CALIFORNIA BROKER

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Finding the Fast Lane for

VOLUNTARY BENEFITS

VIEW FROM THE TOP:

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ALSO IN THIS ISSUE:

HEALTHCARE MARKET
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TABLE OF CONTENTS

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HIDDEN CHARGES IN THE AFFORDABLE CARE ACT

by **ERIC WILSON**

The Affordable Care Act has come to us with a huge price tag. What is arguably the largest tax increase in the history of the United States, did nothing to address the cost of medical care, and still leaves 30 million uninsured. The health insurance industry has changed tremendously since the implementation of the Affordable Care Act (aka Obamacare). The plans that went into effect in January of 2014 look very different than the ones sold prior to the implantation of the Affordable Care Act. The plans prior to January 2014 tended to focus more on the catastrophic while the new plans focus more on preventive care.

Some of the older plans may or may not have a co-payment for doctor visits; more important, it was common to have a $5,000 family deductible and then 100% coverage thereafter. Now most plans in the Bronze and Silver line of plans will come with a $6,000 deductible and a $12,700 family out-of-pocket maximum. They focus on prevention while many of the preventive services are not subject to the deductible and have no co-pay. Supporters of the law call it free preventive care. Others believe that the more you require a plan to cover, the more it costs. While preventive care is great, you might be more likely to get a physical if it were offered at no cost to you. There is, however, cost associated with it. I like to use the auto insurance example. Your auto insurance does not cover maintenance, but most still get their tires changed when needed and get their oil changed every 3,000 miles. These are services that we can afford to pay for while a larger out-of-pocket of $12,700 or $13,200 is a lot to pay when you are sick and perhaps not able to work.

Insurance rates are a derivative of the costs of the insurance carrier's claims in relation to the premiums collected. Now that there is no more underwriting, it is reasonable to see the insurance carrier's claims expense going up as they are adding additional risk to their portfolio, which in turn you can see adding to the premium cost. To offset some of this cost, many insurance companies have narrowed their networks of doctors and hospitals. This means that you may have to change doctors or change insurance carriers depending on your plan.

If you choose to go out-of-network, the costs get more out of control. This will vary from company to company, but in general, if you go out-of-network on a PPO, the deductible and out of pocket expenses double. There are many reasons you may want to go out-of-network, especially for things like cancer or a transplant. Some hospitals across the country are better equipped to handle certain illness than others, but it will cost you a lot more. The out-of-network deductible is usually double that of the in-network deductible as the out-of-pocket maximum also doubles. Some services are not covered out-of-network. In that case, you could pay thousands of dollars and not even have it applied toward your out of pocket maximum.

To support many of these new programs, the Affordable Care Act includes several federally mandated fees to help pay for various parts of reforms, like funding the public exchanges, conducting research, and supporting the individual market. Federally mandated fees are billed to insurance carriers and passed on to the consumer. These fees affect grandfathered and non-grandfathered health plans differently. The market share fee provides tax subsidies for families who buy insurance through a public exchange. This permanent fee began in 2014. It is based on how much each health insurance carrier collects in premiums. This affects grandfathered and non-grandfathered plans.

The Patient-Centered Outcomes Research Institute fee supports clinical effectiveness research. The fee, which began in 2012 and will phase out in 2019, affects grandfathered and non-grandfathered plans. The Transitional Reinsurance Program comes with a fee to help insurance carriers cover individuals with high claim costs. It is designed to be a three-year program, which will decrease in 2016. The fee also affects grandfathered and non-grandfathered plans. The risk adjustment fee funds the government's risk adjustment program, which also helps carriers with high claims costs. The fee does not affect grandfathered plans.

Lastly, the federally facilitated exchange user fee helps fund and support the federal exchange. Health Insurance carriers will be charged 3.5% of their premium for all exchange business. The fee does not affect grandfathered plans.

Under the Affordable Care Act there are over 20 new taxes on individuals and businesses that will amount to over $500 billion by 2023. Some are tax hikes while others are tax credits. Some do not appear to be related to health insurance at all. One of the largest is the 3.8% surtax on investment income, which is expected to generate $123 billion in tax revenue. This is on households making at least $250,000 per year. The individual mandate excise is expected to generate $65 million. This is for those who do not purchase health insurance.

In January 2018, the excise tax on comprehensive health plans goes into effect. This 40% tax on high end health plans will generate $32 billion in new fees.

The Medicare tax was revised in 2013. This .9% additional tax applies to individuals whose wages exceed $250,000 for married tax payers and $200,000 for all other tax payers. This creates an additional $86 billion in tax revenue.

On January 26, 2015 the non-partisan Congressional Budget Office revised its cost estimates. Over the next 10 years the ACA will cost $1.35 trillion or $50,000 per person. This is just the government's role in implementation. This does not include your premium, deductibles and co-pays. The law still leaves between 29 and 31 million uninsured. This includes the income from the Medical Device Tax, which many politicians predict will be eliminated within two years. If they are correct that $50,000 per person gets even higher.

Eric Wilson is president of I Sell Health, Inc., a Chicago area insurance agency. You can visit online at isellhealth.com on phone toll free 888-448-5370.

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American Equity	A-	BBB+		ICC13 MYGA (Guarantee 5) (Q/NQ)	S	2.25%*	5 yr.	None	9%, 8, 7, 6, 5, 0	Yes	$10,000 (Q) & $10,000 (NQ)	3.00%, age 0-75 & 2.10%, age 76-80**
				ICC13 MYGA (Guarantee 6) (Q/NQ)	S	2.45%*	6 yr.	None	9%, 8, 7, 6, 5, 4, 0	Yes	$10,000 (Q) & $10,000 (NQ)	3.00%, age 0-75 & 2.10%age 76-80**
				ICC13 MYGA (Guarantee 7) (Q/NQ)	S	2.70*%	7 yr.	None	9%, 8, 7, 6, 5, 4, 3, 0	Yes	$10,000 (Q) & $10,000 (NQ)	3.00%, age 0-75 & 2.10%, age 76-80**
	*Effective 3/3/15. Current interest rates are subject to change on new issues. **Commission may vary by issue age and state. See Commission Schedule for details											
American General Life Insurance Companies	A	A	A+	American Pathway Fixed MYG 10 Annuity (Q/NQ)	S	3.45%*	1 yr.	None	10%, 9, 8, 7, 6, 5, 4, 3, 2, 1, 0	Yes	$5,000 (NQ)	4.00% age 0-75 2.20% age 76-80 1.70% age 81-85
	**CA Rates Effective 4/13/15. First year rate includes 1.50% interest bonus											
American General Life Insurance Companies	A	A	A+	American Pathway Flex Fixed 8 Annuity (Q/NQ)	F	3.75%*	1 yr.	None	8%, 8, 8, 7, 6, 5, 3, 1, 0	No	$5,000 (NQ) $2,000 (Q)	2.20% age 0-75 1.70% age 76-80 1.20% age 81-85
	*CA Rates Effective 3/16/15. Includes 2.00% 1st year bonus, 1.00% base rate subsequent years.											
American General Life Insurance Companies	A	A	A+	American Pathway Fixed MVA 9 Plus Annuity (Q/NQ)	S	5.60%*	1 yrs.	None	9%, 8, 7, 6, 5, 4, 3, 2, 1, 0	Yes	$5,000 (NQ)	2.75% age 0-75 1.70% age 76-80 1.20% age 81-85
	*CA Rates Effective 4/13/15. First year rate includes 4.0% bonus 1st year.											
American General Life Insurance Companies	A	A	A+	American Pathway Select MVA 10 Annuity (Q/NQ)	S	1.80%*	10 yrs.	None	10%, 9, 8, 7, 6, 5, 4, 3, 2, 1	Yes	$5,000 (NQ) $5,000 (Q)	1.20% age 0-80 (5 yr.) .90% age 81-85 (5 yr.) 2.50% age 0-80 (7 yr.) 1.75% age 81-85 (7 yr.) 2.00% age 0-80 (10 yr.) 1.20% age 81-85 (10 yr.)
										*CA Rates Effective 4/13/15		
Genworth Life & Annuity Insurance Co.	A	A-	A-	SecureLiving Rate Saver	S	2.45%* 2.20%	7 yrs. 5 yrs.	None None	9%, 8, 7, 6, 5, 4, 3 9%, 8, 7, 6, 5, ,0	Yes	$25,000 (NQ) *Effective 4/1/15. Based on $250K or more.	Varies 0-85
Great American Life	A	A+	A+	SecureGain 5 (Q/NQ)	S	1.95%	5 yrs.	N/A	9%, 8, 7, 6, 5	Yes	$10,000	2.50% 18-80 (Q), 0-80 (NQ) 1.50% 81-89 (Q&NQ)
Effective 7/30/14. Includes .25% first-year bonus and is for purchase payments over $100,000. Escalating five-year yield is 1.95%. For under $100,000 first-year rate is 1.85%. Escalating rate five-year yield 1.85%.												
Great American Life	A	A+	A+	SecureGain 7 (Q/NQ)	S	2.40%	7 yrs.	N/A	9%, 8, 7, 6, 5, 4, 3	Yes	$10,000	3.50% 18-80 (Q), 0-80 (NQ) 1.50% 81-85 (Q&NQ)
Effective 7/30/14.. Includes 1.00% first-year bonus and is for purchase payments over $100,000. Escalating seven-year yield is 2.29%. For under $100,000 first-year rate is 2.30%. Escalating rate seven-year yield 2.19%.												
Great American Life	A	A+	A+	Secure American (Q/NQ)	S	1.40%*	1 yr.	N/A	9%, 8, 7, 6, 5, 4, 3	No	$10,000	5.75% 0-70 4.65% 71-80 4.40% 81-89
*Effective 7/30/14.. Eff. yield is 2.42% based on 1.40% first year rate, 1.00% available portion of 10% annuitization bonus (available starting in contract year two) and 0.02% interest on available portion of bonus at the rate of 1.40%. Surrender value interest rate 1.40%. Accepts additional purchase payments in first three contract years. COM12255												
Jackson Insurance Company.	A+	AA	AA	Bonus Max (Q/NQ)	F	3.20%*	1 yr.	None	8.25%, 7.25%, 6.50%, 5.50%, 3.75%, 2.75%, 1.75%,0.75%**	Yes	$5,000 (NQ) $5,000 (Q)	6.00% 0-80 3.00% 81-85 1.50% 86-90
*Effective 10/6/2014. The first year interest rate includes any first year additional interest, if applicable. Interest rates in subsequent years will be less. **Each premium payment, including any subsequent premiums, is subject to the withdrawal charge scheduled as detailed.												
The Lincoln Insurance Company	A+	AA	AA	MYGuarantee Plus 5	S	1.35%*	5 yr.	None	7%, 7, 6, 5, 4, 0	Yes	$10,000 (Q/NQ)	
**Rates Effective 4/1/15 for premium less than $100,000 and are subject to change												
The Lincoln Insurance Company	A+	AA	AA	MYGuarantee Plus 7	S	1.75%*	7 yr.	None	7%, 7, 6, 5, 4, 3, 2, 0	Yes	$10,000 (Q/NQ)	
**Rates Effective 4/1/15 for premium less than $100,000 and are subject to change.												
North American Co. for Life and Health	A+	AA-	A+	Boomer Annuity (Q/NQ)	F	6.57%*	1 yr.	None	15%,14,13,12,11,10,8,6,4,2	Yes	$2,000 (Q) $10,000 (NQ)	7.00% (0-75) 5.25% (76-80)
* 6.57% First Year Yield reflects a 5% Premium Bonus in years 1-5, annuitization bonus after year 10. Penalties are waived at death. This yield assumes no withdrawals. The Interest Rate is based on current rates as of 4/8/15 and is subject to change.												
Reliance Standard	A+		A+	Eleos-MVA	S	3.05%*	1 yr.	None	8%, 7, 6, 5, 4	Yes	$10,000	3.25%**
*Effective 2/9/15. Includes 1.50% 1st yr. bonus. Min. guarantee is 1.00%. **Reduced 20% ages 76-80, and 40% ages 81-85												
Reliance Standard	A+		A+	Apollo MVA (Q/NQ)	S	4.00%*	1 yr.	None	9%, 8, 7, 6, 5, 4, 2	Yes	$5,000	4.00% to age 75**
Includes 2.00% 1st yr. bonus. Min. guarantee 1.00% **Reduced 20%, ages 76-80, and 40% ages 81-85. Effective 2/9/15												
Symetra Life, Inc.	A	A+	A	Custom 7 (Q/NQ)	S	2.60%*	7 yrs.	N/A	8%, 8, 7, 7, 6, 5, 4, 0	No	$10,000	Varies
*Effective 4/22/15. 2.10% base rate with no guaranteed return of purchase payments. Plus 0.50% bonus for $250,000 and above.												

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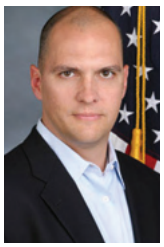

Eric Maddox

Upon graduating from the University of Oklahoma in May 1994, Eric Maddox joined the U.S. Army as an infantry paratrooper for the 82nd Airborne Division. After spending three years as an airborne Ranger, Eric reenlisted as an interrogator and Chinese Mandarin linguist. Since 9/11, Eric has conducted over 2,700 interrogations while deploying eight times in support of the Global War on Terrorism (GWOT) to include multiple tours in Iraq, Afghanistan, South America, Southeast Asia, and Europe. In 2003, while assigned to a special operations task force in Tikrit, Eric conducted over 300 interrogations and collected the intelligence which directly led to the capture of Saddam Hussein. As a result, he was awarded the Legion of Merit, the Defense Intelligence Agency's Director's Award and the National Intelligence Medal of Achievement. Now retired, Eric lives in his hometown of Sapulpa, Oklahoma.

Tom Hegna, CLU, ChFC, CASL

Tom Hegna specializes in simplifying retirement solutions that help advisors sell their products by offering clients easily digestible solutions to complex problems. Lauded as the retirement income expert, Tom will present: *Don't Worry, Retire Happy! Seven Steps to Retirement Security*, which is his latest book based on his popular public television show.

Curtis V. Cloke, CLTC, LUTCF, RICP, Financial Life Planner

Curtis Cloke is an award-winning international speaker, educator and author as an industry recognized retirement income expert. He is an active Financial Life Planner with over 28 years of experience serving his clients around the US from his Burlington, Iowa office. Having created an "industry celebrated" retirement income process uniquely developed for financial professionals, Curtis will present: *Retirement RIOT... Divide and Conquer.*

Van Mueller, LUTCF

Van Mueller is a Registered Representative with The Wisconsin Agency of New England Financial Services and an insurance agent of 41 years. He is an active member of NAIFA and MDRT having qualified for Court of the Table in 1990 and Top of the Table for the last twenty three years. Van has spoken to groups around the world, including being a main-platform speaker at NAIFA, MDRT and the 2001 Top of the Table Meeting.

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*YAT - Under 40 years of age or first 5 years in the business.

NAIFA IT PAYS TO BE A MEMBER

HOW THE ACA HAS AFFECTED *HSA CONTRIBUTIONS*

by **LEILA MORRIS**

In response to the Affordable Care Act, employers have reduced their contributions to Health Savings Accounts (HSAs) by 10% in 2014. A survey by United Benefit Advisors found that average contributions were $515 in 2014 compared to $574. Average family contributions also declined 7% from $958 to $890. "Employer HSA funding strategies have changed in recent years in response to the Affordable Care Act (ACA)...When HSA products were new, the employer could take the premium savings and fully fund the deductible. Now, premium reductions are not as great as they once were. As premiums increase, employers naturally put their contributions toward premiums first and slowly reduce their HSA funding to the point where it becomes entirely the employee's responsibility in some cases, " said Brian Goff, president & CEO of Insurance Solutions.

Mark Sherman, principal of LHD Benefit Advisors said that several factors influence an employer's HSA contribution strategy, such as the deductible, the employee's premium contribution, the out-of-pocket maximum, and whether other types of plans are offered. Andrea Kinkade, president/benefit Advisor at Kaminsky & Associates said, "Either employee payroll deductions (premiums) increase or employer HSA contributions decrease to keep benefit costs within the budget."

Larger employers (50 to 1,000+) have the lowest average HSA contribution at $426 for singles. Smaller employers (one to 50) contribute an average of $890 for families compared to lager employers, which contributed an average of $760.

Goff explains, "The larger the group, the more impersonal some of these decisions are. Plus, many large groups are self-funded so premium equivalents are not as great among HSA plans, HMOs, and PPOs. As a result, the expectation is that the employer contribution to the HSA will not be as great and some employees will enroll in non-HSA plans, making the high-deductible plan not as worthwhile.

Large employers also have lower CDHP enrollment. Even though 26% of large employer plans are CDHPs, only 17% of their employees are enrolled. Generous HSA contributions among small groups are typically designed to help compensate for higher deductibles than those that are offered in larger group plans.

California has the most generous HSA contributions ($808 for singles and $1,316 for families) but the lowest enrollment in CDHPs; only 11% of plans in California are CDHP plans and only 8% of employees are enrolled. Market dominance of Kaiser and a strong HMO preference in California offsets the rate relief offered by CDHPs, making the high deductible not worthwhile, explains Goff.

Higher HSA contributions are linked to increased enrollment in HSAs and consumer driven health plans (CDHPs). The strategy of attracting employees to CDHP plans with generous HSA contributions has worked in the finance and insurance industry where 32% of plans are CDHPs (the highest of any industry) and enrollment is 32% (also the highest enrollment of any industry). HSA contributions in the finance and insurance industry are 21% above average for singles at $634 and 19% above average for families at $1,074.

