

CALIFORNIA BROKER

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SERVING CALIFORNIA'S LIFE/HEALTH PROFESSIONALS & FINANCIAL PLANNERS

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Good Agents Don't Ignore Medicare Supplement Plans

By SUSAN HATCH

As a person (or their spouse) works their entire lifetime, they have money snatched away out of every paycheck they receive. This money goes into the Medicare trust fund. They have no say in the matter. This started in the U.S. in 1966, whether someone likes it or not. This money was slated to be used for Original Medicare.

The beautiful red, white and blue, Original Medicare card is almost "sacred" in my opinion. I am as proud of the Original Medicare card as I am of the American flag. That card is America's original health care promise – it allows a person to go to any Medicare provider in the United States of America -- no permission slips or referrals required. The vast majority – 99 percent -- of 5,815 hospitals take original Medicare and 97 percent of doctors --or over 880,000 physicians -- take Original Medicare. What Insurance plan can give a person that much freedom? Original Medicare gives more freedom than any plan in the nation.

Original Medicare covers around 80 percent of the incurred health care expenses. Roughly 37 years ago, Medigap or Medicare Supplements (two names for the same thing) were created. These plans help pay for the gap, the remaining 20 percent of health care expenses not covered by Medicare. The most popular Medigap-Medicare Supplement plan has been Supplement Plan F. Many people call Plan F the "Cadillac plan." I like to call it the

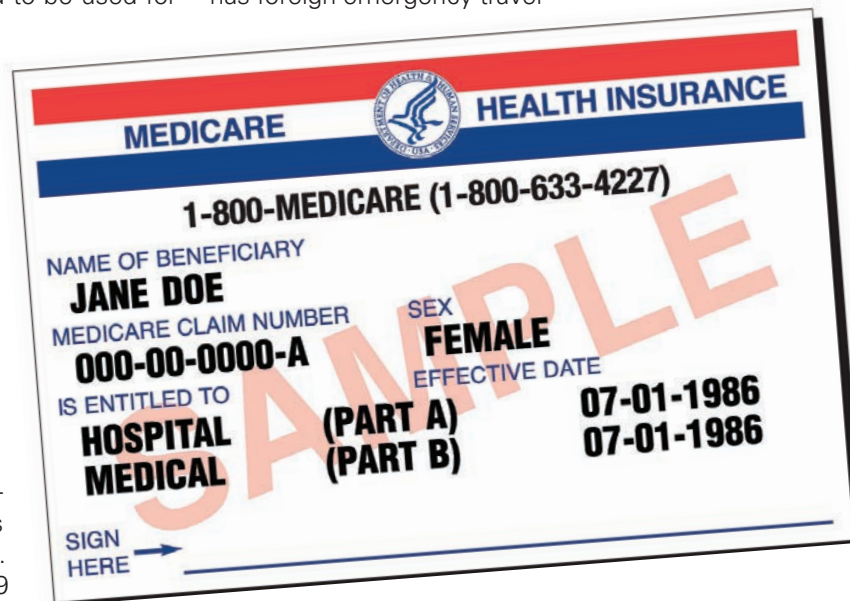
"Full Coverage Plan." Plan F has no deductibles, no copayments, no referrals needed, no prior authorization needed, no networks, no plan changes, no out-of-pocket expenses, no plan cancellations and no excess charges! Even if a person has ESRD (kidney disease), he or she can enroll in Plan F. Plan F even has foreign emergency travel

care and enrolling, a senior can access a comparison of the coverage for her or his medication on all available Part D plans. This way he or she can select the Part D provider that offers the best and lowest prices on the medications needed.

A digression for a bit of history: In 2003, pharmaceutical lobbyists along with Insurance company lobbyists wrote the Medicare Prescription Drug Improvement and Modernization Act. Big Pharma's ability to influence public policy is well known in Washington. They are the top spenders on lobbying activities each year. Early in the morning of Friday, November 21, 2003, a 1,000-page bill landed on House

members' desks. They only had a few hours to read it before having to cast a vote. They voted at 3 a.m. on a Saturday. Almost three hours later, with big money lobbyists twisting arms, it passed (barely). Viola – that's when Medicare Part D was implemented. This meant, though, that unlike the days previous to Part D, Medicare was no longer able to negotiate drug prices. (No surprise then that drug prices have more than doubled in the last six years.) This legislation also brought about another crucial change: the introduction of something called Medicare Advantage plans.

LET'S TALK ABOUT MEDICARE ADVANTAGE PLANS
Medicare Advantage plans are plans



attached to it. Every Medicare provider must take every Medicare-Medigap Supplement plans (unless their practice is full). That's a federal law.

Because of this, Medicare with Plan F is as close to "health insurance perfection" as a person can get in the United States. Of course, Medicare can't enroll anyone in a Medicare Supplement Plan F. Only a licensed, appointed Insurance agent has the authority to do that.

PART D

When a person has Original Medicare and a Medicare Supplement such as Plan F, that person will get prescription drug coverage through a Medicare Part D drug plan. By calling 1-800-Medi-

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run and administered by the insurance industry that completely replace and wipe out a person's Original Medicare. A person on Medicare Advantage is controlled by the insurance company. A person gives away all of his or her Original Medicare freedom of choice. The Medicare Advantage insurance company is contracted and approved by Medicare to offer plans, but Medicare does not endorse or recommend Medicare Advantage plans.

Some Medicare Advantage plans have deductibles, all have copayments. Referrals are usually required. Prior authorization is needed. Plans have networks with a list that continually changes. Some plans only have one hospital. Plans can change every year. Out-of-pocket copayments can be up to \$6,700 a year. The plan can be eliminated or canceled and doctors and hospitals can be taken away at any time in the year with a 30-day notice. If a person has kidney disease, he can't enroll. The sacred red, white and blue Original Medicare card becomes basically inactive and is replaced by a Medicare Advantage plan card. In my opinion, the insurance company is the one with the true "advantage."

When on a Medicare Advantage plan, the Part D drug plan is attached. A person does not have the opportu-

nity to get the best and lowest price stand-alone Part D drug plan available. They have to deal with whatever drug plan is attached to that particular Medicare Advantage plan. Some of a person's drugs might not even be covered at all.

A recent study of the Government Accountability Office, July 2017, shows that as seniors get sicker, they are more likely to drop Medicare Advantage plans because they face many hurdles getting access to preferred doctors and hospitals. Some plans may leave sicker patients worse off.

WHY MEDICARE ADVANTAGE HAS BEEN FAVORED

Why are insurance companies and insurance agents pushing Medicare Advantage plans rather than Original Medicare with a Medicare Supplement plan? Money, Money, Money! Medicare pays the Medicare Advantage plan every month for every person enrolled. The amount paid depends on age, zip code and medical conditions. It can be up to \$7,000 a month per person, for the extreme cases. This equals billions of dollars a year for insurance companies. This is why the mailboxes of senior citizens are stuffed full of Medicare Advantage advertisements. Insurance agents are

rewarded greatly to enroll a person in a Medicare Advantage plan.

Overall, there is much less compensation to insurance agents for Medicare Supplement plans compared to Medicare Advantage plans.

