Nevertheless, 90% of millennials want to grow their careers with their current companies.

Millennials want to know that their company leaders care about them as people, not simply as employees. In addition to a clear path to career advancement, they want a holistic healthcare approach and a connected community.

Millennials value health and wellness

According to Gallup, 57% of millennials say that work-life balance and well-being in a job are “very important” to them. In addition, Clutch, a B2B ratings and reviews company, says 44% of millennials name health insurance as the most important benefit they receive.

Millennials have earned the label as the most health-conscious generation because of their unprecedented access to health information found online. This “connected generation” is comfortable getting healthcare and

wellness advice from Google, WebMD and health support groups found on social media. Millennials have grown up with mobile devices always within reach. Using apps for grocery shopping, counting calories and helping them meditate is second nature. They also helped to popularize superfoods, such as kale, chia and flax seeds, acai and avocado toast.

To the “wellness generation,” working out is as much a social activity as it is a healthy choice. Happy hours have long been a popular way to bond with teammates. Now, many young professionals under 35 years old prefer to strengthen their relationships while strengthening their muscles. Exercising together to socialize and build community has become a part of millennial culture. A Web Index survey found that only 24% of millennials drink alcohol at least once a week, while 76% of them exercise at least once a week.

The millennials’ appreciation for community and wellness has sparked a new fitness culture. Exercise classes are now available for everything from goat yoga and barre classes to high-

Millennials want to know that their company leaders care about them as people, not simply as employees...they want a holistic healthcare approach and a connected community.

intensity interval training (HIIT) and cycling as full-body workouts. In addition to scheduling classes with friends and colleagues, the various gyms and studios have become opportunities to make new friends and meet a partner.

Millennials value wellness programs

With millennials aspiring to healthy lifestyles, employers can attract and engage more young professionals by offering rich wellness programs. This generation welcomes the opportunity to partner with you and your wellness program to promote a healthier lifestyle.

However, millennials and Generation Z (22 and younger) who are beginning to enter the workforce, will expect more from wellness benefits than previous generations. These young professionals want a holistic approach to health and wellness that goes far beyond weight loss challenges, tips to quit smoking and disease management.

Tips to advance your wellness program to attract millennials:

Mobilize

As technophiles, millennials enjoy using the latest tools that offer ease and convenience. Wearables, such as fitness activity trackers and smart

watches, are becoming commonplace. PwC reports that more than 75 million wearables will permeate the workplace by 2020. It's not just a fad!

Employers investing in fitness activity trackers and offering walking-based challenges, weight maintenance programs and other physical activities are seeing traction year-over-year. You can augment the appeal to tech-savvy millennials by including programs that "gamify" wellness. For example, add friendly competition and social interaction through live fitness coaching delivered to your teams using two-way video conferencing.

Millennials check their phones 150 times a day on average, according to Qualtrics and Accel. Consider wellness coaching using text messages and fitness and nutrition apps to make your programs more comprehensive.

Incentivize

Millennials are open to health incentive programs—especially action and progress-based initiatives.

Action-based incentives motivate your teams to adopt healthy behaviors. By creating a feeling of community, millennials will want to join group activities. They will be more apt to complete a risk assessment or get preventive screenings, and then participate in health coaching or join a weight management program.

Progress-based plans offer rewards for improving health concerns, such as cholesterol, blood pressure and weight. Employees are incentivized to choose healthy habits rather than being penalized for having health issues.

Emphasize EAP

Approximately 20% of millennials report experiencing depression compared to 16% of Generation X and Baby Boomers respectively, according to research from Bensinger, Dupont & Associates. Millennials are at the life stage that's most likely to be juggling careers while raising young children, continuing their education and other demands that cause high levels of stress.

Employers can demonstrate that they care about their teams by providing holistic healthcare. Emphasize the benefit of an Employee Assistance Program's (EAP) direct, confidential access to professionals who can assist with areas causing employee distress. EAPs can address concerns from work-related issues to family problems and mental illness.

You may also consider offering the convenience of telehealth services that include behavioral health care.

Prioritize a culture of health

One of the best ways to motivate millennials is for employers to create

A healthy work environment encourages employee engagement and energizes your teams.

a general culture of health. A healthy work environment encourages employee engagement and energizes your teams.

Consider offering flexible work schedules outside of cubicles and traditional 9-5 schedules. Allow parents to attend their children's activities. Encourage employees to take classes, and then login to complete work assignments beyond regular business hours.

Provide convenient opportunities for healthy lifestyles — including apps and mobile-friendly websites — such as:

- Standing desks or treadmill workstations
- Walking trails and work-site gyms
- Onsite fitness programs, like yoga or Zumba
- Discounted gym memberships or fitness classes
- Healthy snacks, food and beverage options

- Nutrition and diet plans on a digital platform
- Stress management programs
- Mental health education and support

Optimize healthcare choices

Millennials want more flexibility, convenience and control over their health care benefits. They appreciate the ability to choose high-deductible health plans for major medical insurance packaged with voluntary benefits. This allows millennials to make the choice of lower health insurance premiums, while protecting them from potential financial exposure created by the high deductible. You can also offer a menu of voluntary benefits, such as disability, accident, critical illness and hospitalization insurance.

In addition to health and wellness plans, Willis Towers Watson says employees are also interested in identity theft protection, student loan repayment programs and pet insurance.