CDHPs have seen enrollment increases of more than 30% in the last two years (16% to 21%), despite decreases in employer contributions. "For large employers and the mining/oil and gas extraction industry, even modest increases in HSA contributions can be a key part of the puzzle in migrating employees to lower cost CDHP plans. For many employers (especially those who have already offered HSA-based plans), the current movement is to offer a full replacement solution, often with two or more HSA-based plans to allow for employee choice," says Sherman. ★

Leila Morris is the senior editor of California Broker Magazine.

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DISABILITY INSURANCE INSIGHTS

AGENTS AND BROKERS ARE THE MAHOGANY AND VELVET OF THE FUTURE

by **W. HAROLD PETERSEN,** RHU, DFP

The T.V. interviewer asked the gentleman clerk of 42 years why many people in the City of Los Angeles were reacting so emotionally to the closing of Bullock's Wilshire department store. His word choice of "mahogany and velvet" compared to "plastic and chrome," summed up the passing of an age of grandeur, pride, and professionalism to an era of uncaring, unprofessional and unattractive places where people buy life's needs and wants.

Bullock's Wilshire opened in 1929, the year of the great stock market crash and ensuing Great Depression. The magnificent 10-story building that housed the famous store was one of the world's greatest examples of art deco. The building stood alone in what was, at the time, a very suburban location. The television show contained a photograph of the store's founder, John Bullock, holding his three-year-old grandson in one arm while unlocking the door to start business in this daring location.

The grand and magnificent store served discriminating shoppers for 64 years before succumbing to the scourge of conglomeration and the unstoppable changes of community and shopping habits. Some of the shoppers interviewed referred to the store as part of the city's culture. Others, chagrined by the closing, felt unattached and fearful for they had been clothed by Bullock's all their lives. Some enjoyed the architectural grandeur while others mourned the loss of long-time friends who had been the proud, professional clerks of a grand department store. Among the employees interviewed was the city's last elevator operator, a man who served in that capacity for 40 years, proudly and with great dignity.

No longer will people enjoy the splendid holiday decor, the sophisticated tea room, the magnificent furnishings, and the caring, friendly professionals who worked at truly serving the store's customers. The viewing of this sad occasion was mindful of negative changes in the insurance industry. The "mahogany and velvet" we enjoyed in days past was epitomized by quality whole life insurance, a policy with absolute guarantees of absolute cash values, absolute mortality costs, and settlement options. It was a time of permanency and stability. Everyone trusted the life insurance company and rightfully so, for in that era, the management dedicated itself to the well-being of the insureds and not primarily to the welfare of top management.

(Continued on page 14)

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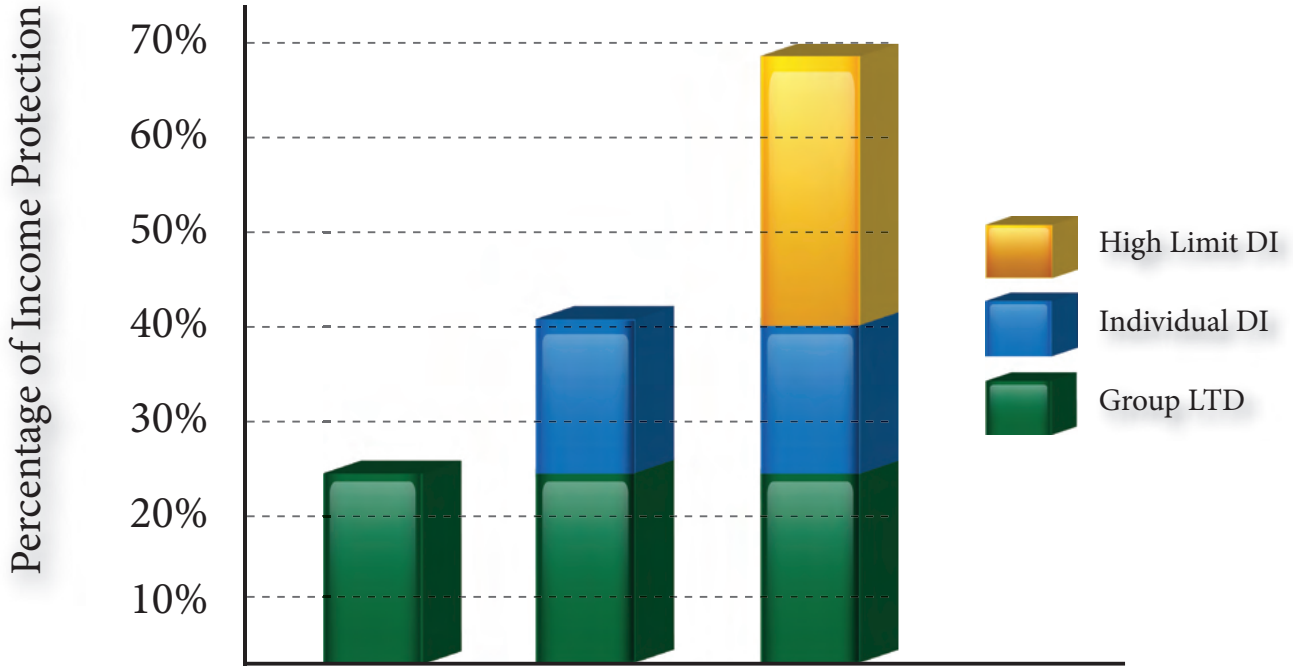

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(AGENTS & BROKERS - Continued from page 12)

In the "mahogany and velvet" era, general agents, not some non-human computer, collected the premiums. The general agents and agents were prominent, respected leaders of the community who had constant contact with policyholders. Companies renewed non-renewable coverages year after year at the pleasure of the insureds. The dependability and comfort of knowing one's coverage and its absolute renewal was an ambiance like mahogany and velvet, compared to the temporary and unknown aspects of the durability of plastic and chrome.

Disability insurance was available to all occupational classes. It was fitted by professionals who knew every word in the policy and the sales features. The well-trained professional agent had the privilege of handling their customers' claims. At the time of the great Bullock's store opening, a great disability purveyor used the baker's dozen concept of handling the claims of his disabled policyholders. With the company's knowledge and without fear of insurance department rancor, he added an extra month's benefit to the last claim check of the recovered insured.

So happy with the service and the benefits were the insureds that they virtually demanded that their friends buy disability insurance from the agency. It was like the mahogany and velvet of Bullock's Wilshire applied to the disability insurance business. The customer's interests came first, last, and always.

Stories abound about the enormous success of the William E. Lebby Agency of Massachusetts. Like Bullock's Wilshire, this agency passed into oblivion when the underwriting company became a victim of conglomeration, the professional agents aged and retired, and their kind of professionalism vanished into the fog of consumer laws, regulations, discounting, and reduced service. Insurance companies, like retail stores, have become imbedded in plastic and chrome. But all need not be lost. There is yet an opportunity to provide the feeling of mahogany and velvet for our clients by showing that we do provide consumer care, service, ambiance, and professionalism in an otherwise plastic and chrome industry. The mahogany and velvet is no longer in the home offices, but in the offices of agents and brokers.

We cannot prevent companies from raising prices on a timetable basis rather than on a necessity basis. Nor can we prevent them from refusing renewal of coverage regardless of the loyalty and affordability of the customer. We are also unable to prevent reduction of commissions and the sloughing off of service costs to agencies. We cannot convince them that it is healthier to have agencies collect premiums and settle claims instead of relying on uninvolved and unemotional headquarter workers whose work is done with numbers rather than names.

But we, the agents and brokers, remain human. We can treat customers with care and dignity. We can be professional and overcome the inadequacies of our underwriting companies. In an era of plastic and chrome companies, brokers and agents have become the mahogany and velvet that consumers seek. And in doing so, our clients will strongly suggest to their friends that they should do business with "my broker." ★

W. Harold Petersen, RHU, DFP is founder of the International DI Society and chairperson of Petersen International Underwriters. He is recognized as an expert in underwriting development and policy innovation in the expanding field of disability financial planning. He has been awarded the Harold R. Gordon Memorial Award (NAHU), the Will G. Farrell Award (NAIFA Los Angeles), the Lifetime Achievement Award (IDIS) and the Distinguished Service Award (NAIFA CA). To reach him, call 800-345-8816 or email whp@piu.org.

A CAHU Forum Interview With Alan Katz

by **MEG McCOMB**

Alan Katz speaks and writes nationally on wellness, health care reform, sales and marketing, and strategic planning. He is the author of *Trailblazed: Proven Paths to Sales Success*.

Alan has a long and successful history leading sales organizations within companies, ranging from startups to Fortune 25 corporations. His consulting firm, the Alan Katz Group, provides sales development and business strategies to health insurance carriers and agencies. Alan is also a principal of Insurgency Benefits, which delivers non-traditional benefit programs that reduce employers' cost, improve employees' health, and provide producers with a market advantage.

A past President of the California and the National Associations of Health Underwriters, Alan led legislative efforts for both organizations, including testifying before several Congressional and state legislative committees. In 2003, he received NAHU's highest honor, the Harold R. Gordon Memorial Award, as Health Insurance Person of the Year. Alan was named CAHU's Member of the Year in both 2000 and 2007. Outside of the insurance industry, Alan served as an investigating attorney with the U.S. Securities and Exchange Commission, Chief of Staff to California's Lieutenant Governor and a member of the Santa Monica City Council.

How much longer do you think we're going to be in the middle of big changes in the health insurance industry?

I think the extraordinary changes will continue longer than we would like, but not as long as we fear. The ACA is not a two footed animal. It's more like a centipede, and there are plenty of shoes available to drop. The next challenge will be when grandmothering expires. All those employer groups that avoided many ACA provisions will suddenly find themselves right in the heart of it all. At the same time, groups of 51 to 100 who have not dealt with the ACA's small group provisions are going to have to do so too. That's going to put a lot of demands on brokers.

I think that, over the next couple of years, you'll see some movement towards improving the functionality of the ACA. There's precedent for it. For example, we sidestepped the provision of the ACA that would have required everyone to give 1099s to Staples if we bought more than $600 worth of office supplies in a year. Democrats and Republicans came together and got rid of that provision. I think we'll see similar agreements on tweaking the law over the next couple of years. When we get a new president, whether it's a Democrat or Republican, they're going to find it a little bit easier to tweak the ACA. First off, there will be more experience under our belts. Secondly, it's not called "Clintoncare" or "Bushcare." It's called Obamacare, so the next president will likely be more flexible when it comes to changes to the law. If Congress can get over its fixation with repealing it and move on to making it better, there could be a lot of welcome changes in the next several years.

That's the long answer; here's the short answer to your question: given what's likely to happen in Washington over the next three years, we're probably looking at a few more years of pretty intense change.

What will happen when grandmothering expires?

Welcome to the wonderful world of sticker shock! These groups will see a spike in the cost of their coverage. They're going to get plans that are probably richer than what they've had before. They'll be getting more value. Still, price-wise, they've had a good thing going for two years. They're going to be shocked when they fully enter the new world.

Do you think that the dysfunctional relationship the two parties seem to have right now in Washington will continue, or will soften, following the next presidential election?

I doubt that it will soften a lot. It's just too easy with Fox News and MSNBC to get locked into fixed, extreme positions. And the rapid rise to prominence of Senators like Cruz and Warren shows that it can be rewarding for politicians to be champions of the far-end of their parties. That dynamic is not going away. There are Republicans who seem to have a special dislike for President Obama (much like there were some Democrats who seemed to have a special dislike for President Bush). But today's dysfunction is not because Republicans are singling out President Obama. They would have done the same thing to Hillary Clinton. Now that the Republicans are in the majority, the Democrats are using some of the tactics Republicans used when they were in

the minority, such as the filibuster, in order to prevent the Republicans from moving forward with their agenda items. It's hilarious to see how quickly both parties switched their outrage. Those who hated filibusters now use them; those who used them now hate them. But that's the silliness of Washington—and not too dissimilar to what happens across the country. I don't see any incentives out there for Democrats and Republicans to work more closely together so long as the primary elections are decided by the extremes.

Do you feel that the open primary, which CAHU supported, is already starting to work in California?

Yes. Since the open primary passed in California, it's easier for moderates to make it to the general election and have a chance of winning office. We've already seen this take place. My neighborhood is a perfect example. In the last election, there was an open state senate seat, an open Congressional seat and an open county supervisor seat. The moderates won the congressional race and the legislative race. A liberal did win the supervisor race, but she won by a fairly narrow margin. Significantly, those were all Democrats against Democrats in the general election. If it had been a Democrat against a Republican, we might have seen only the liberals getting through the primary and they would have trounced the Republicans in my district.

Do you believe that the redistricting reforms, which CAHU also supported, are working well in California?

I think so, but it's a bit early to tell. We've only had one redistricting effort since the reforms passed. We have to wait until 2022 for the next reapportionment. Reapportionment is glacial in its impact. Having said that, I do believe the redistricting reforms CAHU supported have made a difference for the better, at least marginally. Today districts are less gerrymandered and less absurd than in the past.

Do you believe that CAHU and NAHU have played significant roles in the Affordable Care Act landscape?

Absolutely! First, Health Underwriters were deeply involved in the drafting of the ACA. NAHU was able to get language in parts of the bill that were favorable to our members and our clients. Since then, they've been extremely involved with regulators at HHS, the Department of Labor, and the IRS to implement the ACA. NAHU continues to work tirelessly for favorable regulations coming out of Washington. At the state level, I think CAHU has been effective, too. We were obviously very involved when Governor Schwarzenegger was trying to pass healthcare reform. That, of course, failed. Now, with the implementation of the ACA, CAHU members have been deeply involved in making Covered California more agent-friendly and better for consumers.

Impacting health care legislation has been tougher in California than it has been in Washington. It's easier to influence regulation than it is to influence legislation, because politics is a huge factor in drafting legislation, but much less so in developing regulations.

Please explain.

When politicians get elected, they pass laws, and those laws reflect a considerable amount of political calculation. I'm not saying that there's no politics in the regulatory process, but it's far less. First, regulators aren't usually running for office (insurance commissioner aside). In Washington, the folks who are drafting and pushing through regulation are not elected officials. They are more concerned about making the legislation workable than they are in pushing a particular hot button for a constituent. Therefore, it's easier for an organization like NAHU to influence things: our members know what's workable and our association's strength comes from our public policy expertise. Whereas, in Washington, the law was written somewhat broadly with the intent that regulators would work out the details. California's implementation of the ACA was done primarily through legislation. There has been some regulation, but more of the heavy lifting was done through the legislative process. That makes it a lot more difficult for CAHU to influence things.

Are you saying that most of America's healthcare reform was part of a legislative or political process?

That's oversimplifying it. Making a law is like cooking a dish where you have a recipe. More of the ingredients come from the political side than the policy side, relative to the regulatory cooking process. It's the same ingredients, but it's just how much comes from which shelf. When cooking up legislation, there's more politics in the mix than there is when creating regulations. That doesn't mean that there's no public policy. President Obama is a very bright guy. He had some very specific policies he wanted to implement. Members of Congress also had policies they wanted to get through. Some they were able to pass, and some they weren't. I don't know if you remember the discussion on the public option. The President and some Democrats felt very strongly that there should be a public health plan in the non-exchange market. This wasn't a political move as much as it was a reflection of their belief of how the world should work. They were defeated on that element because there were Democrats and Republicans who felt that it was wrong on a public policy level. Public policy plays a huge role in legislation, but so does politics. When it comes to regulation, policy is more important and politics somewhat less so, relative to the legislative process.

Do you think that this attempt to add extra regulations to the ACA is going to continue in California?

I do think it will continue. Health insurance is regulated by the states. The ACA built a framework within which the states can operate. As long as they stay within that framework, states are free to move off in different directions. California is politically a very liberal state. There are strong personalities in the legislature who have both political and public policy beliefs that are going to drive them in a certain direction, giving a distinctive California patina to the ACA's framework. That's natural; there's nothing wrong with it. But it does create a challenge for CAHU and its members.

(Continued on page 18)

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(ALAN KATZ - Continued from page 16)

A lot of national attention has focused on Covered California. What are your thoughts on our exchange, in context of the overall success of health care reform?
Here's what I find interesting: in many American's minds (including reporters and politicians), the exchanges like Covered California are healthcare reform. There's almost a sense that unless you're buying through the exchange, you're not getting any benefits from health care reform. Nothing could be further from the truth. The only thing an exchange provides is a subsidy whether it's through a tax credit for employers or a premium subsidy for individuals. As a result of those subsidies being there, I suppose it's not surprising that people equate the exchanges with health care reform. In reality, the ACA, and the broader health insurance marketplace, is so much more than the exchanges. Perhaps so much emphasis is placed on Covered California and other exchanges because it's easier for the press and the public to oversimplify things to look at health care reform through the lens of the exchange. I think that's unfortunate, but that's the way it is.

Do you think that the private marketplace outside of Covered California will continue to be a viable segment of California's insurance marketplace?
Absolutely. I believe the majority of health insurance will be sold outside of exchanges.

Will that still be the case when the SHOP goes up to 100 lives?
The SHOP is a non-entity in the marketplace. I don't know how many employers signed up this year, but in the overall scheme of things, they're a very small player in the group marketplace. I think the people at Covered California are doing their best under some very trying circumstances and some huge challenges. I happen to have some insight in to how difficult it is to launch a health plan in a state like California, especially during this stage of ACA implementation. Covered California isn't launching a health plan—it's launched a health marketplace, which in many ways is more complex. I think they've done the best job possible, but the reality is that there is little market demand for the SHOP.