There's another reason, too. In talking with agents in California, I find that too many don't even know about Medicare Supplement plans anymore. There is no state or federal law that requires training, testing or certifications for Insurance agents in regard to Medicare Supplement knowledge. Medicare Supplements are becoming almost "secret" plans, in fact. Many Insurance agents are not even telling seniors about Medicare Supplement plans, mostly because too many agents don't even know about them. Even if they did, they may not know how to fill out the application properly. The focus and push now is primarily Medicare Advantage plans.

With the difference in commission and lack of knowledge, it's no wonder that seniors are concerned that nobody is looking out for their best interests. I hope that agents will represent all plan types with multiple insurance companies. I always want my clients to have the best deal available. That takes a ton of continual research, but happy seniors make happy referrals! If agents educate everyone on all available Medicare plan options objectively and in an unbiased manner, plenty of compensation will come with volume. For some clients, Medicare Advantage plans make sense.

While some people believe that Original Medicare with a Medicare Supplement plan is only for the rich, this isn't true. I have Medicare Supplement clients who are very low income, but it still makes sense for them. One couple runs a booth at a local swap meet most weekends to pay for their supplement. Some clients ask everyone who loves them to help pitch in for their premiums.

AGENTS BEWARE: PREMIUMS FOR PLAN F VARY GREATLY

Depending on the insurance company, age, zip codes and certain discounts, Plan F premiums in California vary widely. Central and Northern California seem to have the lower premiums

compared to Southern California rates. For example: The lowest San Jose rates for Plan F, for a 65-year-old is only \$116.51 a month and the highest premium for a 65-year-old is \$215.12 a month. Same town, same exact plan, different companies.

The lowest premium for a 99-year-old in Beverly Hills is \$238 a month and the most expensive Plan F in Beverly Hills for a 99-year-old is \$610.25 a month. Same town, same exact plan, different companies.

An agent must be educated and experienced with Medicare Supplements to figure out what is the best company for their clients. It can be complicated. Insurance companies don't formally teach or train agents about all state supplement guaranteed issue laws. Most all agents think everyone will be denied if they are not in good health. This is not necessarily true.

PLAN F GENERATIONAL ELIMINATION, DECEMBER 2019

Some agents tell me "Plan F is going

away, I don't want to touch it." That is absurd. Agents need to embrace Plan F and enroll as many people as possible. It will be "grandfathered" to everyone who has it. They can keep it for the rest of their lives.

Medicare Plan J was eliminated in 2010 and was also grandfathered. I have seen very tiny premium increases with my clients on Plan J, still to this day. Why? I enrolled them in 2010 with the companies that have the largest risk pools or the largest number of members in the nation. I also have them with community-rated plans that end up being cheaper in the long run since the cost does not go up each year based on age. Those two reasons keep premiums the lowest possible. If agents didn't put their clients with those types of companies, however, the Plan J premiums are now through the roof.

Plan F elimination is generational. Anyone who is on Medicare by December 2019 can still apply for supplement Plan F any year down the road.

No agent can guarantee they will be approved, but one can try.

So here's the bottom line: Medicare Advantage might have a zero a month premium with tons of copayments and no freedom of choice. A Medicare Supplement might have a premium with no copayments and total freedom of choice. I'm a fan of Original Medicare with a Medicare Supplement, but I'm even more of a fan of fairly representing all information to the client and letting him or her decide which is best. ★

Licensed, independent insurance agent Susan Hatch, PHIAS (Professional Health Insurance of Advanced Studies), is an objective advocate, analyst, speaker and talk radio guest about Medicare Supplements. Susan has received the NAHU Soaring Eagle Award and The NAIFA Quality Award. Awarded the #1 Medicare Supplement agent in California, Susan has worked with Applied General Agency (AGA) as her preferred General Agency for many years. Find Susan at MedicareToday.net or email CaMedicarePlans@sbcglobal.net.



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American Equity	A-	A- ICC13 MYGA (Guarantee 5) (Q/NQ)	S	2.30%*	5 yr.	None	9%, 8, 7, 6, 5, 0	Yes	\$10,000 (Q) & \$10,000 (NQ)	3.00%, age 18-75 & 2.10%, age 76-80** 1.50% age 81-85**
		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** 1.50% age 81-85**
		ICC13 MYGA (Guarantee 7) (Q/NQ)	S	2.60%*	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** 1.50% age 81-85**
*Effective 7/10/17. 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 Solutions MYG (*Guarantee Return of Premium) (Q/NQ)	S	2.25%* ^a 2.45%* ^b	5 yr.	None	8%, 8, 8, 7, 6, 5, 4, 3, 2, 1, 0	Yes	\$10,000 (Q&NQ)	1.5% age 0-75 .75% age 76-85
*CA Rates Effective 6/2/17. First year rate includes 1.50% interest bonus. a (less than \$100K) ; b (100K or more)										
American General Life Insurance Companies	A A+	A+ American Pathway Fixed 5 Annuity (*Guarantee Return of Premium) (Q/NQ)	S	1.55%* ^a 2.55%* ^b	5 yr.	None	9%, 8%, 7%, 6%, 5%, 0%	No	\$5,000 (NQ) \$2,000 (Q)	2.00% age 0-85 1.00% age 86-90
*CA Rates Effective 6/2/17 Includes 1.15% 1st year bonus, 1.00% base rate subsequent years. a (less than \$100K) b (100K or more)										
American General Life Insurance Companies	A A+	A+ American Pathway Fixed 7 Annuity (*Guarantee Return of Premium) (Q/NQ)	S	1.40%* ^a 1.60%* ^b	7 yrs.	None	9%, 8%, 7%, 6%, 5%, 4%, 2%, 0%	No	\$5,000 (NQ) 1.50% age 86-90	3.00% age 0-85 1.50% age 86-90
*(Guarantee return of premium Q/NQ) *CA Rates Effective 6/2/17. First year rate includes 4.0% bonus 1 st year. a (less than \$100K) b (100K or more)										
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 6/19/17 Includes .25% first-year bonus and is for purchase payments over \$100,000. Escalating five-year yield is 2.20%. For under \$100,000 first-year rate is 1.90%. Escalating rate five-year yield 2.05%.										
Great American Life	A A+	A+ SecureGain 7 (Q/NQ)	S	1.50%	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 6/19/17. Includes 1.00% first-year bonus and is for purchase payments over \$100,000. Escalating seven-year yield is 2.39%. For under \$100,000 first-year rate is 1.40%. Escalating rate seven-year yield 2.29%.										
Great American Life	A A+	A+ Secure American (Q/NQ)	S	1.50%*	1 yr.	N/A	9%, 8, 7, 6, 5, 4, 3	No	\$10,000	5.75% 0-70 4.65% 71-80 *Effective
1/27/17. Eff. yield is 2.67% based on 1.65% 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 1.65%. Surrender value interest rate 1.65%. Accepts additional purchase payments in first three contract years. COM12255										
The Lincoln Insurance Company	A+ AA	AA MYGuarantee Plus 5 2.05%* ^b	S	1.90%* ^a	5 yr.	None	7%, 7, 6, 5, 4, 0	Yes	\$10,000 (Q/NQ)	
*Rates Effective 2/1/17 (a-for premiums less than \$100K, b-for premiums \$100K or more), and are subject to change										
The Lincoln Insurance Company	A+ AA	AA MYGuarantee Plus 6 2.25%* ^b	S	2.10%* ^a	6 yr.	None	7%, 7, 6, 5, 4, 0	Yes	\$10,000 (Q/NQ)	
*Rates Effective 2/1/17 (a-for premiums less than \$100K, b-for premiums \$100K or more), and are subject to change										
The Lincoln Insurance Company	A+ AA	AA MYGuarantee Plus 7 2.35%* ^b	S	2.20%* ^a	7 yr.	None	7%, 7, 6, 5, 4, 3, 2, 0	Yes	\$10,000 (Q/NQ)	
*Rates Effective 2/1/17 (a-for premiums less than \$100K, b-for premiums \$100K or more), and are subject to change										
The Lincoln Insurance Company	A+ AA	AA MYGuarantee Plus 8	S	2.30%* ^a 2.45%* ^b	8 yr.	None	7%, 7, 6, 5, 4, 0	Yes	\$10,000 (Q/NQ)	
*Rates Effective 12/1/17 (a-for premiums less than \$100K, b-for premiums \$100K or more), and are subject to change										
North American Co. for Life and Health	A+ A+ A+	Guarantee Choice II (Q/NQ)	S	2.25%* ^a 2.50%* ^b	5 yr.	None	10, 10, 9, 9, 8	Yes	\$2,000 (Q) \$10,000 (NQ)	2.00% (0-80) 1.50% (81-85) 1.00% (86-90)
*CA rates effective 6/27/17 - a (less than \$200K) b(200K or more)										
Reliance Standard	A+	A Eleos-MVA	S	3.55%*	1 yr.	None	8%, 7, 6, 5, 4	Yes	\$10,000	3.25%**
*Effective 12/2/16. 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	4.25%*	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 7/17										
Symetra Life, Inc.	A A	A Custom 7 (Q/NQ)	S	2.85%*	7 yrs.	N/A	8%, 8, 7, 7, 6, 5, 4, 0	No	\$10,000	Varies
*Effective 7/24/17. 2.35% base rate with no guaranteed return of purchase payments. Plus 0.50% bonus for \$250,000 and above.										