By offering a holistic healthcare approach, benefits that can be tailored to young professionals' needs, and providing tech-based initiatives, a modernized wellness program will woo millennials and enhance loyalty. The result is better health for your teams and your business.



Jake Lewellen has been with Humana for six years in Health and Wellness.

He held positions in account management for large group clients until

recently taking over as the Wellness Subject Matter Expert for the Midwest/West regions. Jake has deep roots in wellness that can be tied to when he played football and student coached at the University of Kentucky where he graduated with a BS in economics and an MS in kinesiology and health promotion. For more ideas on developing a culture of health and wellness, visit Go365.com or contact your Humana sales rep.

Why Wellness Programs Work

A three-year impact study conducted by Go365.com shows that employees engaged in a wellness and rewards program had:

- A 10% decline in healthcare costs by year three
 - Fewer unscheduled absences
- Reduced lifestyle risks for chronic conditions
 - Fewer emergency room visits

TAKE ADVANTAGE OF REFERENCE BASED PRICING SAVINGS

By DAVID FEAR, SR.

Once again, benefit advisors will be delivering the bad news about rate increases on the group health plans for their clients this fall. To mitigate this, many advisors will share rate reduction strategies with those clients. Aside from continuing to increase deductibles, copayments and out-of-pocket limits on their traditional fully insured plans (what I refer to as cost shifting to the member), benefit advisors can explore the root of the problem—continued increase in healthcare costs.

We all know that the cost of health insurance is in direct proportion to the cost of healthcare. If your health plan is a well-managed plan that restricts the use of non-network providers, the chances are good that your premium is going to be lower than a plan that uses any provider. Since the enactment of the Affordable Care Act (ACA), most carriers now offer better managed plans with smaller provider networks where they are paying less for healthcare services than in a traditional plan. That is a good thing in many cases.

On the other hand, providers continue to play games with billing practices that border on the absurd, with charges for routine services sometimes two to three times what they were just a few years ago. Between the strategies employed by hospitals using the “chargemaster” and billing practices of some medical groups and facilities, the total cost of healthcare continues to skyrocket. And this problem won’t be fixed by simply shifting costs to the backs of members in the form of deductibles and copayments.



Carriers and self funded insurers are seeing enough of a cost difference between a traditional PPO product and a reference based pricing program that the rates they are charging reflect this savings.

Which brings us to the subject of the pricing of healthcare services and supplies. For years insurance carriers paid the “reasonable and customary” fee for services. Then it changed to “usual reasonable and customary” (URC). Then came “discounted” fees for service as negotiated by a PPO or HMO. The HMOs introduced “capitated risk” strategies which work for many medical groups, but are difficult for independent practitioners.

Many things changed after the passage of the Medicare Modernization Act of 2004, in which the federal government Medicare program began to change how providers are reimbursed. This was based on a number of factors including geographic location, severity of the condition and the use of a “reference point” that related to the provider’s cost of doing business.

Today, the federal government contracts with third party consultants who are constantly monitoring charges, payments and utilization. This resulted in participation of more than 90% of healthcare providers in the Medicare program.

So how does that help private insurers or self-funded employers?

Many private insurers or self-funded employers are now negotiating to pay providers a percentage of the Medicare payment instead of a UCR/Discounted Fee arrangement. The results are that employers are seeing their claim costs

reduced substantially.

I’m not claiming that healthcare providers like this, but I think many see the writing on the wall. They either change the way they charge for services or expect a wholesale government takeover of the system (i.e. single payer) where there will be mandated charges for services. I think this is definitely a bigger consideration for hospitals, medical device manufacturers and big pharma.

What we are seeing today is that carriers and self funded insurers are seeing enough of a cost difference between a traditional PPO product and a reference based pricing program that the rates they are charging reflect this savings.

Here is an example of one employer who has a self-funded plan and has an aggregate stop loss policy which reflects these cost differences.

They offered a “Bronze” benefit which featured exclusive use of a Reference Based Pricing arrangement (150% of Medicare for doctors and 175% for hospitals). The pricing for that plan had a baseline cost of 1.00.

They then offered a “Silver” upgrade plan that also used a 150/175% Reference Based Pricing program and the baseline cost was 1.15 above the “Bronze” plan.

The employer also offered a “Silver” plan that used a well-known PPO network and that plan had a baseline cost factor of 1.30.

And finally, they offered a fourth plan which had “Gold” benefits, using a PPO, which priced out at 1.45.

At the end of the day the employer gave his employees a choice of these four plans. They subsidized 100% of the “Bronze” plan and required any upgrades to be paid by the employee. The majority of the group—52%—enrolled in the “Silver” plan with Reference Based Pricing. The stop loss carrier priced their aggregate stop loss out reflecting on claim history of the group which was using both PPO and Reference Based pricing programs.

In conclusion, benefit advisors need to share this data with employers and then design a strategy that introduces the Reference Based Pricing option to their employees as an option and let them choose what is best for them. Having a Reference Based Pricing plan alongside a PPO plan is a good way to get on the long term savings path that employers are asking for.



Cal Broker editorial advisory board member David L. Fear, Sr. RHU is managing partner of Shepler & Fear General Agency and a 40-year veteran of the employee benefits industry. He

is a past-President of CAHU and NAHU and 2015 recipient of the NAHU Harold R. Gordon Memorial Award as ‘Health Insurance Person of the Year’.

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