What are the selling points for the SHOP? There are really just four. One is that employees get to select from multiple benefit plans, but most every carrier out there offers some kind of mix and match option, and have for years. Second, employers can take advantage of a defined contribution arrangement. The employer pays a flat amount toward the premium costs, and employees can put in more of their own dollars if they want to buy up. Many California carriers already offer defined contribution. The third selling point of the SHOP is that employees can choose from multiple carriers. That's already available through other exchanges. And most employees don't really care if their medical card has a particular carrier's logo. They just want to know if their doctor is in the plan's network, and most doctors are in most networks. Personally, I don't believe allowing people to choose from multiple carriers justifies the existence of the SHOP. The fourth selling point is the tax credit. There's no reason the tax credit should be available

solely through the SHOP, but I think when drafting the ACA, folks knew they needed it to give the exchanges an advantage. But that speaks volumes; if you have to bribe people in order to enroll them, there's a problem in the concept. Of course, the tax credit doesn't matter if you're not eligible for it. Especially in that case, the SHOP doesn't really offer much that's different.

None of these points are a reflection of the skill, talent, or professionalism of the people at Covered California. The reality is that you can't sell something that has marginal value and expect to get a lot of customers. That's not just a California issue, that's nationally. The SHOPs just don't have much market appeal because they're not really necessary. The individual exchange is a different story. There's a different dynamic in the individual market because of the need to enable people to move between Medicaid and the individual market. But when it comes to the SHOP, it's really tough to see the value of the small group exchange anywhere in the country.

We all have clients who can't see their doctor anymore due to limited provider networks. Do you think this problem will be fixed any time soon?
I think it's going to take some time. To put this issue in context, let's remember that the issue of overly narrow networks is primarily an individual market problem. Then you need to look at the main areas of differentiation among carriers in that market: price, benefits and networks. Benefits have become more standardized under the ACA, increasing the importance of price and networks. Price remains the most important factor, and premiums are largely driven by the cost of the underlying medical care. The cost of medical care is, in turn, driven in large part by the network. Narrower networks tend to reduce medical costs. So, there's a huge incentive for carriers to offer narrow networks, especially in the individual market. Absent legislation, there's

not a lot in the market to counterbalance that incentive. That suggests narrow networks will remain until legislators or regulators step in.

Do you believe that America is heading toward a single payer system?

No, absolutely not. Look at the political damage the Democratic Party took for championing the ACA, and that was healthcare reform built around the private sector. The ACA, as we discussed earlier, doesn't even include a public option. Yet, passage of the ACA was a major reason Democrats lost control of the House and the Senate. For the foreseeable future, Democrats will be hesitant to go down the road of massive reform again. Sure, there will be people calling for a single payer system, but they won't garner 60 votes in the Senate for a long, long time. I'm not surprised that people still talk about a single payer system. But, given the political blowback, it simply won't happen.

Do you think that this country is going to have a health insurance system that adequately addresses the underlying cost of health insurance, which is the cost of health care itself?

I hope so. There are some seeds buried in the ACA that address cost controls. The move towards performance based payment, as opposed to pay-for-service reimbursements, is headed in the right direction. This approach is strengthened by the Affordable Care Act. Eventually, society is going to have to address this issue.

Can you talk a little bit about agent compensation as it relates to ACA and the future?

The medical loss ratio provision of the ACA squeezes commissions. At the same time, carriers and policy makers alike recognize that agents need to make a living wage in order to continue in this business. A balance needs to be achieved between keeping costs low and enabling brokers to earn a living.

Today, agent commissions in most parts of the country are tied to health insurance premiums. Yet premium increases over time greatly exceed the rate of inflation. Some argue this means brokers have received a huge windfall over the past several decades.

Combine these factors, and I think you'll see a move toward per-employee/per-month broker compensation arrangements. What it will take is carriers, employers, and brokers finding the right payment amount. Once that sweet spot is reached, commissions will be adjusted to reflect general inflation, not the increase in the cost of medical insurance. From a purely financial point of view, this is a logical, defensible system. It's already happening in parts of the country.

Right now, state law makes it difficult for brokers to charge their clients fees like accountants and lawyers do. But the law can change, and a fee-based model would be viable. Meanwhile, the ACA was passed in 2010 and commissions are still the norm. It doesn't really matter what's logical. What matters is where the market lines up. Few carriers are willing to be the first ones to make big changes, as they know the market will punish them if they go too far. Sooner, rather than later, I think we'll see an increase in the number of flat commission arrangements.

NAHU was instrumental in the reintroduction of H.R. 815, which would take the agent compensation out of the Medical Loss Ratio (MLR). What are your thoughts?

The bill makes sense. I spoke to that at the NAHU national convention shortly after the ACA was passed. Including commissions in the MLR calculation is unfair. The purpose of the MLR provisions is to prevent carriers from enjoying a windfall in a world where consumers are required to purchase health insurance.

But carriers don't benefit from commissions. They're simply providing a convenient way for consumers and employers to pay their brokers. One hundred percent of commission payments carriers take in, they pay out to brokers. This actually saves the system money. Think of the expense, frustration and hassle if every employer had to cut a separate commission check. It's similar to the way the ACA handles tax payments. Those are collected from employers and consumers, but passed along to the government. Carriers don't keep any of these dollars. As a result, they're excluded from the MLR calculation. Commissions should be treated the same way.

My hope is that as policymakers continue to gain awareness of the value that brokers bring to the system, they'll see the sense of treating commissions like other pass-through dollars that carriers collect. Yes, there would be a very marginal increase in overall premiums, but that's a small price to pay to strengthen agents' ability to serve their clients.

Please give your perspective on the trend for medical insurance premiums?

Premiums reflect the cost of medical care. In regards to those costs, the numbers are the numbers. In recent years, the rate at which the cost of medical care increases has slowed. There are a lot of factors behind this including the strength of the economy, demographics, technology, and the implementation of the ACA. There's more we can do, but the rate of increases is lower than in the past, and I hope that trend continues.

The media frequently says there are not enough providers, especially primary care physicians, to treat Americans. Do you think the ACA is responsible for the shortage?

The shortage of American doctors is something that predates the ACA. It's easy to blame the ACA for every ill in America's health care system. The fact is that the generation of doctors who are retiring is larger than the generation of doctors coming out of medical schools. Meanwhile, there's an increasing demand for doctors as more Americans become insured (since insured consumers see their doctor more often). The primary care physician crisis began before President Obama was ever elected, and it will continue for a lot of reasons.

What do you think the future looks like for agents?
I am very optimistic about agents' future. Our industry is going through a lot of changes, and this creates a lot of new opportunities and challenges. For example, there are new competitors out there. Very soon, I think we'll see a lot of new tools to help brokers compete with those competitors. (I'm actually working on building some of those tools now.)

I'm not pretending that everything is rosy. It's a lot tougher to succeed in the individual business today. Brokers will need to diversify, but there will be new ways to do that. For example, brokers who want to move up market to work with larger groups will find that there's a new generation of fixed-premium, self-funded plans coming to help them do that. I think there's a great deal of opportunity coming agents' way.

Look, nothing in the Constitution gives anyone the right to be a health insurance agent. People earn that right by bringing value to the products they sell and service. The need for the services professional agents deliver, including their expertise, has not gone away. Professionals who are not only health insurance agents, but also knowledge brokers, will succeed. Consumers need someone who can help them conquer the confusion in health insurance and employee benefits. Big national companies that are bribing people to make them their agent of record can't do that. Nor can they customize solutions to meet clients' unique needs the way local, professional agents can. Call centers have their limits. I've talked to some agents who are close to giving up. If they do, I think they'll be missing out on huge opportunities.

So, you don't think payroll companies or technology-based companies are going to replace the value of the agent?
No way do they replace agents. Think about it. For over a decade, payroll companies have been trying to take the agent-of-record on their payroll clients. They had some initial success. And it wasn't that long ago when PEOs were going to put brokers out of business. But then you saw all these agent-friendly payroll companies and agent-friendly PEOs sprout up! While those competitors have their niche, agents still dominate the market.

Whenever a new player enters the market, agents adapt. The new disrupter-of-the-day is an agency that gives HR software to employers for free in order to be their agent-of-record. I'm confident agents will have tools to compete head-on because that's one of the projects I'm working on. Who is going to win once there's a level-playing field—a call center or a local agent they know? Who is going to win if the client can get free software from a national company or a community-based agent? In that contest, my money is on the agents to win! And when I say my money is on agents winning, I mean that very literally!

This doesn't mean that these types of companies will go away. They'll have a niche. They'll build a huge business working with companies and employers who like the idea of doing everything online, and don't think they need or want an agent. But the fact that they find a niche doesn't mean that professional, community-based agents are going away or can't compete. It's quite the contrary. Given the right tools, agents are extremely capable of competing and winning against those competitors.

Let me close with this: if an agent is just a paper pusher, then these types of companies as well as payroll companies will win. I'm proud to say that most of the agents I know are true professionals. They are experts at what they do; they take pride in their work; they realize that their services are vital to their clients; and they behave accordingly. Successful agents have a calling and they want to do the best job possible. I think those brokers are going to thrive in the years ahead! ★

Meg McComb is CAHU's Vice President of Communications.

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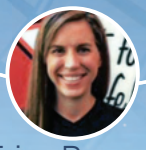
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VOLUNTARY BENEFITS
A VIEW FROM THE TOP

by **LEILA MORRIS**

Executives we interviewed for this year's View From the Top feature say that it's a great time to sell voluntary benefits due to high deductible health plans, health reform, and even the rise of social media. More brokers are jumping into the voluntary benefit market to diversify their offerings and supplement income lost a result of health care reform mandates. The voluntary products that are really gaining traction with employer groups are those that offset out-of-pocket expenses created by the new high-deductible medical plans. These products include critical illness coverage, medical gap insurance plans, HSA-compliant hospital indemnity plans, accident insurance, and limited medical supplement plans. Financial wellness benefits are also getting more popular. The consensus is that health reform has highlighted the value of offering employees more than just the traditional options.

What is a compelling argument for employees to have extra money taken out of their paychecks for voluntary benefits when they are cutting back on all kinds of small expenditures in a tough economy?

Jennifer Lococo, senior vice president of sales, Voluntary Benefit Advisors: The very fact that the majority of the workforce lives paycheck to paycheck is the reason why affording supplemental coverage becomes a necessity, not a luxury. It's about empowering employee choice; some employees will find value and participate and some will not. Should a critical illness or injury occur, employees will appreciate having access to programs that will protect them financially. In many cases, employees can get substantial coverage for a nominal cost invested in comparison to being depleted financially from an illness or injury.

Toney Chimienti, President and Founder of Chimienti & Associates Insurance Services: With deductible and coinsurance expenses continually increasing, there are advantages for employees to manage their expenses by choosing the less expensive higher deductible and coinsurance plans offered by their employer. They can then use some of the savings of the lower premium HDHP to fund the cost of a voluntary supplemental coverage, which will offset the financial risks associated with the high deductible medical plans. This combination of coverages often costs less than choosing a lower deductible medical plan while mitigating more of the out-of-pocket expenses. Using supplemental benefits, such as an HSA-compliant hospital indemnity plan or medical gap plan, can offset the exposure of the higher deductible medical plans. Disability insurance is also a benefit that every employee should be sure to purchase if they can. The most valuable asset an employee has is their ability to earn an income, which can be protected with a voluntary disability insurance plan. This will provide income to pay for their house payments, out-of-pocket medical bills, utilities, groceries, car payments, and other personal expenses during a period of disability.

Meredith Ryan-Reid, senior vice president, MetLife Group, Voluntary and Worksite Benefits: With more and more employees living paycheck to paycheck, having voluntary benefits is an integral part of employee's financial well-being. Voluntary benefits have two primary objectives: one is to provide financial protection, and the other is to save employees money. Voluntary benefits allow employees to personalize their benefit selections to meet their age and life situation. When a slow growth economy has limited employees' ability to save, voluntary benefits, like critical illness coverage, provide a level of financial protection against unexpected events that could devastate an employee with limited to no savings. Receiving a lump sum benefit of $15,000 or $30,000 after a diagnosis of a major illness, could be the deciding factor about whether someone has to declare bankruptcy. Voluntary auto and home insurance provides a great example when looking at the savings voluntary benefits provide. This benefit, which offers necessary protection, may also save employees money when offered as a voluntary benefit. This saving puts more money in the employee's pocket, which in turn can be used for other things.

Michael Stachowiak, director of U.S. Broker and Field Strategy at Aflac: Many employees come to understand that they can address very real financial risks when

voluntary benefit options are integrated into the medical plan presentation and explained correctly. As employees become smarter health care consumers, they have greater awareness of the benefits of voluntary insurance.

When developing their pre-renewal strategy, brokers can integrate voluntary benefits into the medical plan design conversation. I've found that this is the most successful way to explain and position voluntary insurance benefits. It often leads clients to deeper medical plan design discussions and better cost-saving strategies. Once employees see the bigger picture, it will be easier for them to deduct from their paycheck to help cover the financial risk that an unexpected accident or illness could pose.

The risk of a health-related incident creating financial problems is at an all-time high. The majority of employees don't have money set aside for emergencies. At the same time, they face increasing deductibles, copayments, and out-of-pocket costs that major medical simply isn't covering or is covering at a lower level than in years past. Employees understand this new reality now more than ever. The average employee doesn't mind budgeting for a new smartphone or stopping for their daily $4 latte, so why shouldn't they want to plan and set aside money to help protect themselves financially in case of an unexpected accident or illness?

Rich Williams, senior vice president, Growth Markets for Colonial Life: Although the economy continues to improve, many of America's workers are still working paycheck to paycheck. They're struggling just to pay bills and expenses, let alone set aside money for an unexpected illness or injury. Voluntary benefits offered at the worksite provide significant financial protection. They're very affordable since premiums are typically deducted from an employee's paycheck, often on a pretax basis. Many types of voluntary coverage can be purchased for as little as 1.5 hours of an employee's pay. Unlike major medical insurance, voluntary benefits are paid directly to policyholders so they can use the money where it's most needed, whether it's to pay out-of-pocket medical costs, make a car payment, or pay the mortgage.

It's obvious that America's workers are seeing the value in voluntary benefits. We're seeing all-time highs in the number of customers keeping their coverage for multiple years. This tells me that many employees see greater risk in not having financial protection in such a tough economy, and they're willing to have a few dollars deducted from their paychecks to get financial protection.

Elizabeth Halkos, chief revenue officer, Purchasing Power: Every employee will have a unique unexpected financial situation at some point. Examples include a death in the family, a child going to college, or even the need to replace a broken appliance. Many employees don't have savings to cover these unexpected expenses. In fact, 36% do not have $2,000 in savings. Voluntary benefits typically only require a small premium that addresses these types of unique situations for each employee. It's just like life insurance or an employee purchase program – it's there when you need it, and employees have the power to choose the voluntary benefits that fit their life.

Tom O'Keefe, VB regional practice leader, Unum: When employees truly understand all their core benefits (most don't) they realize that there are some gaps in the offering. Those same employees are willing to budget a few dollars a week to help offset financial exposure due to accidents, critical illnesses, disabilities and even death. Some of the exposure can come in the form of deductibles, copays, out of pocket expenses, HDHPs etc.

Considering that brokers generally make less commission on voluntary benefits options, how can they offer these benefits to clients in an efficient way that provides a good return-on-investment for the broker's efforts?

Toney Chimienti of Chimienti & Associates: Brokers can significantly increase their revenue while helping the employer and their employees manage the cost of their health benefits. They can do this by incorporating voluntary benefits that address the employee's financial needs created by high deductible medical plans. These coupled and tailored plans can establish financial advantages to employees, improving participation in HDHP plans that have often a lower cost to the employer as well.

Jennifer Lococo of Voluntary Benefit Advisors: The Voluntary Benefits revenue can have significant impact to a firm's profit. However, brokers will keep an arm's distance if the execution seems too difficult or trust in a voluntary benefits carrier or partner is poor. The broker agencies that move the most voluntary benefits do so by aligning with a team of voluntary benefit experts that help organize an implementation strategy from analysis to employee education. Thereby, making offering voluntary benefits easy and rewarding. Critical to ROI is ensuring employees will have a platform to be educated on the voluntary benefits made available. If education is absent, participation will be poor, and revenues will be low, ultimately resulting in a false perception that voluntary benefits aren't worth the effort.

Michael Stachowiak of Aflac: Brokers with the foresight to fills gaps in their clients' portfolios with voluntary benefits are reaping major rewards: They are more likely to be increasing their client bases than are brokers who don't offer voluntary insurance products, and they're also more likely to be growing their sales. An efficient way to tell the holistic benefits story to clients is to integrate voluntary benefit offerings with core products and include voluntary insurance in benefit communications during open enrollment. With the continued increase in out-of-pocket costs, a benefit package without a well-planned voluntary benefit option is inadequate. Brokers should begin discussing voluntary benefits when medical plan designs are being considered and renewal strategies are being planned. Just like employees need to see the bigger picture, brokers shouldn't look at voluntary insurance as being a separate piece of their clients benefit package, but as an essential part of providing their clients the best coverage.