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SELF-FUNDING: YOU'VE COME A LONG WAY BABY!

By STUART SLONIN

With health care reform discussions going in different directions, it's time to take stock of how the group market has evolved. The early 70's were a period of rising group health premiums. Comprehensive major medical plans (the go anywhere / see any doctor or hospital you wanted plans), were the "hot products" at that time! Not surprising, premiums rose by double digits each year. Employers attempted to reduce these costs by changing deductibles, plan designs, cost sharing arrangements and, if needed, carriers.

Carriers also saw tighter underwriting standards and changes in a three-year period became a "declined to write." Some SIC industry codes appeared on "will not write" lists. Older average age groups were reviewed closely. Selected ZIP codes were deemed "high utilization" areas. Surgical schedules were upgraded from RVS to CRVS. Claims data forced carriers to limit some plan availability. Carriers looked at three years worth of claims experience or three years worth of plan design and premium information to determine if they would write the business. Some employers resorted to "carve-out plans."

ENTER: HELP AT THE FEDERAL LEVEL

The Nixon Administration contracted with Dr. Paul Ellwood Jr. to come up with a solution to these cost problems. The result was passage of the HMO Act of 1973 (signed on December 29, 1973). This law was designed to promote and encourage the development of HMOs as a way to curb medical inflation. Just one year later, Congress (as a result of the bankruptcy of the Studebaker Auto Company and its failed pension plan), passed the Employee Retirement Income Security Act of 1974 (signed on September 2, 1974). Together, employers now had two different roads to travel in order to gain medical and benefits plan structure and relief from the high costs that were continuing from prior years. ERISA created a new model of employer responsibility for both health and welfare plans and pensions. ERISA's importance was in its introduc-

ing the concept of fiduciary responsibility in employee benefit planning.

The message was clear: if employers wanted to use these new tools effectively, they must abide by the strict new rules imposed by the law. Those included the following:

1. Requiring the disclosure of financial and other information concerning the plan to beneficiaries
2. Establishing standards of conduct for plan fiduciaries and
3. Providing appropriate remedies and access to the federal courts for lack of plan performance

It's important to note that as Federal laws (for interpretation and enforcement), these come under the jurisdiction of the Department of Labor, the Department of the Treasury (namely, the IRS) and the Pension Benefit Guarantee Corporation.

ERISA PAVES THE WAY FOR SELF-FUNDED PLANS

Several issues contributed to group health increases including: federal & state benefit mandates, aging population, increased utilization of benefits, unhealthy lifestyles, direct-to-consumer TV and print advertising, increased consumer demand, and fee-for-service medical practices.

ERISA pre-empted state law, offering self-funded plans the advantage of not being controlled by state laws that relate to insurance. This precept has been tested in the courts for many years with several landmark decisions affirming this area of control. Now employers were able to weigh the decision of using a self-funded program for their employees – or not. Self-funding isn't for everyone, but ERISA gives employers the latitude to make that decision for themselves. A self-funded plan is better able to meet an employer's unique health funding needs. As an example, plan design can ensure uniform benefits for all workers in companies with locations in multiple states.

Why do employers want to make the self-funding decision? Employers are uniquely qualified (usually with HR and CFO's help) to understand the makeup

of their workforce and how they use the benefits that the company provides. If it is a younger or middle age group, the employer can decide that they want the group to stand on their own (relatively better) claims experience, than to accept the pooled renewals presented to them from the carrier marketplace. They must understand that when they make that decision it should be for the long term (at least two to three years to see any meaningful positive results). A risk-averse employer should not be in this kind of program. It is also not a one-year bandage to a high renewal that was presented from a carrier. I've watched employers switch back to a fully insured plan after one year because they were not properly educated about how these programs work and the protections that are built into them if they were set up the right way. And as with all things, today's marketplace requires education to make these programs operate efficiently as presented. An employer must be willing to make that investment and a presenting agent must obtain the necessary education to feel confident to work in this area. This is not "spread sheet alley!"

Why would an employer want to consider a self-funded program? Here are a few good reasons: the ability to customize benefits for the employer's unique workforce, the ability to help attract and retain the best and brightest new employees to the company, build a positive employee reaction to this new benefit arrangement and limit potential losses with stop-loss insurance and other planning tools. Oh, and also: savings of state premium tax of between 1.5 and 3 percent, plus they could enjoy a more favorable claims experience track-record – adding to the company's overall bottom line.

While all this sounds great, employers must be aware that more employer involvement is needed in order to achieve the results. ★



Stuart Slonin, LUTC, RHU, CBC, IFA, is currently president of Boynton Beach, Florida-based S.I.G. Consulting Resources, LLC.

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SENIORITY IN THE SENIOR MARKET:

GETTING YOUR MEDICARE MOJO WORKING



FEDS TO WAIVE PENALTIES FOR SOME WHO SIGNED UP LATE FOR MEDICARE

By SUSAN JAFFE



Each year, thousands of Americans miss their deadline to enroll in Medicare, and federal officials and consumer advocates worry that many of them mistakenly think they don't need to sign up because they have purchased insurance on the health law's marketplaces. That decision can leave them facing a lifetime of enrollment penalties.

Now Medicare has temporarily changed its rules to offer a reprieve from penalties for people who kept Affordable Care Act policies after becoming eligible for Medicare.

"Many of these individuals did not receive the information necessary [when they became eligible for Medicare or when they initially enrolled] in coverage through the marketplace to make an informed decision regarding" Medicare enrollment, said a Medicare spokesman, explaining the policy change.

Those who qualify include people 65 and older who have a marketplace plan or had one they lost or canceled, as well as people who have qualified for Medicare due to a disability but chose to use marketplace plans.

They have until Sept. 30 to request a waiver of the usual penalty Medicare assesses when people delay signing up for Medicare's Part B, which covers visits to the doctor and other outpatient care. Medicare beneficiaries who already pay the penalty because they had a marketplace plan can request that it be eliminated or reduced.

Medicare also imposes a waiting period for coverage on people who do not sign up when first eligible. If they meet the waiver requirements, they now can request that be lifted.

"This has been a problem from the beginning of the Affordable Care Act, because the government didn't understand that people would not know when they needed to sign up for Medicare," said Bonnie Burns, a consultant for California Health Advocates, a consumer group.

"Once they had insurance, that relieved all the stress of not having coverage and then when they



became eligible for Medicare, nobody told them to make that change.”

One of them is Lisa Grimes’ 49-year-old sister, who receives Social Security disability benefits because of mental illness. She became eligible for Medicare because she receives those disability benefits but had marketplace coverage at that time.

For the past year, Grimes, a St. Louis real estate lawyer, has been trying to unravel the problems that ensued after her sister opted to keep her marketplace plan and drop her Part B coverage, probably because her marketplace premium at the time cost half as much. Only after that \$50 monthly premium ballooned to \$360 did they learn that marketplace customers lose their premium subsidies when they join Medicare. (Grimes agreed to be interviewed as long as her sister was not identified.)

Other Medicare beneficiaries have made similar mistakes by assuming they didn’t need Part B if they had a marketplace plan, retiree coverage from a former employer or coverage through a current employer with fewer than 20 workers or with the Department of Veterans Affairs. None of these is a substitute for Medicare Part B.

Grimes said her sister couldn’t afford the new marketplace premium and had to drop her plan last year. The Social Security Administration denied her appeal to reinstate her Part B coverage with no penalty or wait period. Then she learned about the new Medicare waiver from a Missouri counselor at the State Health Insurance Assistance Program.

It took several hours for Grimes to find the right letters and other docu-

ments needed to apply since her sister’s “filing system was a large shopping bag,” Grimes said. With assistance from the Medicare Rights Center, her sister received Part B coverage without a late fee or waiting period. It was retroactive, so she might be reimbursed for the medical bills she paid last fall and winter when she had no insurance coverage for doctor visits.

People need to sign up for Part B usually within three months before or after turning 65 if they aren’t getting job-based insurance, or when their job-based health insurance ends if they are older than 65, according to Medicare rules. Most people under 65 who receive Social Security disability benefits qualify for Part B after 24 months of benefits.

Under the health law, people who qualify for Medicare will lose subsidies in the online exchange plans. And enrolling in one of those plans does not protect them from a permanent late enrollment penalty.

Marketplace insurers, who are often the first to spot when a member is turning 65, are barred under the health law from canceling coverage because that member may qualify for Medicare, Burns said. They are required, however, to cancel a Medicare-eligible member’s subsidies.

Last summer, Medicare officials began sending emails each month to about 15,000 people with subsidized coverage through the federally run marketplace. The notices target people approaching their 65th birthday and tell them how “to avoid an unwanted overlap in Marketplace and Medicare coverage.” Officials also began contacting individuals who already

have both Medicare and subsidized marketplace coverage, urging them to discontinue the latter.

Yet the warnings have missed some people with marketplace coverage, who could find themselves on the hook to cover their own medical bills if their private insurer indicates they should have been on Medicare and refuses to pay.

“These are very complex rules,” said Stacy Sanders, federal policy director at the Medicare Rights Center, a consumer advocacy group that spearheaded an effort in 2015 by nearly 50 unions, insurance companies and seniors’ advocacy organizations urging Medicare officials to address the problem. “The lack of good notification was leading people down a dangerous path in terms of declining or delaying Part B.”

Those who enroll in Part B 12 months or later after becoming eligible can face a permanent penalty of 10 percent added to the Part B premium for each full 12-month period that a beneficiary could have had Part B, but didn’t enroll. This year, the Part B standard average monthly premium is \$109.

Medicare began emailing letters in March about the temporary waiver to some people 65 and older who are enrolled in plans sold on the marketplaces run by the federal government. But the federal government is not reaching out to others who may be eligible.

California, with the largest state-run marketplace — serving 1.4 million consumers — is planning a similar information campaign. So are some other states that run their own marketplaces, including Connecticut, Massachusetts and New York.

For information on how to apply for the waiver, officially called “time-limited equitable relief,” go to the Medicare Rights Center’s Medicare Interactive webpage or call the center’s helpline at 800-333-4114. ★



Susan Jaffe is a writer for Kaiser Health News, a nonprofit health news organization. This article originally appeared June 6, 2017, on Kaiser Health News (khn.org). Jaffe can be reached at Jaffe.KHN@gmail.com or on Twitter @SusanJaffe.

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MEDICARE WORLD

What's the latest buzz, made-for-TV crimes and tips for Medicare producers? We thought you'd never ask...



MEDICARE CRIMINAL DRAMA

A consultant who boasted to a finance executive: “I am a beast that cannot be stopped” may be rethinking that statement. In a scenario straight out of *Billions* or *House of Cards*, the Securities and Exchange Commission arrested consultant David Blaszczak and three co-defendants, including an executive-level Medicare employee, for allegedly turning confidential government information into windfall profits on Wall Street.

The SEC’s complaint alleges that Blaszczak, a former government employee turned political intelligence consultant, obtained key confidential details about upcoming decisions by the Centers for Medicare and Medicaid Services from his close friend and former colleague at the agency, Christopher Worrall. According to the SEC’s complaint, Worrall serves as a health insurance specialist in the Center for Medicare and tipped Blaszczak about at least three pending decisions that affected the amount of money that companies receive from Medicare to provide services or products related to cancer treatments and kidney dialysis.

Blaszczak allegedly tipped two analysts at a hedge fund advisory firm that paid him as a consultant. The analysts, Theodore Huber and Jordan Fogel, are charged with using the nonpublic information to recommend that the firm trade in the stocks of four health care companies whose stock prices would likely be affected by the decisions once Medicare announced them publicly. The alleged scheme resulted in more than \$3.9 million in illicit profits.



Blaszczak’s LinkedIn page says the Temple University grad is founder and partner of D.C.-based Precipio Health Strategies. (Precipio’s website says Blaszczak lives in Charleston.) Consulting firms like Precipio often traffic in information coaxed out of federal employees, or simply good hunches, and make money by getting contracts with Wall Street for such information.

“As alleged in our complaint, a federal employee breached his duty to protect confidential information by tipping a political consultant who then passed along those illegal tips,” said Stephanie Avakian, Acting Director of the SEC Enforcement Division. “There’s no place on Wall Street or in our government for such blatant misuse of highly confidential information.”

According to the SEC’s complaint, Blaszczak’s firms were paid at least \$193,000 in a 19-month period by the hedge fund where the analysts worked.