Meredith Ryan-Reid of MetLife Group: Brokers can achieve a great stream of commission revenue from voluntary benefits; the key is having an enrollment and communication strategy that produces the highest possible participation rate. The broker must play an integral part, working with the customer and the carrier to ensure that the enrollment and communication strategy provides a call to action

that helps employees to see the value in these benefits. It will be the broker's role to consult with the customer, understand their needs, and partner with a carrier that can provides the best solutions possible including communicating the benefits to employees. These efforts by the broker will produce the highest participation rate possible which, in turn, will generate a strong return on investment.

Elizabeth Halkos of Purchasing Power: Many brokers take advantage of bundling voluntary benefit offerings so that it's a win-win for them and their clients. With the ACA in effect, many brokers have seen reduced commissions for healthcare products. They need something to differentiate themselves while still earning a commission; voluntary benefits help them offer unique packages.

Rich Williams of Colonial Life: Voluntary benefits aren't as well known by employees as are other products, such as health insurance. So the most important thing a broker can do to ensure a solid return on investment is setting up strong one-to-one enrollment conditions. Having an experienced benefit counselor explain the need for a critical illness, cancer, or accident policy goes a long way toward educating employees about their financial protection. The typical self-enroll voluntary participation is in the single digits. The main reason for this low participation is that the average employee doesn't understand these types of benefits. These products are needed in the marketplace and without a solid enrollment strategy the results won't meet the broker's expectations. Partnering with a trustworthy carrier with the capabilities to handle all the work and overhead will help ensure a quality ROI. When a broker selects the right partner, the financial risk is virtually eliminated.

Tom O'Keefe of Unum: I don't see it that way. Right now many of the brokers are not making any money from voluntary commissions simply because they don't offer them. For most, adding these very important employee benefits will add to their income stream and round off their total portfolio offering. With health exchanges, market uncertainty and commissions reducing on medical, the voluntary benefits offer a nice way to supplement their income while providing needed choice to the employees.

How can you tell whether a particular voluntary benefit product will provide real value to your clients?

Toney Chimienti of Chimienti & Associates: Brokers should seek expert advice from managing general underwriters, managing general agencies, or worksite carriers. Many plans have been designed to help manage the rising cost of benefits. Plans, such as HSA qualified hospital indemnity, limited medical supplements, and gap plans, can offset significant out-of-pocket medical expense that come with high deductible medical plans.

Jennifer Lococo of Voluntary Benefit Advisors: There is no one size fits all. Demographics, industry, and wage scale can all play a significant role in deciding plan design for a respective client. Certain voluntary benefits have been proven to positively impact workers comp, such as a non-occupational accident plan and/or short term disability while others have had significant savings impact on core health premiums, such as hospital indemnity plans. The real value is often realized once employees participate in the programs, thereby validating the broker and client's decision to offer the additional coverage.

Tom O'Keefe of Unum: First you need to analyze the entire core program. It does not need to be a HDHP for voluntary benefits to be a good fit. Permanent life products can be a great complement to employer- or employee-paid term life coverage. Products that mitigate deductibles and co-pays can include accident and critical illness coverage. Also hospital indemnity products can be tailored to fit medical offerings. Voluntary short term disability can be a good fit if there is a gap in what the employer or state provides. The bottom line is that a review with the customer can help fill those gaps with the appropriate products.

Rich Williams of Colonial Life: Voluntary products can encourage prevention and early detection of several serious diseases by including wellness screening benefits. The short-term value is that the employee gets a benefit check for having an annual health screening. The long-term value is that the employee may discover a condition that can be treated before it progresses.

Meredith Ryan-Reid of MetLife Group: The idea of real value varies by customer. Whether the goal is to recruit new talent or lessen the impact of changes in medical benefits, clients always find real value when voluntary benefits meet their particular needs.

Michael Stachowiak of Aflac: It's important to look at the demographics (age and industry) of your client's business to see what plan they'll find the most value in. For example, critical illness insurance might be more important for teachers while accident insurance might be more relevant for manufacturing employees. Evaluate your client's major medical plans, and narrow voluntary insurance options to what makes sense to their company and what meets their employees' needs. For larger employers, evaluate the medical plan's experience and utilization as a guide to recommending a voluntary benefit plan.

Elizabeth Halkos of Purchasing Power: To provide value for clients and their employees, the broker must understand the employees' needs and the client's company objectives/HR strategy. Look at the employee demographics (generations, income level, etc.) and their needs to determine the types of benefits to offer. Once launched, take the time to survey employees to understand the effectiveness.

Are there certain types of voluntary benefits options that go well with different types of employer groups, such as blue collar vs. white collar?

Jennifer Lococo of Voluntary Benefit Advisors: Yes. A blue collar workforce tends to appreciate plans such as accident, disability, and life insurance while a white collar workforce may find more value in critical illness, hospital indemnity, long term care, and permanent life insurance.

Toney Chimienti of Chimienti & Associates: Risk factors and high turnover in certain industries has a direct effect on pricing and underwriting of many voluntary benefits. But the policyholder's financial needs remain the same. Employees need paycheck protection; they need life insurance coverage for their families; and they need medical gap

(Continued on page 26)

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(A VIEW FROM THE TOP - Continued from page 24)

coverage to supplement high deductible medical plans that will offset their financial burdens. Whether you work in a manufacturing industry or financial industry, what remains constant is your need to have money to cover the cost of high deductible exposure, to make mortgage payments, pay college tuition funds, or protect your family from the permanent income loss associated with a premature death.

Michael Stachowiak of Aflac: Yes, historically there has been a correlation between the types of plans employees select and the industry of the employer, such as accident plans in a manufacturing company. But as different generations enter into the benefit decision-making landscape at work, it will become less about the type of industry and more about each employee's family and financial situation. Brokers should work with clients to identify what products would work best for the workforce. Offering a few voluntary options tailored to the major medical plan lets employees select the best plan for their personal situation.

Meredith Ryan-Reid of MetLife Group: Not too long ago, voluntary benefits were associated with specific employer groups; benefits like auto and home insurance and prepaid legal plans were more prevalent across white collar groups while benefits like critical illness and accident insurance were more common with blue collar or service groups. Over the past couple of years, the line between white collar and blue collar has blurred and voluntary benefits are now being considered across all industries. Every type of industry is looking at ways to offer some level of voluntary benefits.

Tom O'Keefe of Unum: I used to think so, but I have found that, in working with all types of groups from high-tech to agriculture, the benefits you offer them will vary based on many factors. What benefits do they have now, what will change in the next one to three years, and what is the demographic makeup of the group, average age, core product gaps etc? Some industries may have more similarities and therefore some of the same voluntary needs, but with groups becoming more diverse and ever changing, you really need to dig deeper into the client's needs.

Rich Williams of Colonial Life: We don't find significant differences across income levels in the need for financial protection, although there is some variation in coverage levels for different types of employer groups. Everyone, regardless of their income or assets, has something worth protecting. The opportunity for companies like ours is to understand employees' needs and help them select the right voluntary benefits and coverage levels that will help protect what's most important in their particular situation. This is where the one-to-one working conditions come into play.

Which voluntary benefits options are becoming more or less popular?

Jennifer Lococo of Voluntary Benefit Advisors: With the continued rise of health premiums and the decrease of coverage, the awareness of all voluntary benefits is gaining momentum. Many clients and brokers alike are utilizing Hospital Indemnity plans as a strategy to bridge the gap in high deductible health plans which can save on overall health premiums. Additionally, we continue to find that critical illness, accident, and life insurance solutions to be amongst the most participated in.

Toney Chimienti of Chimienti & Associates: With the cost of health insurance constantly on the rise, employers have fewer dollars available to provide additional benefits, such as life insurance and long-term disability. These plans have always been very popular with employees, but in today's economy, they have become essential voluntary benefits for the employer and employees. New products that are gaining traction with employer groups at a high rate are the plans that are designed to offset the employees' high out-of-pocket expenses created by the new high deductible medical plans. These products include critical illness coverage, medical gap insurance plans, HSA-compliant hospital indemnity plans, and limited benefit medical supplement plans.

Michael Stachowiak of Aflac: We've seen critical illness becoming more popular since it offers broader coverage and appeals to a variety of employees. Hospital indemnity products have also jumped in sales recently due to the standardization of deductibles from health care reform. But, regardless of the specific plan, each employee has unique needs. Voluntary plans that are custom-tailored to the employees' out-of-pocket costs are becoming popular, which is why brokers should continue to stress the value of personalized benefits to their clients. Make it your goal to help employers better understand and respond to the generational and demographic compositions of their workforces.

Elizabeth Halkos of Purchasing Power: We see financial wellness benefits gaining popularity. This means more than just retirement benefits: credit reports, education, savings and budgeting tools, alternative financing options, coaching and more. Companies understand that their bottom lines are affected when employees face significant financial stress. Eighty percent of employees say they are financially stressed, according to a 2014 Harris Poll.

Tom O'Keefe of Unum: I have seen a drop in requests from brokers for home and auto since there are many companies selling direct to people in the mainstream media and this coverage is easier to understand and has some deeper discounts than in years past.

Meredith Ryan-Reid of MetLife Group: The recent implementation of the Affordable Care Act has raised the interest and discussion around benefits, such as accident and critical illness insurance, which have grown in popularity. Recent headlines about high-profile security breaches have increased interest in identity-theft coverage among employers and employees.

Rich Williams of Colonial Life: The more recent voluntary products, such as accident, cancer, critical illness and hospital confinement, have emerged to help fill gaps not covered by major medical insurance. With health care costs increasing, many employers are moving to plans with higher deductibles and co-pays, leaving employees with greater financial exposure. We've seen an increase in group voluntary products during the last few years, for several reasons. They're typically simpler to enroll and administer, and they can sometimes be more affordable because of the group rate. Insurers can also make more underwriting concessions for group products, such as guaranteed issue, so all employees, regardless of their health condition, can take advantage of the offering.

How do you choose a carrier?

Toney Chimienti of Chimienti & Associates: Many carriers offer plans that are competitively priced, but some can leave you with a lot more client service issues and frustration. Billing issues can also cause bookkeeping and accounting problems. Managing voluntary benefits can become tenuous if you don't have the right carrier partners or administrative software and streamlined processes. This is one of the most important reasons to partner with an experienced worksite managing general underwriter, or a managing general agency with established long-term carrier relationships. They will have developed key management contacts to provide influence and direct responses for the broker and their client issues, thereby simplifying administrative processes and claims issue for the broker and the clients. If these key influential relationships are not established with the carriers, brokers can spend hours attempting to assist their clients.

Jennifer Lococo of Voluntary Benefit Advisors: Having a deep awareness of each carrier's underwriting capabilities, participation requirements, flexibility in plan design, and administrative back office can all play a role in electing the right carrier for the respective client. Aligning with voluntary benefit experts that are carrier agnostic will provide confidence that best in class products are being analyzed and offered. Understanding the distribution channel of each carrier can also have impact as some carriers have more restraints than others in regards to enrollment.

Meredith Ryan-Reid of MetLife Group: You want to make sure that the employer and employees have a positive experience at every step of the transaction. Look for a firm with a recognizable brand name to help increase interest and trust. Choose a carrier with a good track record for paying claims fairly and speedily. By providing solutions that address a variety of employee needs, the right carrier can help you create a customizable benefit program to meet the needs of a diverse workforce. Look for a carrier that offers a comprehensive suite of benefits. Also work with a carrier that offers benefit solutions through more than one channel, including through exchanges and work site enrollment. This will allow you to offer solutions that fit your client's needs in a channel that works for them. Make sure that the carrier has the technology to back up the sale and is focused on a smooth implementation process. Make sure that the carrier offers seamless payroll deduction since it greatly increases participation rates.

Michael Stachowiak of Aflac: Historically, brokers have offered clients a spreadsheet of options looking at voluntary plan design versus price, an approach that has been used for employer-paid medical plans. It has caused some carriers to compete on the limited details in a spreadsheet, making concessions where they should not have. This is why some carriers constantly evaluate their desire (or lack thereof) to continue offering a voluntary benefits line or retreat from certain markets (i.e. under 100 or under 1,000 employees). When picking a voluntary carrier, brokers should look to historical performance and stability. Brokers would be well-served to review the carriers' speed to pay claims. In today's fast-paced, digital world, employees demand expedient claims processing. The carrier's brand should resonate with employees since enrollment in voluntary benefits is the employees' choice. Voluntary benefit options are implemented most successfully as part of a total benefit strategy. So brokers should chose a carrier that provides ideas, gives support, shares benchmarking, and is totally aligned with the brokers' goals of providing real solutions for their clients in today's changing market.

Rich Williams of Colonial Life: Look for a company with a track record in the voluntary benefit industry. Many new players are entering the market because they see the growth potential. But, very few can offer proven end-to-end benefit services. Consider the services and strategies the carrier can provide to enhance the service you give your clients. What does the carrier offer that can help differentiate you from your competition? What can they offer you and your clients that can make a significant positive impact on your business and your clients' bottom line? Look for a carrier that measures its effectiveness and customer service, internally and through external, unbiased research. Companies that continually scrutinize themselves are the ones that continually improve. Companies that are continually improving are the ones that want to be with you for the long haul and not just for a single enrollment.

Tom O'Keefe of Unum: Great question. There are many carriers now getting into the voluntary space so you need someone with experience in the market, dedicated service, and a backroom that can handle everything from electronic feeds, benefit/administrative connections, and billing reconciliation.

When you are presenting voluntary products, do some types of coverage just naturally sell well together?

Jennifer Lococo of Voluntary Benefit Advisors: Yes, absolutely. Disability/accident, dental/vision, critical illness/life, legal insurance/pet insurance are all popular combinations and strategic pairings. It's common play to look 60 to 90 days from renewal to identify what voluntary benefit plans

will fill gaps in the core coverage. When all the benefits are communicated in tandem, core and voluntary, it rounds out the benefit offerings and employees are able to identify the coverage that makes sense for themselves and their families.

Toney Chimienti of Chimienti & Associates: It's important to evaluate the benefit structures that are in place, identifying areas where you can assist and complement their existing programs, to fill the gaps in their benefit structure with excellent products that bring the best value to the employees and the employer. Some products go well together because they're designed to address the employee's needs. Needs selling is the most successful way of providing benefits, and helps create long-term relationships with your clients.

Meredith Ryan-Reid of MetLife Group: The strongest connection seems to occur when it comes to accident & health benefits. The vast majority of quotes we receive from customers or brokers have critical illness and accident insurance quoted together. When it comes to offering financial protection, these two products cover a wide range of unexpected scenarios. One benefit pays on accidents, and another pays on major illnesses.

Michael Stachowiak of Aflac: It typically goes back to risk. A product's combination (i.e. accident and illness policies or accident and hospital indemnity plans) will pay out on top of each other and will not cancel each other out. Employees often pick two policies that offer the broadest protection with the lowest out-of-pocket costs per month. But, the broker needs to help educate employees on how voluntary policies work and which policies complement each other. The key is for brokers to make sure that voluntary options are limited to two or three plans and that the details are well-communicated.

Elizabeth Halkos of Purchasing Power: A company with a wellness program may be missing the key component of a financial wellness program that helps reduce stress and healthcare costs.

Tom O'Keefe of Unum: I break the coverage into categories. Accident, critical illness and hospital indemnity fit into supplemental health; whole life, universal, and permanent term fit with the life and financial planning category; and individual disability fits into the general disability bucket with long term disability and long term care.

Rich Williams of Colonial Life: Some coverage types pair well to build safety nets. For example, having life and short-term disability insurance is a simple, effective way for employees to protect their income and their families' well-being. Pairing these types of coverage creates a financial foundation package. Accident and critical illness insurance can serve as a health foundation package. These products can help employees prepare for unforeseen medical expenses, particularly those not fully covered by major medical insurance.

How do you present voluntary benefits in a way that doesn't overwhelm employees with confusing options?

Toney Chimienti of Chimienti & Associates: Keep choices simple in each benefit category, and only offer plan options that truly compliment the employees current benefit plans. Offering too many variables, riders, or tier levels creates confusion for employees. By offering simplified choices that complement the core benefits, you make it easier for employees to choose the plans that are most beneficial to themselves and their family.

Jennifer Lococo of Voluntary Benefit Advisors: Minimizing the amount of products offered tends to be the best method; typically two to three products offered initially is received well. When employees are overwhelmed with too many options it leads to confusion and indecisiveness. Pre-enrollment communication and a platform to effectively educate employees are key to driving a successful enrollment.

Tom O'Keefe of Unum: Start with the conversation with the HR manager or owner. How do they communicate, educate and provide benefits to their employees? With these

answers, you will know how to guide them with solutions that won't overwhelm them. It really comes down to asking the right questions, listening, and solving pain points.

Michael Stachowiak of Aflac: If brokers take the time to understand the client's workforce, they will know which products will be effective, and they won't overwhelm employees with too many options. Brokers can work with clients to create benefit packages that will best fit their employees' needs. This consultative approach, especially during the open enrollment period, will help solidify the broker-client relationship and provide employees with the coverage they need to help them be protected financially.

Meredith Ryan-Reid of MetLife Group: The most effective way is for an employer to offer voluntary benefits on ballot with the core benefit offerings. We recommend a communication plan that includes these steps: an announcement about the upcoming enrollment period with an overview of the new benefits, a formal introduction of the new benefit offerings, and then a reminder that time is running out for employees to elect these benefits. With all of these communications, there should be simple and clear marketing materials that explain the need for these voluntary benefits, how the products work, and how to enroll.