“We remain committed to using all resources available to detect sophisticated schemes and stop those who try to create a revenue stream by tipping or trading on material, nonpublic information,” said Robert A. Cohen, Co-Chief of the SEC Enforcement Division’s Market Abuse Unit.

The SEC’s complaint, filed in U.S. District Court for the Southern District of New York, charges Blaszczak, Worrall, Huber, and Fogel with violating Section 10(b) of the Securities Exchange Act of 1934 and Rule 10b-5 as well as Section 17(a) of the Securities Act of 1933. The complaint seeks to reclaim the ill-gotten gains plus interest, penalties, and permanent injunctions.

Cha-cha-cha-Changes (to Medicare cards)

The Center for Medicare and Medicaid announced changes are coming to Medicare cards. By April 2019, old cards will be replaced with new ones that no longer shows Social Security numbers. Instead, cards will have a new Medicare Beneficiary Identifier (MBI) that will be used for billing and for checking eligibility and claim status. CMS wants the public to be well aware that this change will happen automatically – Medicare recipients will not have to pay or give info to anyone.

Having Social Security numbers re-

moved from Medicare cards helps fight medical identity theft and protects medical and financial information. But even with these changes, scammers will still look for ways to scam. Producers can alert clients of these ways to avoid Medicare scams:

- If someone calls, claims to be from Medicare or asks for your Social Security number or bank information, it’s a scam. Medicare doesn’t call and will never ask for Social Security numbers or bank information.

- If someone is asking for money for the new card, it’s a scam. The new Medicare card is free.
- If someone threatens to cancel benefits if you don’t give up information or money, it’s a scam. New Medicare cards will be mailed out automatically. There won’t be any changes to your benefits.

For more on the new changes to the Medicare card, visit CMS.gov. Scams can be reported to www.ftccomplaintassistant.gov.

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Increasing competition?
Narrowing networks?
Really bad hair day?

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If one of your client's employees is diagnosed with a serious illness, such as cancer or heart disease, they will have lots of questions about how their life is about to change. But there is one question they should never have to ask: do I have access to the best possible medical advice?

In a world of narrowing networks they'll have to worry about finding the right in-network specialist to get a second opinion before treatment and also deal with scheduling appointments, travel, and the resulting, potentially conflicting, diagnosis.

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MEDICARE WORLD

What's the latest buzz, made-for-TV crimes and tips for Medicare producers? We thought you'd never ask...



Helpful Resources for Medicare Producers ...



LOOKING FOR FACTS ABOUT MEDICARE?

The Center for Medicare Advocacy has plenty of information and research about Medicare. Go to www.medicareadvocacy.org

ACCESS VIDEOS FILMED AT NATIONAL MED SUPP CONFERENCES

The American Association for Medicare Supplement Insurance organizes the national Medigap industry conference. Video recordings of sessions from the 2016 and 2017 conferences are available online where they can be accessed and viewed free of charge. To access the videos go to: www.medicaresupp.org/videos

NATIONAL FIND-AN-AGENT ONLINE DIRECTORY

Consumers looking to find local insurance agents who specialize in Medicare Supplement insurance solutions are increasingly accessing the online directory hosted by the American Association for Medicare Supplement Insurance (AAMSI). According to Jesse Slome, AAMSI's director, a significant percentage of consumers prefer to work with a local agent and the online resource is the only one exclusively focused on Medigap agents. To learn more, go to: www.medicaresupp.org/get-listed.



AHCA and BCRA: What Are the Implications for Medicare?

It's anyone's guess what will really happen with health care legislation and how that will influence Medicare. At press time in mid-July, Senate Republicans had just released a revised BCRA proposal and were still receiving a lukewarm reception. But earlier in the month, the Kaiser Family Foundation's Juliette Cubanski and Tricia Neuman answered Medicare concerns in the form of a KFF issue brief on the topic. Here's what they said...

"An important question in the debate over proposals to repeal and replace the Affordable Care Act (ACA) is what might happen to the law's many provisions affecting the Medicare program. The American Health Care Act (AHCA), which was passed by the House of Representatives on May 4, 2017, and the Better Care Reconciliation Act (BCRA), released by Senate Republicans on June 22, 2017, would leave most ACA changes to Medicare intact, including the benefit improvements (no-cost preventive services and closing the Part D coverage gap), reductions to payments to health care providers and Medicare Advantage plans, the Independent Payment Advisory Board, and the Center for Medicare and Medicaid Innovation.

However, both bills would repeal the Medicare payroll surtax on high-income earners that was added by the ACA. That provision, which took effect in 2013, provides additional revenue for the Part A trust fund, which pays for hospital, skilled nursing facility, home health and hospice benefits. The Part A trust fund is financed primarily through a 2.9 percent tax on earnings paid by employers and employees (1.45 percent each). The ACA increased the payroll tax

for a minority of taxpayers with relatively high incomes—those earning more than \$200,000/individual and \$250,000/couple—by 0.9 percentage points.

In addition to repealing the ACA's Medicare payroll surtax, both bills would repeal virtually all other tax and revenue provisions in the ACA, including the annual fee paid by branded prescription drug manufacturers, which would decrease revenue to the Part B trust fund. The bills would also reinstate the tax deduction for employers who receive Part D Retiree Drug Subsidy (RDS) payments, which would increase Medicare Part D spending.

According to the Congressional Budget Office, the provision in the AHCA and the BCRA to repeal the Medicare payroll surtax would reduce revenue for Part A benefits by \$58.6 billion between 2017 and 2026. Proposed changes to the ACA's marketplace coverage provisions and to Medicaid financing in both bills would also increase the number of uninsured, putting additional strain on the nation's hospitals to provide uncompensated care. As a result, Medicare's 'disproportionate share hospital' (DSH) payments would increase, leading to higher Part A spending between 2018 and 2026 of more than \$40 billion, according to CBO.

Altogether, changes to Part A spending and financing in the AHCA and BCRA would weaken Medicare's financial status by depleting the Part A trust fund two years earlier than under current law, moving up the projected insolvency date from 2028 to 2026, according to Medicare's actuaries."

Interested in more? Get the complete brief at KFF.org. ★

"Both bills would repeal virtually all other tax and revenue provisions in the ACA, including the annual fee paid by branded prescription drug manufacturers"

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7 POWERFUL PRACTICES: SELLING PRESCRIPTION DRUG PLANS TO SENIORS

By ROXANNE ANDERSON



An apple a day might help keep the doctor away, but eating all the apples in the world won't prevent the average person from getting sick from time to time.

To put patients on the mend, a doctor may prescribe an antibiotic, a painkiller, or a more complex pill regimen. However, those who visit the pharmacy hoping to find healing are increasingly coming down with another ailment: sticker shock.

Most seniors live on limited incomes and suffer from at least one chronic condition. Skyrocketing prescription drug prices have made their pills quite bitter to swallow. As a broker, you can help ease their pain by promoting sound prescription drug plans (PDPs). How can you streamline these sales and ensure you set your clients up with the right plan for their budget and needs? Consider these best sales practices.

1 BE UPFRONT: ASK YOUR CLIENTS ABOUT THEIR PRESCRIPTIONS RIGHT AWAY

Besides having your clients sign a Scope of Appointment (SOA), one of the first things you should do is get

personal and ask for a list of their prescription drugs.

Knowing what prescriptions your clients take is key to finding them the best plan. Why? They'll want a PDP that makes their current medications more affordable. Wouldn't you?

While your clients must sign an SOA 48 hours in advance of discussing their PDP options with you, you can ask about their prescriptions when you schedule the initial appointment. Getting this information ASAP allows you to work quickly and efficiently, which shows your clients you're proactive.

To simplify the process even further, inform your clients they can get a list of their medications from the pharmacy where they refill their prescriptions. For most large pharmacies, your clients can obtain and email this list to you themselves by registering for an online account.

2 CONSIDER WHAT TYPE OF PLAN WORKS BEST WITH THEIR HEALTH COVERAGE

Seniors can obtain prescription drug coverage through either stand-alone PDPs or Medicare Advantage Pre-

scription Drug (MAPD) plans. Your clients' current or desired form of major medical coverage determines which type of plan they may choose.

"If your clients have, or will enroll in, Original Medicare, they can select a stand-alone PDP. Conversely, if your clients desire to enroll in a Medicare Advantage plan, they can enroll in an MAPD plan if one is available. A small number of counties in a few states do not offer an MAPD plan. In these counties, individuals can enroll in a Medicare Advantage plan without prescription drug coverage and a stand-alone PDP.

An important note: If your clients have an MAPD plan but plan to enroll in a stand-alone PDP, make sure they know they'll be disenrolled from their current plan and enrolled in Original Medicare.

3 FIND OUT IF THEY QUALIFY FOR ADDITIONAL HELP

According to the Centers for Medicare and Medicaid Services, over 2 million Medicare beneficiaries who aren't enrolled in the Extra Help program may qualify for it.

Extra Help is a government program

that can assist your eligible clients in paying the copays, premiums, and deductibles of their PDPs. To be eligible, your clients' incomes and assets must be below certain levels determined by their state. Those who have full Medicaid coverage, membership in a Medicare Savings Program, or Supplemental Security Income benefits automatically qualify for the program.

Further, your clients who don't qualify for Extra Help may qualify for a state pharmaceutical assistance program (SPAP). SPAPs can pay for your clients' Part D coverage entirely or at least lower the cost of their prescription drugs. Their availability and eligibility requirements can be found on Medicare.gov and vary by state.

Programs like these can save your clients thousands of dollars on their prescriptions annually. More notably, they can put your clients' medications within reach. Because your clients' financial circumstances can change at any time, it's important that they contact you if their income or resources decline. Beneficiaries who become newly eligible for Medicaid or Extra Help qualify for a Special Enrollment Period to enroll in a new plan.

4 USE THE MEDICARE PLAN FINDER TO COMPARE PLANS

Once you've determined if your clients qualify for additional help, you can get to the core of your work: finding the right PDPs for them. Performing a simple search using the Medicare Plan Finder online tool is a great way to compare options.

As you're searching, your top priority should be finding PDPs that work with your clients' medicinal needs. Examine plans' copays, premiums, deductibles, and network restrictions next. If a client is unwilling to try less expensive drugs first, make sure you're looking at plans that don't require step therapy. Additionally, check if plans offer coverage in the "donut hole" and if they work with programs that can offer your clients help with paying for prescriptions.

When it's time for you to help your clients make their final decision, provide wise recommendations. If they take high-cost prescription drugs, recommend plans that offer coverage for them in the gap stage. Do they take

several generic drugs? Suggest plans with low copayments. Don't have many prescription drugs? Advise they go with a low-premium plan. You're the expert. Show your clients you know your stuff.

5 MAKE SURE YOUR CLIENTS UNDERSTAND THEIR NEW PDP

Insurance is one thing almost everybody has, yet only a select group of people understand it. A 2016 study by PolicyGenius and Radius Research found only 50 percent of the Americans they surveyed could correctly define "deductible," only 42 percent could correctly define "out-of-pocket maximum," and only 22 percent could correctly define "coinsurance."

Teaching your clients what basic health insurance terms like these mean is a great way to set yourself apart from your competition and add value to your services. Making certain your clients know how much they will pay for their prescriptions now, after they hit the coverage gap, and after they reach out-of-pocket limit is also a good move. Doing so can build your credibility and your clients' trust in you.

6 LET THEM KNOW OTHER WAYS THEY CAN SAVE

Another way to score some more brownie points and help lock in your role as your clients' top advisor is to inform your clients of other ways they can reduce their out-of-pocket expenses.

Oftentimes, your clients can spend less on their prescriptions by switching to generic or brand-preferred drugs. Ask them if they're aware of that. Additionally, check to see if your clients can save money by utilizing their plan's in-network, preferred pharmacies or mail-order pharmacies, and let them know if they can. Even the pharmaceutical companies that produce your clients' drugs may offer assistance programs to help pay for them. See if your clients qualify for one or more of these programs at Medicare.gov/pharmaceutical-assistance-program.

Finally, confirm your clients know they have a right to ask their plan to cover a prescription drug. Their prescriber can ask their plan for an exemption if a drug in a lower tier does not

exist or won't work for them. Providing all this information to your clients will show them you truly have their best interests in mind.

7 ENCOURAGE YOUR CLIENTS TO REEVALUATE THEIR PLAN EVERY YEAR

Though seniors can change their PDP every year, research shows few review and consider switching plans during the Annual Enrollment Period (AEP). The Kaiser Family Foundation found that an average of 87 percent of Part D enrollees did not switch plans during any of the four AEPs between 2006 and 2010. However, when averaged over the four AEPs, nearly half (46 percent) of those who changed plans had premiums that were at least 5 percent lower the following year.

So lastly, at your final appointments with clients, stress to them the importance of reevaluating their PDPs during AEP. What was their best option one year, may not be the next. Plans can change their premiums, copays, deductibles, formularies, network and preferred pharmacies. Additionally, your clients could become newly eligible for additional help.

Before you leave any appointment, express to your clients that you're more than happy to help them shop around and ensure they know how to get in touch with you in the future. By tackling this topic, you're not only giving them sound advice, but you're also securing their future business.

PDPs are a natural cross-sell with Medicare Supplements and Medicare Advantage plans. Those who employ these best practices when selling them will not only maximize their time, but also their production and profits. ★



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Ritter offers agents state-of-the-art tools, including their Medicare Quote Engine; a lead-generating CMS-accepted permission-to-contact website, Medicareful.com; and an award-winning educational website, AgentSurvivalGuide.com. For more information, please visit RitterIM.com.

BIGGER ISN'T ALWAYS BETTER

By RODNEY MATTOS, VP, Commercial Group

At Premier Access, we don't have the largest provider network—and that's the way we like it.

Some dental insurance carriers claim hundreds of thousands of "access points." But what are access points? It's a simple calculation: take the number of dentists in a network and multiply them by the number of locations where those dentists practice. So if one dentist practices at two offices, she counts as two access points. It's easy to see how access points can inflate a network's numbers.