Elizabeth Halkos of Purchasing Power: Categorizing the benefits by purpose makes it easier to employees to understand the value of the benefit, such as buying and banking, lifestyle and convenience, personal care and improvement, and financial safety nets. It's vital to use a variety of communication channels. Employees learn and understand in a variety of ways, especially looking at it through the lens of generational preferences.

How has health care reform affected the market for voluntary benefits?

Jennifer Lococo of Voluntary Benefit Advisors: Health Reform has been the best form of advertisement and marketing for Voluntary Benefits. The need for additional coverage and supplemental insurance has dominated all forms of media and has raised awareness and consideration to purchase voluntary benefits.

Toney Chimienti of Chimienti & Associates: Health reform has decreased brokers' revenue. At the same time, it has increased financial costs and risks. To manage the rising cost of health insurance, we have seen ever-increasing premiums, deductibles, and coinsurance limits. These soaring costs have created tremendous opportunities in the voluntary market. Voluntary products can keep the employee's financial exposure down and offset the broker's shrinking revenues on health insurance sales.

Michael Stachowiak of Aflac: Ninety percent of brokers agree, at least somewhat, that rising health care costs are making it difficult for their clients to offer adequate benefits. Also, 49% of employers say that controlling costs is a top business objective, according to the 2014 Aflac WorkForces Report. The same study found that 63% of employees saw an increased need for voluntary insurance benefits in 2014 compared to previous years. Fifty-two percent of those without access to voluntary insurance options say they'd be at least somewhat likely to apply for voluntary benefits if their companies offered them.

Elizabeth Halkos of Purchasing Power: There is still a lot of uncertainty surrounding healthcare legislation. In regards to voluntary benefits, it has highlighted the value of offering employees more than just the traditional options. With employers having to look for ways to reduce costs (healthcare, overhead, operating), many companies are looking to non-traditional voluntary benefits in order to fill the gap or offer benefits that can help employee without costing the company more.

Meredith Ryan-Reid of MetLife Group: Health care reform has really driven interest in voluntary benefits. There are still many unknowns and uncertainties about how health care reform will play out over the next few years, including the effects of the 2018 Cadillac Tax. Whatever may occur, interest in voluntary benefits will only continue to increase.

Rich Williams of Colonial Life: It has made communication and benefits education more important than ever. Most voluntary products aren't directly affected by health care reform, but employers and employees still need help navigating the requirements, responsibilities, and options of health care reform. Many of America's workers are taking on greater responsibility for making decisions and paying for health care coverage and other benefits. They'll need to be more knowledgeable about what benefits they need. With any type of health care plan, there will still be out-of-pocket costs related to coverage and treatment. Employees will still need a way to pay the bills if they're recovering from an illness or injury. We're also seeing more brokers enter the voluntary benefits market to diversify their offerings and supplement income lost as a result of health care reform mandates. This is a great time for brokers to explore voluntary benefits.

Tom O'Keefe of Unum: Health reform has brought about huge awareness from every angle. We have brokers and clients scrambling to figure out how it affects them and their employees. This is a great opportunity for brokers and consultants to step into that role to sift through and make sense of it all and provide solutions that are tailored to the client. ★

THE BLUEPRINT FOR SUCCESS IN VOLUNTARY BENEFIT SALES

by **JENNIFER LOCOCO**

The landscape has changed. Now, more than ever, the awareness of voluntary benefits is heightened and the pressure to adapt in a dynamic environment has become the new normal. Offering voluntary benefits is no longer just for large companies to leverage as bells and whistles for their benefits portfolio. They have now become necessary and vital for the majority of the working class to financially survive an illness or injury. Studies by the American Journal of Medicine and other sources have found that more than 62% of all bankruptcies have a medical cause. Statistical data offers us industry insiders one form of validity. However, even more relevant is that millions of people (employees) are exposed to the financial consequence when supplemental programs are absent. This exposure is revealed on all forms of media, social media taking center stage. For instance, a friend or family member posts a status update with the unfortunate news of a cancer diagnosis. A tragic car accident on a daily route to work is posted with graphic pictures of the car wreck. The sudden passing of a loved one is posted and their Facebook community becomes grief stricken. Throughout these examples of illness and injury there often resonates a common thread amongst the majority of Americans, the lack of finances in preparation for an unexpected event. Therefore, the voluntary benefits space is presented with a unique opportunity, which is to expose employees to ancillary benefits while awareness and consideration of these products is at an all-time high. So, as a health broker, P&C broker, or advisor to a client, how can you position voluntary benefits as solid strategy, but more importantly, have faith that it will be executed without error or back-end fall out? As we walk through this blueprint, if you will, I'm confident you'll begin to find great value in positioning voluntary benefits with all clients.

ANALYSIS—PREPARATION IN RECOMMENDING VOLUNTARY BENEFITS TO EMPLOYERS

Prior to analysis of the type of voluntary products you will choose or the carrier partners you will align with comes the desire to do so. First, identify and decide that offering ancillary benefits to fill in gaps and round out benefit offerings is a plan worth pursuing. In regards to ROI, the brokers who have committed to proposing voluntary benefits as strategy have become more comprehensive and consultative with their clients and have made a significant impact on their firm's revenue stream. Upon analysis of your client's renewal, begin to identify current gaps in coverage and reflect on what the client was forced to remove in previous years in an effort to maintain affordability. Bringing back lost benefits such as disability plans, life insurance, dental, and vision are all simple conversation starters to discuss additional voluntary lines. Furthermore, adding in a hospital indemnity plan to bridge the gap in a HDHP is often well received by the client and employees alike. With that said, regardless if employers offer fully funded plans or are self funded with their healthcare coverage, voluntary benefits are perceived valuable by employees to fill in the gaps and are most often paid for 100% by the employee.

FOUNDATION—HOW DO I POSITION ADDING VOLUNTARY BENEFITS TO MY CLIENTS

As a trusted advisor it doesn't take much arm twisting to counsel an employer to offer additional benefits to their employees, especially considering it will burden no hard cost to them. Employers tend to have a perception that employees will not want to pay for extra coverage on their own. Additionally, employers may have a little guilt if they were forced to make benefit cuts; therefore, offering additional coverage to employees that the employee would have to pay for may harness some stigma. However, when it comes to voluntary benefits, education to the client, similar to education to the employee, is key. So, after the conclusion has been made to now position voluntary benefits to all clients, the opportunities begin to reveal themselves. As brokers, you are not on your own. Leverage experts in the voluntary benefits space, be it carriers or enrollment firms, to offer recommendations and plan designs to ensure a well received voluntary benefits roll out.

CONSTRUCTION—STRUCTURING A SUCCESSFUL ENROLLMENT

Gaining buy in from the client to allow employees the platform to be educated on voluntary benefits is essential. In the absence of education, employees will not likely identify with the value in voluntary benefits and as a result there will be little if any participation in the products. Once agreement is gained to add voluntary benefits, all efforts should be exhausted to make sure it is a worthy endeavor. To do this, rely on a voluntary benefits expert who can help orchestrate everything with the enrollment from A to Z. Kicking off with pre-enrollment communication is key to begin to build momentum and offer a high level overview of what the employee can expect of the future enrollment date to come. Enrollment methods have advanced, although in person education still dominates as a preferred method of communication, web based technology platforms and call center enrollments absolutely hold their place as an effective tool to communicate benefits.

INSPECTION—REVIEWING THE RESULTS

The validation to offer voluntary benefits will be realized post enrollment and once the employees have participated. Employers will have a sense of satisfaction acknowledging that they were able to offer additional programs that were perceived valuable by employees. It's important to share the results of the enrollment with the client as communication and education would have likely played a large part in the participation of the programs. On the other hand, if communication and education were lacking, it's vital to share the future improvements that can be made to make the benefits offering more worthwhile for all going forward.

MAINTENANCE—HOW TO ALLEVIATE THE ADMINISTRATIVE BURDEN

HR has enough on their plate! As a broker, how can you get them to add more benefits, do more deductions, and deal with more questions from employees? It's simple. Offering voluntary benefits should not be complex and when it's executed correctly, it's not. Make sure to vet your potential voluntary benefits experts or carrier partners in an effort to have a better understanding of their back office capabilities, claims paying history, and ongoing service plans. A partner should be able to take on much of the heavy lifting on behalf of the broker and the client. A voluntary partner, in essence, should be an extension to HR, by handling all pre-enrollment communication, employee education, post enrollment review, and all on-going service. Therefore, making voluntary benefits easy! ★

Jennifer Lococo is the Senior Vice President of Sales for Voluntary Benefit Advisors (VBA). VBA is a voluntary benefits brokerage and enrollment firm. For more information visit, vbadv.com, e-mail info@vbadv.com, or call 866-797-3236.

RETIRE Rich

Solo 401(k) for Small Business Owners

by **RICK PENDYKOSKI**

In the recent times, there has been a drastic increase in the number of American entrepreneurs who are not saving enough for their retirement. Retirement is the last thing on the minds of self-employed workers as they fear to set aside the money that might come handy in keeping their business rolling. This is the biggest mistake that small business owners make and, therefore, miss out on the opportunity to build up their retirement savings.

INDIVIDUAL 401(k)/SOLO 401(k) PLAN

A solo 401(k) plan is one of the best retirement plans for the self-employed and small business owners whose income is $100,000 or more. This plan offers tax-deferred growth potential and is very easy and cost-effective plan for small business owners. The feature that makes this plan an attractive retirement savings instrument is that the allowable contribution to an individual 401(k) plan will be much larger than what you can make under any other retirement plan. Since a solo 401(k) plan is a regular plan in combination with a profit-sharing plan, the owner can defer the maximum compensation under this plan, and can still contribute up to 25% of the total amount to the profit sharing plan.

The eligibility criteria for a solo 401(k) plan mainly comprise of the following two requirements:

No Full Time Employees

Under this plan, only business owners who do not have any full-time employees or if their full-time employee is their spouse, can invest under this plan.

Self-Employment Activity

To be able to benefit from this plan, one must have one of the following self-employment activities:

- A limited liability company
- An S corporation
- A C corporation
- Ownership of sole proprietorship
- A limited partnership

A solo 401(k) plan also comes in another version as Roth solo 401(k) to benefit those who are looking for a tax-free retirement solution for their proprietorship. As the state income tax rates are expected to rise, it is one of the most effective ways of making your retirement investment tax-free, including currencies, precious metals, real estate, etc.

THE BENEFITS OF A SOLO 401(k) PLAN

The features that make solo 401(k) or individual 401(k) plan so popular among self-employed business owners are the following:

- The flexibility to borrow: Unlike other retirement plans like IRAs, which do not offer any loan to the participant, this plan allows the participants to borrow up to 50% of their account value in case of an emergency. This loan can be paid off within five years at the minimum prime interest rate.
- Easy check book control: The solo 40(k) plan has simplified investment (as simple as writing a check) so that a participant can act quickly when a good opportunity comes up.
- Easy administration: This plan is very easy and cost effective to operate since there is no annual filing requirement until the assets are under $250,000 in value. In case the assets increase beyond $250,000, you would be required to file a short information return along with the IRS.
- High contribution limits: A solo 401(k) or individual 401(k) plan has a striking feature that allows the participant to make up to $49,000 of annual contributions with an additional catch up of $5,500 for those over the age of 50.
- UDFI exemption: Unlike IRAs, which are leveraged with mortgage financing in case of real estate purchase, solo 401(k) plans are usually exempted from unrelated debt finance income (UDFI).

Therefore, the solo 401(k) plan is a great retirement investment vehicle for small business owners, owing to its numerous benefits while planning your retirement. ★

Rick Pendykoski is the owner of Self Directed Retirement Plans LLC, a retirement planning firm based in Goodyear, Ariz. He has over three decades of experience working with investments and retirement planning, and over the last 10 years has turned his focus to self-directed accounts and alternative investments. Rick regularly posts helpful tips and articles on his blog at SD Retirement as well as Seeking Alpha, MoneyForLunch, Biggerpocket, SocialMediaToday and NuWireInvestor. He can be reached at rick@sdretirementplans.com or sdretirementplans.com.

HELPING YOUR CLIENTS
Fill the Long-Term Care Gap

by **CHRISTINE McCULLUGH**

Employee retirement readiness is a frequent topic of discussion. Your employer group clients understand that their employees now have the primary responsibility for funding their retirement. Employers are doing more than ever to help employees figure out how to meet the need. But there is a significant gap in this education; what if the money disappears due to a need for long-term care? By educating your employer clients, you can add value for them and for their employees. And by doing so, you can firm up your working relationships.

A retiring employee may walk away with a significant lump sum of cash that they have worked hard to save. Ideally, the employee has done some planning, perhaps seeking advice from an investment professional to determine how much money they would need, each year, to maintain their lifestyle. But if an accident or an illness occurs, they may have to divert that money toward long-term care.

Nearly 70% of people turning 65 will need long-term care at some point in their lives, according to the Dept. of Health and Human Services website, longtemcare.gov. Sometimes an event triggers the need for long-term care. It can happen to anyone at any age. In fact, 37% of people using long-term care services in 2000 were 18 to 64. That leaves the majority of people who use long-term care services in the 65+ age bracket, according to a study by the Georgetown University Long-Term Care Financing Project.

This is not medical care, which is paid by health insurance. It is assistance with the activities of daily living (ADL). ADLs include bathing, dressing, toileting, transferring, eating, and managing continence.

The need for long-term care often arises gradually. In the early stages, it may mean family members managing medicines, bringing in part-time household help, or providing rides to doctor's appointments. Later, moving to an assisted living facility could be an option as more help is needed. If the person's needs are outside the scope of care in an assisted living facility, they may need care in a nursing home.

The cost of nursing home care is significant. The average hourly cost for a home health aide was $21, or $30,576 per year for four hours a day, according to a 2012 study by MetLife's Mature Market Institute. Assisted living facilities averaged $42,600 a year, and care in a private room in a nursing home averaged $90,520 a year. It is easy to see how quickly the average 401(k) balance of $91,300 could evaporate.

THREE WAYS TO PAY: MEDICAID, SAVINGS, OR INSURANCE

Your employer clients and their employees probably don't realize that their hard-earned retirement savings are at risk. They may believe that their health insurance, disability insurance, or Medicare will pay for long-term care. Not so; health and disability insurance only pay for those specific issues. And Medicare only pays for a maximum of 100 days of skilled nursing or rehabilitative care if provided immediately after a hospital stay. It does not pay for assistance with ADLs.

Medicaid (MediCal in California) is the government's long-term care safety net. It will pay for long-term care for those who have spent their assets down to the poverty level (minus the family home).

But financial pressures on the Medicaid system have grown significantly in recent years. The system now pays for 40% of long-term care spending in the United States. Spending has increased from $75 billion, 20 years ago, to more than $400 billion today. All of this has the government tightening the controls. Qualifying for benefits is harder. The government has the right to review an applicant's financial records for five years before they apply for Medicaid to ensure that they haven't transferred their assets. What's more, as a condition of continued federal funding to the state Medicaid system, the federal government is now requiring states to seek recovery of amounts spent on a person's care. The program agrees to pay for the person's care with the understanding that the estate will be billed for the money spent on care once the person has died. For many families, this means selling the family home.

You can help your clients help their employees by educating them about long-term care and three ways to pay for it. With enough information, employees can decide whether to purchase coverage, save money for long-term care, or spend down and let MediCal take care of it. They may choose to simply roll the dice and hope they will be among the roughly 30% of people who won't need long-term care.

PRICE INCREASES MEAN STABILITY FOR CARRIERS

You may hesitate to present long-term care coverage to your clients because you've heard that it has increased in price in recent years, or that insurance companies are no longer offering the product. A few companies no longer offer long-term care coverage, and the prices have increased. You need to understand how these things came about in order to educate your clients about long-term care coverage.

With any insurance product, actuaries determine rates based on educated assumptions and expectations of the economy, utilization, plan design,

and a variety of other factors. Those factors determined the pricing when long-term care insurance was introduced in the 1970s. Since then, plan designs changed; utilization and lapse rates have been different than expected; the economy entered a period of extraordinarily low interest rates; and the population aged significantly.

Some 40 years later, the industry recognized the need to adjust the pricing of long-term care products. Beginning in 2010, companies increased premium costs an average of 25% to 75%. Also, from 1999 to 2014, employee out-of-pocket costs for health insurance rose 212%, according to the Kaiser Family Foundation.

We have all come to expect price increases, each year, in the health insurance market. But long-term care coverage has seen an increase just once in many years.

In part, this is because each state regulates the coverage on its own; insurance commissioners must be approached individually about any increase and grant permission for that state. Because this is such an arduous process, long-term care carriers try to set accurate pricing that covers their risk for many years. I expect prices to increase more often than they have in the past. But, in my opinion, the increases might be in the neighborhood of 5% to 15% every five to 10 years.

Long-term care insurers have responded to the changing demands of the marketplace in the design of their LTC products. According to AARP, about 8,000 people turn 65 each day in the United States. Many of us have been forced to deal with the realities of care for our loved ones. The most expensive care option is a nursing home. But that is generally a last resort. Policies now cover care provided at home and in assisted living facilities, allowing policyholders to choose their mode of care.