A more accurate measure of a carrier's network is unique dentist counts. But there's more to consider. Customer service, member utilization, and cost savings are just as important as network size

SETTING THE INDUSTRY'S BENCHMARK

Each year, Ruark Dental Consulting independently surveys the market to determine which dental insurance carrier offers the most value to its members. The industry's leading source of objective data, Ruark's findings are used by insurance providers across the country to evaluate their cost-effectiveness in the marketplace. In the last five years, Premier Access has topped the list of carriers for effective discounts three times, which means our members have lower out-of-pocket costs and realize greater benefits from our dental plans.*

The annual Ruark Dental Consulting report offers an unbiased view of the dental insurance industry. More than 75 percent of the market is represented in their surveys, creating a benchmark that allows insurance carriers to determine whether their members are utilizing their networks in line with the industry. Rather than relying only on the negotiated cost savings or the size of a network, Ruark developed a formula that analyzes both data and evaluates an insurer's effective discount rate. The higher the effective discount, the more value a carrier offers its clients and members.

CONSISTENTLY CREATING VALUE

From the beginning, we set a standard of excellence for all our service providers. Not every dentist meets our requirements, but those who do tend to remain in our network because they recognize the advantage of being a Premier Access provider. For quality assurance and member satisfaction, we use independent firms to audit our dentists' performance and help us stay on track. To keep costs low, Premier Access negotiates competitive provider discounts and then regularly analyzes statistically relevant samples of services to determine overall network savings.

Our commitment to being on the leading edge of technology gives us the ability to make objective decisions about the effectiveness of our network. But we never lose our laser focus on the human side of the business. Our member advocacy team is always listening to feedback to identify potential challenges early on. This open communication allows us to monitor our provider network continuously and to ensure accurate claims. The result is a stable and diverse provider panel that offers the greatest overall value while meeting the service needs of our members.

REGIONAL RESPONSIVENESS, INDUSTRY LEADERSHIP

When The Guardian Life Insurance Company of America® (Guardian) purchased Premier Access in 2014, they immediately saw the value in keeping Premier as its own brand. As a regional provider, Premier Access can remain flexible and responsive to our clients and members. At the same time, Guardian's strength and reach in the marketplace offer us opportunities—like industry experience and network discounts—that might not be readily available to an independent company.

Instead of building a provider network with hundreds of thousands of access points, we focus on recruiting and maintaining a network of dentists who reliably provide high-quality services and are

conveniently located for our members. In fact, our clients and members are one of the best sources of dentist referrals. And once providers are on board, our quality assurance teams ensure that they continue to provide the level of care our members expect. When an issue arises, we're able to address it quickly and maintain our members' satisfaction.

GETTING EVEN BETTER

As Premier Access expands into new states, we'll continue to combine our skills in technology and commitment to customer service. Whether we're serving the State's largest employer or helping a small business owner navigate the world of dental and vision benefits, Premier Access is dedicated to helping working Americans get the most value for their hard-earned money.

When your customers are seeking competitive ancillary benefits to help them retain their best talent, put Premier Access at the top of your list.

Because that's where you'll find us in the industry's most-acclaimed survey.

CALCULATING EFFECTIVE DISCOUNT RATES

First, Ruark determines the carrier's in-network discounts, which is the difference between a carrier's negotiated rates and the average charges in that same location. Then they add the in-network discounts and the in-network utilization, or the percentage of claims that are within the carrier's network, to find the effective discount of that carrier.

Effective discount = in-network discount X in-network utilization

Premier Access is proud to be in the number one spot once again in Ruark's 2017 report for the California and Nevada markets. Our ranking tells us that we're doing it right.

*Based on all benefit designs sold in California and Nevada. Effective discounts are not normalized for differences in benefit mix among companies.

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INCREASING YOUR INCOME POTENTIAL

TRAVEL MEDICAL INSURANCE

4 TIPS FROM KNOWLEDGEABLE BROKERS

By BRENDAN SHARKEY

Recent changes in the health-care market have undoubtedly become a source of anxiety for brokers everywhere. The market, however, contains a solid, untapped and underutilized resource: travel medical insurance. With international travel (whether leisure, business or expat assignments) more popular than ever, there are profits to be made through the sale of short- and long-term travel medical policies.

I recently spoke with two west coast brokers each with over a decade experience in the travel medical insurance business: Naama O. Pozniak of Paz Holding, Inc. (d/b/a A+ Insurance), one of the 30 Most Influential Women in Benefit Advising as voted on by Employee Benefit News, and Erin Fish of Wanderwell, an agent with a focus on social impact who grew up in Southern California. We discussed the benefits of selling these products and how to maximize your sales and profits if you have already taken the leap. Here's some useful advice that all brokers can latch on to.

1 Making the switch over to selling international medical insurance, or adding it to your portfolio of products, is a logical step for seasoned professionals already in the healthcare market.

For Erin Fish selling international healthcare policies is the main focus of his business, which began through the encouragement of his father, a suc-

cessful agent in the insurance industry himself.

And after 30+ years of experience in healthcare overall, Naama Pozniak realized that her skills in selling domestic products were easily transferable to the international side. When she began selling plans in this market in 2006 she quickly recognized how attractive a medical plan with 100 percent coverage would be to her clients.

Brokers with experience in the domestic market have a clear advantage when it comes to benefits advising and will find that they already possess the tools and knowledge needed to successfully inform their clients on the benefits available to them. And with an already existing base of customers and established relationships, the opportunity to upsell or for word-of-mouth marketing to friends and family is exponentially greater.

2 Even with some short-term supplemental policies selling for as little as under \$100, the industry remains profitable when it comes to international healthcare coverage.

As Naama explains, though every sale won't be a big-ticket item, there are plenty of leads to go around. It's incumbent upon brokers to know their market well and take advantage of the gaps in domestic coverage that need to be filled. Let's look at the state of California specifically. The Kaiser Family Foundation cites it as the state

with the most Medicare enrollees as of 2015; over 5.6 million and rising steadily as the population continues to age. For an agency looking to proactively market to designated target segments, this presents a clear strategy: while Medicare offers domestic services for its beneficiaries, it lacks the necessary international benefits. So for Medicare beneficiaries from California traveling internationally (41 percent of which reported having one or more chronic conditions in a 2015 Center for Medicare & Medicaid Services study) they will view travel medical insurance as a necessity. On the other end of the spectrum, millennials have an unquenchable thirst for travel and are taking longer trips outside the country, so the potential here should not be underestimated either.

Another factor that keeps this industry profitable, according to Erin, are the margins that brokers selling travel medical insurance can enjoy. Commissions as high as 15 to 20 percent can be made from a relatively small amount of work and easily multiply through sales from accompanying family members. The opportunity cost from selling one policy is made all the more inconsequential when you consider that the actual servicing of the account thereafter falls squarely on the insurer. Erin also points out that while you can and should strive to market proactively, many of your prospective clients will look for you. "Customers are enthusiastic about their trip and their excite-

ment is contagious," he says. "Nine out of 10 customers who approach you are already eager to buy so they will most likely buy regardless."

3 "Peace of mind" is a powerful value proposition when closing a sale and creating a return customer, but make sure you know what to look for when choosing an insurance carrier: a quality travel medical or expat program.

Naama and Erin are in agreement that "peace of mind" is the prevailing mindset that closes the sale. In the majority of cases, there will be no utilization of the services but embarking on a trip knowing you are covered is sufficient enough justification for making the purchase. It's crucial for brokers and agents to drive home the point that this kind of assurance will allow clients to enjoy their time abroad and mitigate the stress that comes with traveling and pre-trip planning in general.