EDUCATION IS KEY

Ours is a business of relationships. You add value and help cement relationships when you help clients meet their goals by bringing them something they didn't know they needed. Your corporate clients can show their interest in helping employees reach a comfortable retirement by giving them the opportunity to purchase long-term care coverage. Your clients spend time and resources educating employees about how to save money and even how to invest it. They may not ask you about long-term care insurance because neither they nor their employees understand the risks of needing it. This is your opportunity to help them fill the coverage gap—one they don't know they have. ★

Christine McCullugh is a nationally known expert in long-term care, and the president of LTC Solutions (ltc-solutions.com). A speaker, consultant, and member of AHIP's Long-Term Care Curriculum Review Committee, McCullugh provides insights to employers, carriers, and industry associations in an effort to guide and develop the future of LTC insurance. She provides expertise and partnership opportunities to colleagues desiring a deeper understanding of this unique market, and help presenting it to their employer clients.

LIFE INSURANCE

Life Insurance That Promotes Healthy Living

John Hancock teamed up with Vitality to integrate life insurance with a comprehensive healthy living program. New products offer potential for savings on annual premiums. According to John Hancock, the California Department of Insurance, which is famously slow, approved the innovative product in only 48 hours. The products also offer discounts and rewards from leading retailers. New policyholders get a free Fitbit to help track their progress. After identifying a need for life insurance and completing the application process, new policyholders take an online Vitality Health Review to determine their Vitality Age. This indicator of health may be higher or lower than their actual age, and can improve over time as they work toward living a healthier life. Vitality has concluded that, on average, most Americans are five years older than their actual age, based on various health and wellness factors. Policyholders begin accumulating Vitality Points after their policy is issued and when they complete health-related activities like exercising, getting an annual health screening or even a flu shot. The healthier their lifestyle, the more points they can accumulate to earn valuable travel, shopping and entertainment-related rewards and discounts from leading retailers. Depending on the type of product they purchase, a policyholder could save as much as 15% off their annual premium. As part of the new offering, John Hancock unveiled two products: Protection UL with Vitality, a universal life product, and John Hancock Term with Vitality, a term life product. For more information, visit thevitalitygroup.com.

eDelivery of Life Policies

Legal & General America is offering a flexible solution to deliver life insurance policies to customers electronically, saving time and money for brokerage general agencies. To create its eDelivery platform, Legal & General America partnered with DocuSign. On average, eDelivery policies are activated two weeks sooner than paper policies. For more information, visit abcofca.org.

Index Variable Annuity

Voya Financial is offering a flexible premium deferred index-linked variable annuity. Voya PotentialPLUS offers customers the potential for investment growth tied to the performance of up to four major market indexes while providing a level of protection against a drop in those indexes.

HEALTH & EMPLOYEE BENEFITS

Prescription Discount Card

Watertree Health is offering a free prescription discount card. Simply entering a zip code and a drug name yields a list of discounted prices and the names and locations of the pharmacies. For more information, visit watertreehealthcard.com.

App Manages Disability Claims

The Hartford launched a mobile app that allows group disability plan members to manage their claims. With the app, consumers can start a short-term disability claim, update personal data, and check on the status of a claim, including payment information. The app also features definitions and benefits details to help customers navigate through the claims process. For more information, visit thehartford.com.

Guide to Employee Leave Laws

XpertHR has created an online employee handbook tool to help employers struggling to stay compliant with employment law throughout the United States and especially in California. For more information visit XpertHR.com.

Free Estate Planning Guidebook

ARAG is offering the estate planning guidebook, "Building Your Legacy" as a free download. For more information, visit ARAG.com.

Affordable HR Hotline and Compliance Platform for Non-Profits

The Unemployment Services Trust (UST) is offering a cloud-based HR platform that shields nonprofit organizations from costly risk and liability by offering reliable, on-demand HR help. For more information, visit chooseust.org.

One-day Processing of Voluntary Benefit Claims

Aflac can now receive, process, approve, and disburse payment to policyholders for eligible claims in one business day. For more information, visit aflac.com.

Benefit Communication Resource Center

Guardian Life launched Guardian Enrollment Maker (GEM), which helps brokers transition clients to online enrollment. For more information, visit GuardianAnytime.com.

Cloud-Based Identity Verification

Acuant launched cloud-based identity verification offerings that enable companies to capture and verify a customer's identity and critical personal information. For more information, visit actuant.com.

MEDICARE SUPPLEMENT & PART D *Make a Great Couple*

by **ERIN ACKENHEIL**

Batman and Robin. Peanut butter and jelly. Medicare supplement and Medicare Part D. These things go together. Or at least they should. Unfortunately, too many agents are missing the opportunity to link a Medicare supplement sale with a prescription drug plan (PDP). Perhaps they think it isn't worth the time. Instead, they give their client a website or a phone number and send them on their way. When this happens, agents lose an opportunity to serve clients better, make themselves more valuable and boost their bottom line.

Medicare supplement plans are sold year round by many insurers. They are popular because they fill the holes in original Medicare while providing broad access and predictable costs. However, it's important to remember that they don't cover everything. Everyone who purchases a Medicare supplement plan also needs to buy a Part D plan (also known as a PDP) for their drug coverage. The following are just a few reasons why agents ought to capture these sales together when they have the chance to do it.

- Become a one-stop destination: Clients want the convenience of doing all their insurance business at the same time in the same location. By providing these services together, you are providing them with a go-to destination and person.
- Differentiate yourself from the competition: As long as some agents are neglecting the prescription drug business with the Medicare supplement sale, you can differentiate yourself by filling this important need.
- Meet your clients' needs: There is an old adage that all business is personal. This is particularly true of older adults and their Medicare coverage. Your clients need medical and drug coverage, but Medicare can be confusing, especially for people who are aging into it for the first time. You can help direct beneficiaries through this maze, helping them find the best coverage at the lowest cost, including matching them with the drugs they need. By doing so, you increase your esteem in their eyes, making them more likely to refer their family and friends to you in the future.
- Keep them coming back: Medicare supplement sales are famously sticky, meaning that Medicare beneficiaries tend to buy a supplemental plan and stick with it. That becomes even more likely when buyers add a prescription drug plan to their purchase. In contrast, if a beneficiary leaves your business in search of a PDP plan somewhere else, it becomes more likely that they will take the rest of their business with them.
- Boost your bottom line: Commissions can add up over time for agents who sell a PDP plan with most Medicare supplement plans. Assuming the typical payment structure for the original sale, plus annual renewals, an agent with a book of 50 PDP clients would earn roughly $10,000 over six years. So investing a little time up front could pay off nicely over time.

So there is the case for pairing Medicare supplement with a PDP. It may take some time, training, practice, and patience to incorporate this into your process. But, over time, I believe you'll be glad you did as you make yourself a more valuable resource to your clients, earn referrals, and differentiate yourself from your colleagues.

Erin Ackenheil is vice president of sales with the senior business of Anthem. In this role, Erin oversees all Medicare sales efforts nationwide for the company, including direct (field/telesales), personal producing agents (PPA), managing general agencies (MGA), brokers, field marketing organizations (FMO) and electronic marketing organizations (EMO). Erin held progressively challenging sales roles at Health Net. Prior to Health Net, she was at the Health Plan of the Redwoods in Santa Rosa, California.

How to Value your Book of MEDICARE BUSINESS

by **BILL HAYNOR**

The beginning of any year is always a good time to review the health of your Medicare business. For some brokers, it's a critical step as their retirement plans begin to take shape and the need to formalize an exit strategy becomes a real necessity.

Maybe you're considering selling your book of business to another agent. How much is it really worth? This may be brave new territory for you. Understandably, your focus has been elsewhere—generating current income from commissions. To get started, here are five points that you should review to determine the proper value. It's what insurance companies like mine look at.

ONE: AVERAGE AGE OF YOUR CUSTOMERS

The younger the policy holder, the greater the lifetime value of the plan. Insurance companies will see your portfolio as much more valuable if the average age of your Medicare clientele is closer to 65 than 85. Like you, they know that it's far cheaper and more profitable to keep a policy holder by providing good customer service than to hunt and peck for new clients. Take this a step further by evaluating your book not just for age, but also for gender and geographic location. They can make a difference as well.

TWO: YOUR POLICY UNDERWRITERS

The shakeup in the Medicare industry means that some smaller players may be going away through mergers and acquisitions or simply going out of business. The latter happened not too long ago in Florida when Orlando-based Physicians United Plan Inc. was declared insolvent by a circuit court judge in June 2014, leaving its 38,000 Medicare Advantage subscribers scrambling to find other coverage. Your book of Medicare business is more valuable to another insurance company if it's underwritten by the big national players in the space. Take a look at how much of your business is supported by those types of firms.

THREE: ADVANTAGE VERSUS SUPPLEMENT POLICIES

Depending on the type of client you have supplement (Medigap) policies may be more valuable when you sell them as opposed to Medicare Advantage plans. The reason is stability. Advantage policy holders turn over a great deal more because of annual policy changes the insurer can make each year that affect out-of-pocket costs as well as the network of providers. Supplement plans do not require a physical exam; they are portable to any provider that accepts Medicare; and they are generally guaranteed renewable even if a senior has health problems. This means that the insurance company can't cancel their Medigap policy as long as the insured pays the premium. The resulting long-term value to the broker can be more than an Advantage policy.

FOUR: RATINGS MATTER

How well plans stack up with the Medicare five-star rating system can add or reduce the value of your Medicare Advantage book. The score is based on several factors including the quality of care, access to care, responsiveness of the plan and the member's satisfaction. The higher the score is, the higher the value. Be sure that you know how your policies are holding up and stay on top of it. The score can change year to year.

FIVE: YOUR PLAN AFTER SELLING YOUR BOOK

Your book is of higher value if you stick around after selling it. Staying licensed and certified and practicing means you may be available to help with customer retention and policy renewal. That doesn't mean that you shouldn't consider selling some of your policies even if you want to retire. Just be prepared to answer the question. No matter where you are in your professional life, it's always a good idea to evaluate how much your business is worth. If nothing else, it will keep you apprised of all the options you have. ★

Bill Haynor is the founder and CEO of SeniorQuote Insurance Services, a nationwide provider of Medicare-related products and services. Haynor holds more than 30 years of experience in the insurance and the financial services industries and personally knows the issues related to seniors navigating through the confusing Medicare insurance market. To learn more visit seniorquote.com or e-mail him at bhaynor@seniorquote.com.

INCREASE EMPLOYEE SATISFACTION BY PROMOTING CHOICE IN VISION BENEFITS

by **MIKE MOREY**

As a California broker for more than 25 years, I know that attracting and retaining top talent is a constant challenge among employers. And those employers are looking to their brokers to bring recommendations to help their benefit package stand out and increase satisfaction.

While medical remains the goliath of benefits, I've long been fascinated by vision coverage, which I consider the dark horse of the benefits industry. While vision coverage is often low on an employer's radar, it can produce powerful results—lowering employee medical costs and increasing productivity. Offering a premium vision benefit can also be an easy way to differentiate a benefit package. Helping clients take this secret weapon to another level, I've been working with several to further differentiate their vision benefit by offering two tiers of coverage. Adding a layer of choice has allowed my clients to give a wider range of their employees what they want. In fact, every time we offer a two-tier plan, our clients see an increase in enrollment and increased member satisfaction.

But beyond my personal experiences, recent studies reinforce the power of vision benefit choice. In one study conducted by EyeMed Vision Care, the majority of members preferred choice in vision plan levels. They also expressed an interest in paying more for enhanced plans that provide full or partial coverage of premium eyewear options, like photochromic lenses. These results are in-line with Transitions Optical's 2015 Employee Perceptions of Vision Benefits survey, which showed that nearly nine out of 10 employees believe choice between levels of coverage is important when selecting a vision plan.

My firm serves a lot of privately held, white-collar clients in industries including financial services, non-profits, and private schools. These clients employ 100 to a few thousand employees. The majority of them already offer a 12-12-12 vision benefit, which provides employees a comprehensive eye exam, eyeglasses or contact lenses, and new frames on an annual basis. For those clients who don't offer the 12-12-12 vision package, we recommend a buy-up plan, which has worked very well.

In the buy-up plan, the employee has the opportunity to pay slightly more premium to receive added benefits (e.g., changing out frames or lenses on an annual basis versus every two years). We see a lot of excitement, particularly around the frame allowance. California is a fashion-conscious state, and many of our clients' employees are happy to contribute an extra $20 to $30 from their paycheck so they can purchase new frames more frequently. And when vision is voluntary, which it is in most cases around the country, there is no additional cost to the employer. Employers who contribute to vision premiums generally see the same employee engagement, even when the buy-up option does not feature a proportionate employer contribution.

THE BONUS TO BOOSTING VISION COVERAGE ENROLLMENT AND USAGE

So, what else do multi-tiered vision plan mean to the employer? A lot. An employee who is swapping out frames on an annual basis is more likely to schedule an annual eye exam. Annual eye exams are important for not just for early detection and treatment of eye diseases, but also for systemic diseases detected through the eye. These early detections can have a big impact on a client's medical costs and the employer's bottom line. In fact, The Vision Council estimates that employers who add a vision plan to their benefit package can reap a return-on-investment of $7 for every $1 spent.

When employees visit the eye doctor, their eye health addressed and can get an up-to-date eyeglass prescription. This process is important since even slightly miscorrected vision—to a point where the employee doesn't even notice—can result in up to a 20% loss in productivity. More frequent eye exams also give employees an opportunity to inquire about lens options for protecting and enhancing their vision at work and home.

EDUCATING ABOUT MULTI-TIERED VISION PLANS

When it comes to offering multi-tiered vision plans to employers, education is key. We explain to our clients how other companies have experienced success and an increase in enrollment and utilization when offering a multi-tiered vision plan. We walk them through a side-by-side comparison of plan options, highlighting how often employees can get an eye exam with each. We explain all of the enhancements and additional discounts and allowances offered by the premium tier.

We focus on lens technology because it has become increasingly important to stay on top of the latest trends. In fact, in the 2014 Transitions Employee Perceptions of Vision Benefits survey, nearly nine out of 10 respondents said it was important that their vision benefit covers new lens technologies. This is good news for the employer, considering that offering new lens technologies, like improved photochromic lenses and anti-reflective coatings, can play a critical role in minimizing light and glare, which affects the quality of work and contributes to more work breaks to rest strained eyes. Employees who opt for higher-tier coverage aren't just pleased with the high-value coverage they receive. They also gain access to innovative lens options that can lead to a boost in productivity. For employers and employees, it's a win-win. ★

Mike Morey is chief operating Officer of Bolton & Company. With over 25 years of experience in the insurance industry, Morey is responsible for driving growth and recognition of Bolton & Company as one of the leading privately-held insurance brokerages in Southern California, as well as overseeing the day-to-day operations. Morey also sits on the advisory board for multiple national property/casualty and health insurance carriers.

COBRA IN THE AGE OF EXCHANGES

by **HECTOR DE LA TORRE**

Since the individual mandate of the Affordable Care Act (ACA) went into effect, millions of Americans have signed up for private health insurance through the state and federal marketplaces, or exchanges. A recent report by the Department of Health and Human Services estimates that 87% of those people will qualify for discounts if they buy insurance through a government-run exchange and, based on their income, over half of those enrolled in a plan through an exchange will pay less than $100 a month in premiums.

With the increase in access to subsidized health insurance, some are beginning to re-examine the viability of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), which requires most employers with group health insurance plans to offer employees the opportunity to continue their coverage under their employer's plan after termination, layoff, or other change in employment status as long as they pay the full premium.

The vast majority of Americans receive health care benefits from their employer. For years, COBRA benefits have been an important part of the health care system, allowing workers to temporarily keep their insurance when they leave their employer by continuing to pay their share and adding their employer's share for the entire premium due. In most cases, this full cost more than doubled their monthly payment.

The average monthly cost for single coverage in an employer-based plan was $490 (employer plus employee share) in 2013, according to the Kaiser Family Foundation's 2013 employer health benefits survey. However, according to a survey conducted by the Transamerica Center for Health Studies last year, 42% of the uninsured could afford health insurance premiums of just $100 per month. With the loss of employment, total premiums of around $500 per month are out of reach for many workers, making subsidized coverage in an exchange an attractive option in these circumstances.

One of the effects of the ACA has been the decoupling of health insurance and employment. Individuals who lose coverage through their employer now have the option of purchasing a plan through an exchange (the only place to receive income-based discounts) or the traditional insurance marketplace in addition to COBRA. Of course, if a worker gets a subsequent job that offers health insurance, they are free to take it.

Individuals who have COBRA insurance are considered covered according to the ACA's individual mandate that all Americans have a qualified health plan or pay a tax penalty. However, COBRA is an optional benefit; being offered COBRA does not preclude an individual from enrolling in a (possibly discounted) plan through an exchange within 60 days of losing their employer-based health insurance. People who lose their employer-based health care coverage and are offered COBRA can enroll in an exchange plan under the following circumstances:

- When they become initially eligible for COBRA.
- When their COBRA coverage is exhausted (usually after 18 months).
- During the ACA's annual open enrollment period.

It's important to note that once a person enrolls in a COBRA plan, they can only switch to an exchange plan during the open enrollment period or when COBRA benefits expire.

When deciding whether to enroll in COBRA, step one should be to compare the premium of the COBRA plan (employer plus employee cost) to a premium through an exchange (possibly with an income-based discount), or an individual market option (without an income-based discount). Lastly, enrollment in Medicaid is available year-round and lower-income individuals who have left their employer for any reason could qualify for this government sponsored coverage. ★

Hector De La Torre is the executive director of the Transamerica Center for Health Studies, a nonprofit focused on helping consumers and businesses navigate the health care landscape. De La Torre served as a State Assemblymember for California's 50th District from 2004 to 2010. Among his accomplishments as an elected official were expanding access to doctors in underserved communities, consumer protections against retroactive cancellation of health insurance, and supporting improvements at Children's Hospitals. De La Torre is also a member of the Board of Trustees at Occidental College, serves on the California Air Resources Board and on the Board of L.A. CARE, the largest public health plan in the United States. The Transamerica Center for Health Studies (TCHS) informs the national health care conversation by bringing clarity to the complex decision-making regarding health coverage and personal health and wellness.

Photo courtesy of Pavan Kumar N/Wikimedia Commons

LIFE SETTLEMENTS ARE ALIVE AND WELL

by **DOUG HIMMEL**

Over the years, many advisors have asked us if the life settlement market was dead. It's a valid question coming off a period of transition. To summarize very quickly, from 2008 to 2012 the market slowed and buyers retreated as they had to digest several issues that came up nearly simultaneously: increased or new regulation, extensions to life expectancy estimates, and the financial market meltdown. Needless to say, that's a lot to digest in a short amount of time. Many buyers went to the sidelines to wait it out.

The upside of having understandable regulations is that investors feel more comfortable allocating new dollars based on new compliance standards and processes. Also, buyers are more optimistic due to more thorough underwriting of cases including more heavy-duty purchase and sale agreements and overall due diligence of the insured, owner, and policy. In addition, due to the current interest rate environment, buyers are looking for investments that pay a higher than average yield. All of the above brings more interest and dollars to the market.

The reality is that the business has come back slowly but steadily and most recently with vigor. Bidding has increased in the number of bidders and the number of rounds of bidding. This increased interest in the life settlement market leads to higher prices paid to sellers, more transactions closing, and happy referral sources, which lead to more submissions and closed cases and so on.

We are seeing demand greatly outweighs supply of policies. In fact, this is the most competitive market we've seen since 2009. We met with two direct funders last week; each has $100 million+ of committed capital to purchase policies. There are also plenty of other funds and SPVs that are contemplating an entrance or a return to the market.

In general, the buyers are looking for the following:

- Insureds who are 70+. What we are seeing, more and more, is that buyers are looking for impairment and focusing on life expectancy rather than age
- Universal life and indexed or variable universal life as well as convertible term policies
- $500,000 or more in death benefits

As well, some new and different alternatives to a traditional settlement have materialized, including the following:

- **No life expectancy/No Medical Record buyers:** A buyer will bid without medical underwriting or life expectancies and deliver indicative pricing within 24 to 48 hours of receiving a current illustration. This might be a great potential alternative when a insured is too healthy for a traditional settlement, but has determined that the policy is no longer necessary or financially feasible to maintain. Indicative pricing is usually delivered 24 to 48 hours of receiving a current illustration.
- **Non-recourse loan programs:** When there are extreme medical impairments, lenders can loan money to the policy owner, enabling them to retain the benefit of the policy (minus loan payoff). In certain larger cases, when medical impairment isn't as significant, we've seen lenders add a degree of leverage to cases that would have gone the traditional life settlement route. This leverage allows the policy owner to maintain needed coverage and benefit from their policy.
- **Shared death benefit deals:** Buyers are now more active in delivering partnership type deals to sellers. The process and the paperwork is similar to that of a traditional life settlement with the buyer agreeing to fund all ongoing premiums and the seller retaining a percentage of the death benefit.
- **Charitable gifting programs:** If qualified, a seller can donate the policy, get an immediate charitable deduction, and designate a charity as the recipient of a portion of the death benefit. This could be a solution for those who want to fulfill charitable obligations, get immediate relief from paying premiums, and get a tax deduction.

Although the life settlement option has indeed become more mainstream, this market still has a long way to go. Many advisors and policy owner don't understand the market. Worse yet, even in 2015 with regulation and full disclosure all around us, there are advisors who are prevented from even discussing the life settlement option with their clients (by their broker dealer or captive insurance carrier) in a move that may ultimately come back to haunt them.

About 250,000 of senior insured policies, with a combined face value of more than $57 billion, are lapsed or surrendered each year, according to a recent analysis by the Life Insurance Settlement Assn. In addition, about 90% of seniors who lapsed or surrendered a life insurance policy said they definitely would have considered selling their policy and wished they had known about the life settlement option when they terminated their policies, according to a survey by the Insurance Studies Institute. The Lifeline Program and WealthManagement.com recently surveyed financial advisors about life settlements, and more than 40% of these financial advisor respondents were either unfamiliar with, or had only heard of, life settlements. While nearly half of respondents were aware of life settlements, only 11% had either recommended a life settlement or assisted a client with a transaction.

Like all other financial decisions, each case is unique and not all solutions are right for all policy owners. Life settlements are no different. Sellers, and their advisors, must weigh the risks, opportunity costs and rewards before engaging in any potential transaction. ★

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WHEN REGULAR INSURANCE ISN'T ENOUGH

by **MARK ROBERTS**

The days of having regular health insurance have changed. Even those who are forced to buy insurance on private or public exchanges admit that figuring out the coverage has become a whole new ball game—one with rules that don't seem to make sense sometimes. Over the past couple of years, employers, carriers, insurance companies, and brokers have been scratching their heads trying to stay ahead of the curve in choosing the right medical plan as well as various gap coverages.

There has definitely been a noticeable rise of consumers purchasing high deductible health plans (HDHP), mostly through their employer. In large, it's part due to the Affordable Care Act. The market forces that have fueled the growth of HDHPs indicate that more changes are sure to come. Plan holders face increased financial exposure while employers and underwriters are taking less risk. Consumers are faced with choosing various product options to manage their fiscal outcomes and responsibilities.

Developed in the 1990s, critical illness coverage is one of the most popular insurance benefits. When offered at the workplace, employers typically offered it on a pure voluntary basis. This specialized insurance provides a lump sum, tax-free payment if a policyholder suffers from specific critical conditions, according to the American Association for Critical Illness Insurance (AACII).

Critical illness insurance typically covers three primary conditions: cancer, heart attack, and stroke. However, policies may also cover conditions, such as heart transplant, coronary bypass surgery, angioplasty, kidney (renal) failure, major organ transplant, and paralysis. The policy may also be structured to pay out regular income. The payout may also be on the policyholder who is undergoing a surgical procedure.

Examine your policy's waiting period, also called the "elimination period," which is the time you have to wait after diagnosis before receiving the insurance payment. For most policies, no benefits will be paid to you or your estate if you die as a result of the critical illness during the waiting period (and have no special rider to cover that), according to Insure.com. This period varies from company to company. However, 14 days is a typical waiting period, but it can be longer. Many use a 30-day period.

Before buying a policy, understand its exclusions and limitations. Typical exclusions include critical illnesses that are diagnosed during your policy's waiting period, self-inflicted injury, and suicide or illness resulting from illegal activity. Other exclusions may include balloon angioplasty surgery, pre-malignant conditions or conditions with malignant potential, and most skin cancers. Most critical-illness policies are issued for a minimum of two years and a maximum of 20 to 25 years. Most insurers won't sell you a policy if you are over 65. Also, you face steep costs if you purchase a policy in your early 60s.

The contract terms define what is a valid critical illness diagnosis. The terms may state that the diagnosis needs to be made by a physician who specializes in that illness or condition or certain tests must confirm the diagnosis, such as EKG changes of a myocardial infarction.

The finances received could be used to pay the costs of the care and treatment, recuperation aids, replacement of lost income due to a decreasing ability to earn, or even funding for a change in lifestyle.

This insurance can provide financial protection to pay a mortgage when the policyholder contracts a critical illness condition or dies from it. Some insurers structure the product to repay a portion of a mortgage upon diagnosis of a critical illness. The full outstanding mortgage debt is paid upon the policyholder's death. An alternative is to pay the full sum upon diagnosis of the critical illness, but make no further payment upon death, which effectively makes the critical illness payment an accelerated-death payment.

Some employers take out critical-illness insurance for their employees in the form of a group contract. Employers around the world have used it as an essential strategy to protect their employees financially and attract job applicants.

A 2008 Harvard University study found that medical problems have contributed to over 60% of all bankruptcies in the United States. And 78% had health insurance at the start of the bankrupting illness. This study was performed before the economic downturn in 2009 and likely understates the current burden of financial suffering.

Sixty-three percent of Americans have received a medical bill that was more than they expected to pay, according to a study, last year, by NerdWallet. Some of that is a result of errors; nearly half of the Medicare insurance claims that NerdWallet examined contained billing mistakes. Roughly 40% of Americans owe collectors money for times when they were sick. Adults in the U.S. are more likely than those in other developed countries to struggle to pay their medical bills or forgo care because of cost.

Critical illnesses strike more Americans every year. Annually, 1.6 million Americans are diagnosed with cancer, according to the American Cancer Society. An estimated 720,000 Americans have a heart attack each year, and 600,000 will experience their first stroke, according to the American Heart Association. The vast majority will survive. However, few people are prepared for the financial consequences of surviving a critical illness.

Critical illness insurance helps fill in the first-dollar coverage in case you are diagnosed with one of the covered diseases, especially if you have a high-deductible plan. Although it's a good idea to include this type of product in your health care budget, you need to analyze the cost of coverage. In other words, what is the risk expense worth to you?

According to MarketWatch, the most basic critical-illness coverage offers relatively modest payouts for modest premiums. The cost of $10,000 in coverage can be as low as $14 per month for a 50 year old to more than $300 per month for $100,000 in face-value protection. Baseline coverage offered by employers generally doesn't require medical underwriting, but some policies offer additional coverage to workers who pass underwriting.

As with any other financial product, it's important to read the fine print when evaluating a critical illness plan. Perhaps most important, patients must meet the policy's definition of illness. There are other important technicalities, as well. Some policies have age-reduction schedules with payouts that decline as the policyholder gets older.

Policies are generally portable if the employee switches jobs, retires, or gets laid off or fired. It's worth double-checking. Lump-sum payments aren't taxed if the employee pays the full premium, but they are taxed if the employer pays part of the cost. Some employers choose to pay for a baseline amount of coverage.

The decision to buy critical illness coverage also depends on your risk tolerance. Most people are probably best off self-insuring against critical illnesses. However, many advisors say that they wouldn't try to dissuade a client who would sleep better at night with additional coverage. Advocates say that Americans' incredibly bad savings habits make this type of coverage all the more needed.

Are there are better ways to prepare for potential acute sickness? Experts agree that the answer is yes for most disciplined savers. A tax-advantaged health-savings account can work for non-reimbursed medical costs, and the money in the HSA can roll over from year to year to build retirement savings if not used. You even some very good investment options with it.

Another option is to pay for short- or long-term disability insurance. Experts say that those with adequate disability coverage are less likely to need critical illness coverage. Many advisers recommend disability coverage that replaces 60% to 70% of a worker's salary. It varies, but policies paid for by individuals directly are generally not taxed at withdrawal. Sixty-percent to 70% would replace most of a high-earner's taxable income. Disability awards from policies that are paid for entirely by employers are taxed.

Purchased individually, disability policies generally have higher premiums than commensurate critical-illness insurance, but they also tend to cover more ailments that prevent someone from working, such as a back injury and mental health conditions. Some companies pay for short-term disability coverage for employees. But employees are still on the hook for long-term coverage, which kicks in after 90 days, in most cases. Hopefully, you have some savings to carry you over if you don't have a short-term policy.

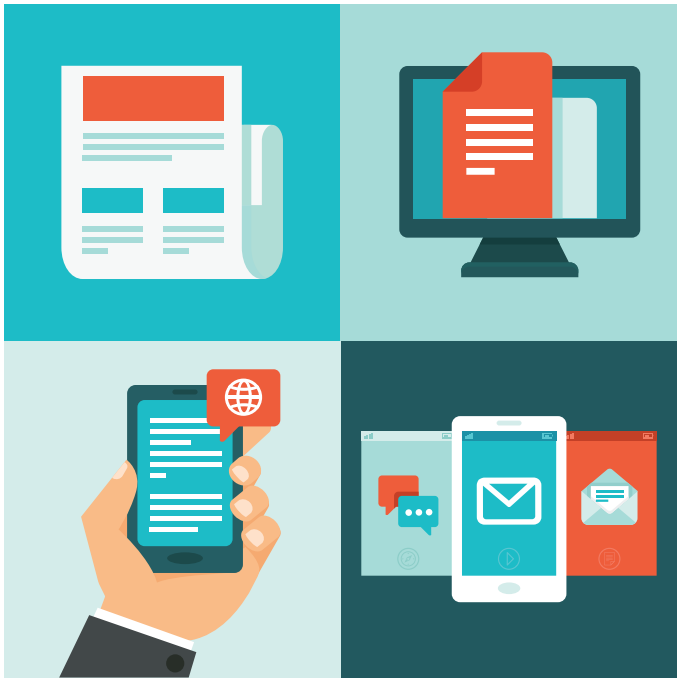
Critical-illness plans provide a form of catastrophic insurance that is meant to supplement, but not replace your major medical insurance. Premiums are based on your age and health when you enroll. Also, there are issues that need addressed with survival periods. First, check with your employer. They may offer a form of critical-illness insurance protection available on a guaranteed-issue basis, which simply means that everyone can qualify.

The insurance company takes this into account when setting rates. If you are in good health, you should definitely look into an employer-offered plan. But you might find that you can get better coverage for less on an individual basis because of your good health status. You should also verify if the policy is guaranteed renewable. It pays to do your homework when analyzing critical-illness insurance policies.

Each insurance company determines the survival period so it is important to ask your insurance professional about the policy they are recommending, according to the ACII. That said, the survival period is the number of days you must survive before a benefit is payable following the diagnosis of a covered critical illness. A survival period applies to all covered conditions. There can be a difference in the number of days that need to pass before a person is considered to be critically ill, according to the definition in the policy.

For brokers, this voluntary benefit is a gold mine due to the number of uncovered employees in America. The Bureau of Labor Statistics reports that there are 157 million employees working, but less than 1 million have a critical-illness insurance policy. And only 35% of mid- to large-size employers offer it, according to Towers Watson. Talk about filling a need. So, do you want to boost commissions? Consider adding critical-illness insurance to your bag of tricks. ★

Mark Roberts' professional sales background includes over 30 years of sales and marketing in the tax, insurance and investment markets. Mark is a licensed life, health and accident insurance agent in all 50 states and DC, for insurance products and discount health plans. Mark has also been writing a health care blog for the past seven years, (yourbesthealthcare.blogspot.com), which is a topical weblog about various health care issues. You can reach Mark at MarkR1955@gmail.com.



NEWS

IN CALIFORNIA
Blue Shield of California Under Pressure

Blue Shield of California has been in the news lately and not in a good way. The *Los Angeles Times* originally broke the story that the company has been stripped of its tax-exempt status. Also in the news, the company's former chief technology officer is suing after being dismissed before collecting on his $450,000 bonus.

Tax authorities stripped Blue Shield of California of its tax-exempt status in California and ordered the company to file returns dating to 2013, potentially costing the company tens of millions of dollars. Insurance commissioner Dave Jones said, "The Franchise Tax Board decision to terminate Blue Shield's tax-exempt status confirms what I have said for years—that Blue Shield charges excessive rates and acts like a for-profit health insurer. Blue Shield is also dodging the payment of premium taxes by taking advantage of a legal loophole that allows Blue Shield to move its health insurance products from Department of Insurance regulation to Department of Managed Health Care regulation."

The Department of Insurance collects premium taxes from all for-profit and non-profit health insurers. Jones said that Blue Shield has moved most of its health insurance policies over to the Department of Managed Health Care. "We need to pass AB 1434 by Assembly member Kevin McCarty to close the loophole that allows Blue Shield to move its health insurance products to the Department of Managed Health Care to avoid the strong consumer protection oversight of the Department of Insurance and avoid paying premium taxes," he said. The Blue Shield loophole costs the state $100 million in premium taxes annually. As a tax-exempt company with surplus of $4.2 billion Blue Shield was able to accumulate an enormous amount of money on which it did not pay state taxes by evading the tax on the premiums it collects, he added.

Blue Shield of California issued the following statement in response: "Blue Shield of California is a mission-driven not-for-profit health plan with a demonstrated commitment to the community. A longtime supporter of healthcare reform, we limit our net income to 2% of revenue and have contributed $325 million to our foundation's efforts to improve the health safety net and address domestic violence. We pay federal income taxes, state gross premium tax and Affordable Care Act taxes and fees. We believe we meet the requirements for a state income tax exemption and have challenged the California Franchise Tax Board's finding to revoke our tax exempt status. We filed California state income tax returns beginning in the 2013 tax year. The FTB decision has no bearing on our ability to continue to meet the needs of our members and community and we remain in strong financial health. Regardless of whether we prevail in our tax dispute, we will remain a not-for-profit."

HEALTHCARE
Insurers Fall Short in Mental Health Coverage

Health insurance plans are falling short in coverage of mental health and substance abuse conditions according to a report by the National Alliance on Mental Illness (NAMI). The organization surveyed 2,720 consumers and analyzed 84 insurance plans in 15 states.

A federal parity law, enacted in 2008, requires mental health benefits in some employer-sponsored plans to be provided on the same terms as other medical care. Coverage was expanded under the Affordable Care Act (ACA) in 2010. However, the report finds the following problems with mental-health coverage:

- A lack of mental health providers is a serious problem in health insurance networks.

- Nearly a third of survey respondents reported insurance company denials of authorization for mental health and substance abuse care. For ACA plans, denials were nearly twice the rate for other medical care.
- More than half of health plans analyzed for the report covered less than 50% of anti-psychotic medications.
- High out-of-pocket costs for prescription drugs discourage people from participating in mental health and other medical treatment.
- High co-pays, deductibles, and co-insurance rates create treatment barriers.
- There is a serious lack of information about mental health coverage that would enable consumers to make informed decisions in choosing health plans.

The report makes these recommendations:

- Strong enforcement of the 2008 parity law is needed at the federal and state levels, including establishing easily accessible procedures for filing complaints.
- Insurance companies should be required to publish the clinical criteria that's used to approve or deny mental health and medical-surgical care.
- Health plans should be required to publish accurate providers lists in their networks and to update them regularly.
- The Dept. of Health & Human Services should require all health plans to provide clear, understandable, and detailed information about benefits and make this information easily accessible. HHS should develop tools to help consumers compare plans before enrollment.
- Congress and the Executive Branch must work together to decrease out-of-pocket costs under the ACA for low-income consumers.

For more information, visit facebook.com/officialNAMI.

Top 10 Employee Questions on Private Exchange Enrollment

Towers Watson compiled these top 10 questions that full-time employees ask when enrolling in the company private exchange:

1. **Which plan has the lowest cost?** Using premium cost as the most important criterion for making health plan choices could be a mistake because the least expensive plan is not always the best one. Employees should also consider their health status, the doctors and hospitals they use, and the prescription medications they take.
2. **What are the copays for the medical plans being offered?** Historically, employees have gravitated toward the predictability of PPOs with copays, but these plans may cost more out-of-pocket and may not be the best choice for them. Some employees may be surprised to learn their employer doesn't offer any copay plans. In these situations, it's important to explain that there may be plans of similar value even if they have different coverage features.
3. **Why do my health plan options have high deductibles?** Employees need tools to help them understand the workings of high deductible plans that are connected to HRAs or HSAs and why they may actually be the better choice for them. Employees also need help understanding how accounts work and the tax advantages of HSAs. Some employers enhance this transition by jump-starting the balance with a cash contribution.
4. **What are the differences among gold, silver, bronze, and safety net plans?** The metal tiers mandated by the Affordable Care Act (ACA) for public exchanges (and adopted by many private exchanges) are designed to make it easier for people to compare plans but employees should delve deeper into the details beyond the metal hierarchy. Coverage, premiums and out-of-pocket costs vary by plan and insurer within the metal plans. Employees should make decisions based on a thorough comparison of plan details; they often need the help of decision support tools and live, personalized advice from an expert to do that.
5. **What do I need to do to earn my wellness dollars?** Over 50% of enrollees say they will engage in wellness activities. They have many questions on how to earn wellness dollars, when they'll have the money in their account, and what they can spend it on. This is good news for employers that have struggled to engage employees in wellness programs.
6. **How do I know if my doctors are part of the plan I choose?** Being able to continue seeing their current medical providers is top of mind for employees when evaluating new health plans. However, answering this question can be a moving target as contracts among doctors, hospitals, and insurance companies can change from year to year. Exchange providers can make this complicated task easier by integrating doctor and facility lookup tools into the exchange enrollment experience. Many physicians are part of multiple plans, giving employees the choice of carriers and price points while still keeping their family physician.
7. **What are the differences among an HRA, HSA, and FSA?** Health insurance is a complex topic with confusing jargon and acronyms. HRA, HSA and FSAs refer to the options employers have for funding health benefits through accounts that offer tax advantages

to employees and employers for offsetting health care costs. These types of accounts have been available for some time, but are increasing in popularity as employers seek new ways to fund health benefits and encourage employees to save for health expenses.

8. **What does the prescription drug plan cover?** Employees are confused by the array of pharmacy provisions, copays, coinsurance minimums and maximums, formularies, and more. They want to know what their drugs will cost for each plan and insurer option. In addition to using the decision support tools available, many employees want to discuss their circumstances with an informed service center representative.
9. **What are the differences between insurers?** Confronted with different price points from different insurers for similar plan designs, employees want to know what added value they might be getting from a higher-cost insurer. While most insurers believe they do a good job of marketing and differentiating themselves from the competition, the prevalence of this question suggests there is more work to be done.
10. **If I want to keep the same plan I had last year, do I need to do anything?** Historically, plans have had default rules that place employees in a predetermined safe plan choice if they don't take action during open enrollment. In an exchange offering, some employers want to encourage an active enrollment choice each year so employees get to know the available options through a shopping experience. As employers offer more voluntary and ancillary benefits, employees should evaluate annually which of these to keep or change, as well.

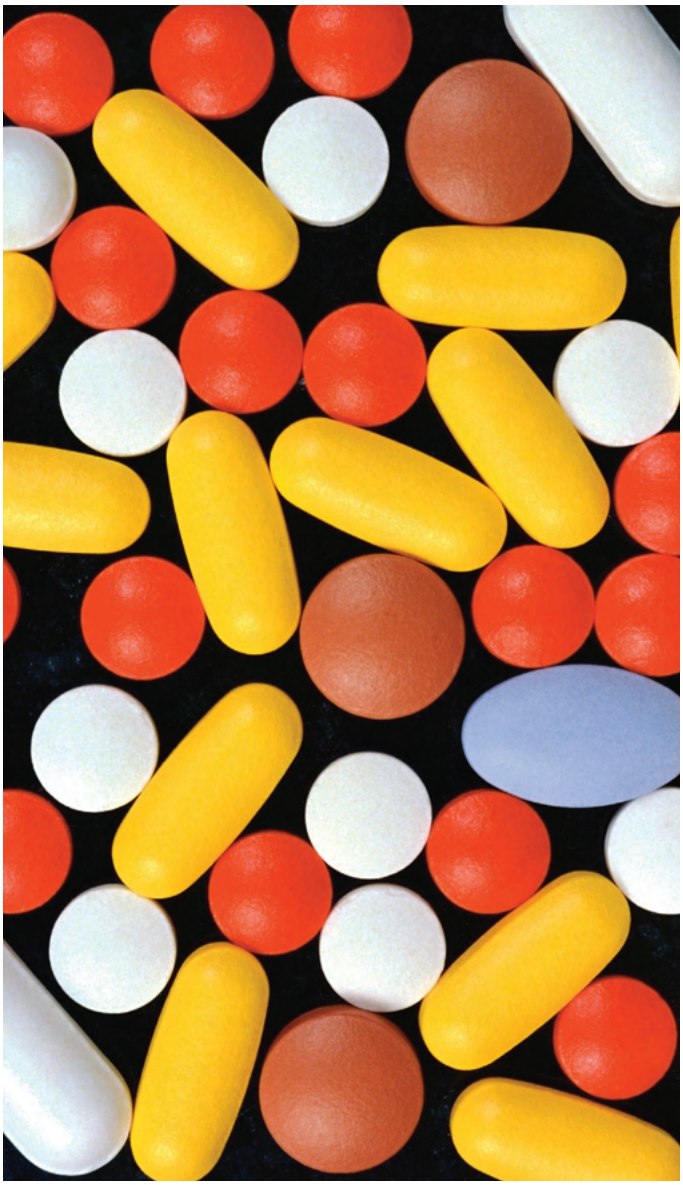
For more information, visit towerswatson.com.

Health Plan Leaders Reveal Challenges in Managing Vulnerable Populations

Health Integrated and the Assn. for Community Affiliated Plans (ACAP) surveyed health plan executives on the challenges they face serving people who are enrolled in Medicaid, Medicare Advantage, and Children's Health Insurance Programs (CHIP). For the second straight year, having access to data was a primary concern for plans of all sizes. "Data is playing a bigger role in how health plans manage their populations. With multiple data sources available from claims feeds to electronic medical records to information from patients themselves, isolating and analyzing the most useful data points is critical," said Sam Toney, MD, Chief Medical Officer and EVP of Clinical Integrity of Health Integrated.

The cost and appropriate management of specialty drugs is another major concern. Certain costly medical conditions, such as hepatitis C and pulmonary hypertension, are more commonly seen in vulnerable populations. Pricey specialty drugs accounted for more than 31 cents of every dollar spent on prescriptions last year even though they represented only 1% of all U.S. prescriptions filled, according to Express Scripts. This creates a growing challenge for health plans to manage costs while delivering quality care.

Plans serving dual-eligible members are facing concerns, such as improving Star ratings while managing costs. Dual eligible beneficiaries are among the sickest and poorest people covered by Medicare or Medicaid and account for a significant portion of costs for programs. Health plans are also considering the importance of addressing the social determinants of health, such as housing, food, and nutrition. ACAP plans have developed special programs, such as the "UPMC for You," which provides stable housing to homeless members with a history of avoidable visits to ERs and inpatient, and skilled nursing facilities. Another example includes CareOregon's Food Rx pilot project, which provides vouchers to members who don't get enough food or don't have access to healthy food items. John Lovelace, President of UPMC for You said, "As plans are being held more accountable for outcomes, we need to take the lead in bringing all services together to fully support our members. You can't have healthier members without addressing all of their medical, social, economic and behavioral needs." For more information, visit healthintegrated.com.



LAAHU 2015 Show Coverage

by **LEILA MORRIS**

The Los Angeles Health Underwrites (LAAHU) University Day, last month, featured plan changes, commission controversy, and bureaucratic nightmares. At a panel for small group health plans, Kathy Dibble, head of Sales and Service for Aetna Small Group said that brokers should budget a 30% to 40% cut in commissions for group health plans. She does not expect group commissions to drop to what they are for individual plans because of the value that brokers bring to group sales. Commission cuts won't happen right away because carriers don't want to put their December business at risk, she said. "We are seeing a lot of broker consolidation," she added. The crowd applauded executives from Kaiser and United who said they had no plans for commission changes.

Jack Lyons, director of Individual & Small Group Sales at Anthem Blue Cross said, "We all have to have these conversations. Most 50 to 100 groups are in a 5% commission structure. That's $35 million in December." *California Broker* magazine asked executives on the panel what their companies have done to limit executive compensation since the ACA's medical loss ratio (MLR) provisions went into effect. No one had a ready answer on any compensation cuts for top executives in their companies. However, Dibble said that her own pay has been cut by 30%. Lyons of Anthem said, "We have tightened belts in all departments." He added that compensation packages have been capped. Juan Lopez, regional director of sales for Southern CA Kaiser Foundation Health Plan said that his company has also reigned in expenses.

Phil Lebherz, founder and chairman of LISI said, "If commissions go down too far, we won't be there, and no one can replace us. We are a less expensive delivery channel. Insurance companies are not thinking about distribution channels right now, but they will. Don't underestimate your value. No one has figured how to replace a broker…Tell me any industry that does not have a wholesaler and a retailer. This is the natural distribution channel for everything… Commission percentages are market driven."

Lebherz said that, in today's market, brokers will be forced to improve their product knowledge. He sees large groups breaking away from third-party payers. "Larger companies can go direct and pay the providers. Provider networks are better able to understand lower cost options. The good news is that our expertise is needed to deliver these products." As for online mega companies that are handling benefits, Lebherz said he is not worried, "If they can take your client with a phone call, you need to up your game." Lebherz advised agents to get as much market share as they can now and get vested contracts.

As for plan changes, Kathy Dibble of Aetna said that her company has eliminated grandmothered plans. Under the ACA, actuarial values have narrowed. "You can't have as many plans. You will get variety in networks and plan types," she said.

Allen Patrick, director for Small Business Sales for United Healthcare said, "Our strategy is to keep it simple. Our plans on the PPO side are only nine. We have taken a network strategy as we go into 2016. We did not increase the number of plans." He said that United has just started getting more competitive in the market. When United took over PacifiCare, it faced a disadvantage in that it had to re-contract with doctors and hospitals.

Brent Hitchings, vice president and general manager of Blue Shield's Small Business Market said that the company will be rolling out a portfolio of new plans including a PPO for groups of one to 100 to fit with the new Affordable Care Act's (ACA) definition of "small group," which goes into effect in 2016. Small groups will be defined as up to 100 employees. The definition is now one to 50 in California. Insurers will need to combine the small and mid-size risk pools to set their rates. They will also need to extend the ACA's rating and benefit standards to larger employers. As a result of the new definition, two-thirds of mid-size groups (51-99) could face an average premium increase of 18%, according to an Oliver Wyman study. Hitchings of Blue Shield said, "Where we have control is through risk adjustments. We are just starting to see data on our risk score. That will come out in July. Until that, we can't predict the future [of rates]." Juan Lopez, regional director of Sales for Southern CA Kaiser Foundation Health Plan said that his company expects a low single digit pricing increase.

At the afternoon panel for large groups, Dibble of Aetna said her company has already created a two to 100 team to support the new small group segment. Other panel members said that their companies are also on track to roll out the new plans for 2016. Carrier representatives said that their companies are offering extended contracts to groups and early renewals. For example, Lyons of Anthem said, "If you have a renewal date in July, you can take an extended contract to 2017 as an option."

Dibble said that brokers who are familiar with two to 50 group sales will have an edge over those who only work with larger groups.

A state government panel turned into a contentious town hall meeting as agents vented their frustration over problems integrating MediCal enrollment with Covered California enrollment. Agents and their clients are being caught in a bureaucratic nightmare when clients are dropped from Covered California with no warning and funneled to MediCal where they get lost in the system and sometimes don't get coverage. This sometimes happens when some family members are deemed eligible for Covered California while others are eligible for MediCal. Agents who try to intervene on behalf of clients find that MediCal does not recognize their delegation code and doesn't know how to deal with them. Audience members questioned why the two state departments can't communicate. One agent said that Medi-Cal needs a dedicated agent line similar to what Covered California offers. For now, one recommendation is to get enrollment forms directly from MediCal for clients to fill out. Agents also complained about waiting months to get paid for enrolling clients in Covered California. State representatives said they are working on the problems and have made some progress, but could not give a timeline on when problems will be solved.

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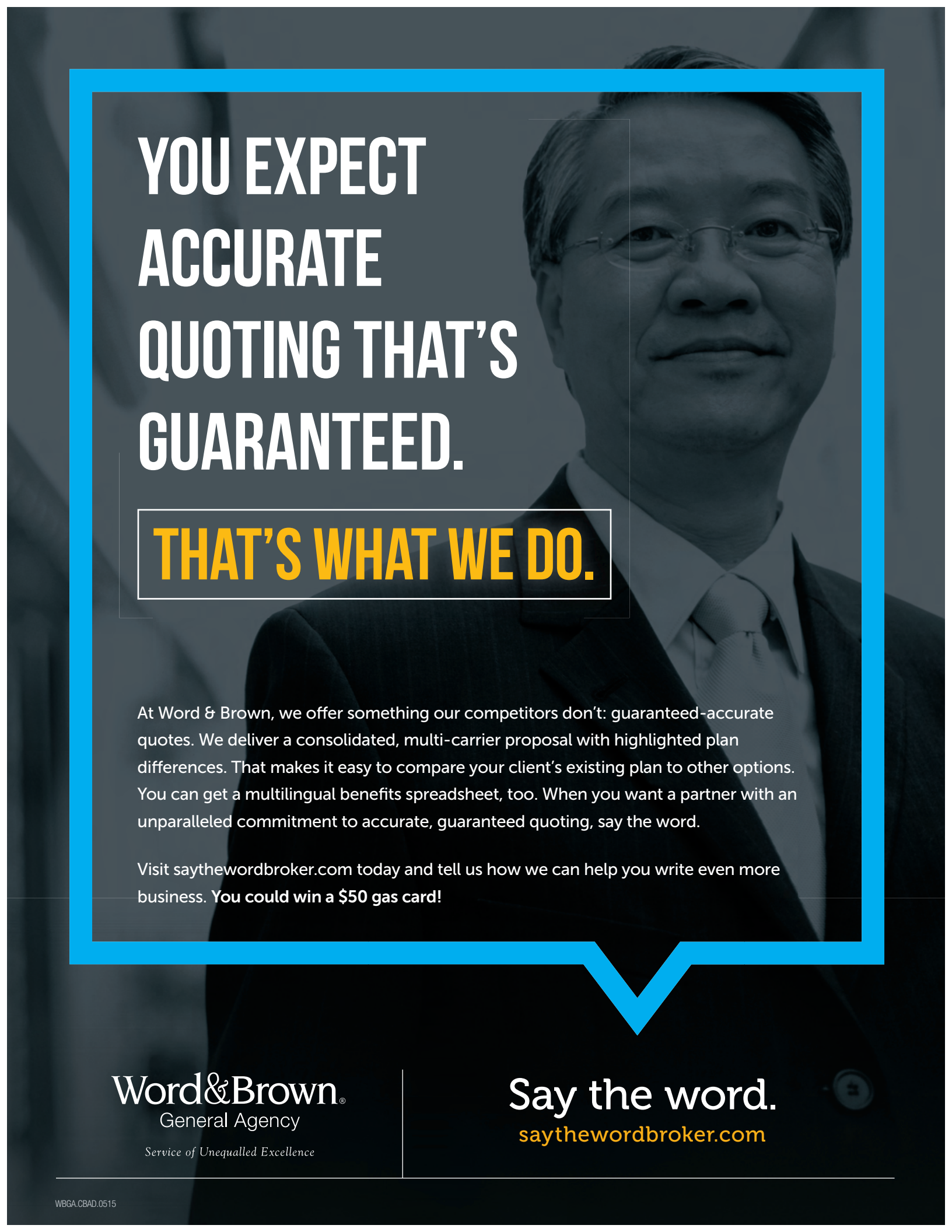
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