The repeat or return business hinges largely on a positive experience with a solid insurance carrier. The most positive feedback and reviews are typically garnered through exceptional customer service, quick and efficient turnaround of claims, access to an extensive provider network, 100 percent coverage or limited out-of-pocket costs, inpatient hospitalization coverage, and the inclusion of medical evacuation services.

When choosing a short-term or expat program make sure you find the right carrier. Make sure you inform prospective customers on the benefits and services at their disposal and use anecdotal evidence to make the connection of why these plans matter: the family traveling in Japan with a small child hospitalized due to an unforeseen injury who were able to break through a frustrating language barrier with doctors and nurses by reaching out to their

international medical insurer for assistance, or the young and healthy traveler hiking in Central America who unexpectedly broke his leg and not only had access to the best medical care locally but was fully covered so he didn't need to worry about crippling medical debt.



"I am looking into a very bright future for the travel healthcare industry as we slowly, slowly educate our clients to travel safely and to bring peace of mind while traveling."

4 Stay ahead of trends you see in the market, and look to what's next.

Erin reports that more and more customers are shifting from buying trip protection plans to supplement a medical international plan to looking for a travel medical plan that includes the benefits of a conventional trip protection policy. To adapt, brokers should look toward selecting and selling plans that offer robust medical coverage internationally in addition to increased bedside visitation coverage, lost luggage benefits and trip interruption protection when possible.

The expanding interest in travel aligns nicely with Naama's vision, "I am looking into a very bright future for the travel healthcare industry as we slowly, slowly educate our clients to travel safely and to bring peace of mind while traveling. Further, I see the future of international policies being sold mainly because people will be able to save and make a better healthcare choice with a policy that allows them the right access. We need to educate our clients and make sure that they stay healthy and make better choices for their healthcare. I think that transparency and education will allow more people to travel and access care everywhere."

Erin's agency focuses on making a positive social and environmental impact and he believes this carries favor with the younger generation- millennials with a "more for your buck" mentality. But he also believes sincerity and an easy-to-navigate website are the way to go. "Our agents are honest. Just be sincere," he says. "Don't be afraid to tell the customers information they may not want to hear."

Ultimately, every broker has the potential to turn his or her experience into a profitable return with this product line. Once you decide what aspect of it is most natural for you and appealing for your client, you'll enjoy a whole new level of growth. ★

Brendan Sharkey is the director of individual product sales for GeoBlue. GeoBlue is the trade name for the international health insurance programs of Worldwide Insurance Services, an independent licensee of the Blue Cross Blue Shield Association.



GeoBlue combines mobile technology and worldwide healthcare expertise to deliver assistance and health benefits for the health, safety and convenience of world travelers.

COMMISSIONS AND LIFE EVENTS

WHAT HAPPENS TO AN AGENT'S COMMISSIONS WHEN... THEY RETIRE/BECOME DISABLED/PASS AWAY

By PHIL CALHOUN and MAGGIE STEDT

Consider what happened to Barbara an agent in her fifties who passed away leaving a husband of three years. The agent's substantial book of business was comprised of primarily Medicare Advantage and some Medicare Supplement policyholders. She had most of the business under her C corporation but had no other licensed agent in the corporation. Her

"How many times have you heard about someone who failed to complete a plan for their retirement and the result ended in financial disappointment? As health benefits agents, we frequently have the opportunity to discuss future planning with our clients."

husband was not licensed (nor was he certified or appointed) so he could not assume the business. She had intentions to bring a licensed friend in, but the plan was not completed and no agreements were in place. The result was a total loss as her family lost all of the income and could not sell the book. Many of the carriers just absorbed the



business as house accounts.

How many times have you heard about someone who failed to complete a plan for their retirement and the result ended in financial disappointment? As health benefits agents, we frequently have the opportunity to discuss future planning with our clients. It's our nature to look out for our clients and their business, so this role comes naturally.

This article focuses on two important aspects of planning: How agents can plan to keep their commissions under various life events and how to include in one's succession plan methods to sell or transfer commissions for maximum value. Succession planning for agents is not complex. Understanding all options and how to develop a comprehensive plan just takes some time.

KEEPING YOUR COMMISSIONS WHEN LIFE EVENTS HAPPEN

For those insurance professionals who own their own book of business, the majority do not have a plan to maximize their commissions when various life events occur. After reading this article we hope you will consider working on your plan to protect commission income, preserve the value of your book of business, and evaluate

Carrier	What Happens When: Broker/ Agent is Disabled	What Happens If the Broker/Agent Dies	Transfer of Cases While Alive	Sale of Cases While Alive	Broker of Record Change While Alive
Aetna					
Group	Must maintain an active license	Total Loss of Commissions	Complete bulk transfer form	Complete bulk transfer form	Standard Format Accepted
Medicare Supp	Must maintain an active license	Total Loss of Commissions	Complete bulk transfer form	Complete bulk transfer form	Standard Format Accepted
Medicare Advantage	Must maintain an active licensed and certify annually	Total Loss of Commissions	FMO restrictions	FMO restrictions	FMO restrictions
Anthem					
IFP	Must maintain an active license	Total Loss of Commissions	Complete bulk transfer form	Complete bulk transfer form	Not effective, need multiple releases to receive less than 100%
Group	Must maintain an active license	Total Loss of Commissions	Complete bulk transfer form	Complete bulk transfer form	Standard Format Accepted
Medicare Supp	Must maintain an active license	Total Loss of Commissions	Complete bulk transfer form	Complete bulk transfer form	Not effective, need multiple releases to receive less than 100%
Medicare Advantage	Must maintain an active licensed and certify annually	Total Loss of Commissions	Complete bulk transfer form	Complete bulk transfer form	Standard format accepted
Blue Shield					
IFP	Must maintain an active license and be certified or commissions could drop to 70%	Total Loss of Commissions unless transferred to your beneficiary then 70% to 100% paid	Complete bulk transfer form	Complete bulk transfer form	Complete bulk transfer form
Group	Must maintain an active license	Total Loss of Commissions	Complete bulk transfer form	Complete bulk transfer form	Standard Format Accepted
Medicare Supp	Must maintain an active license	Total Loss of Commissions	Complete bulk transfer form	Complete bulk transfer form	Complete bulk transfer form
Medicare Advantage	Must maintain an active license certify annually	Total Loss of Commissions	FMO restrictions or Complete bulk transfer form if no FMO	FMO restrictions or Complete bulk transfer form if no FMO	FMO restrictions or Complete bulk transfer form if no FMO

Carrier	What Happens When: Broker/ Agent is Disabled	What Happens If the Broker/Agent Dies	Transfer of Cases While Alive	Sale of Cases While Alive	Broker of Record Change While Alive
Cal Choice					
Group	Must maintain an active license	Total Loss of Commissions	Complete bulk transfer form	Complete bulk transfer form	Standard Format Accepted
Health Net					
IFP	Must maintain an active license and be certified	Total Loss of Commissions	Complete bulk transfer form	Complete bulk transfer form	Not possible
Group	Must maintain an active license	Total Loss of Commissions	Complete bulk transfer form	Complete bulk transfer form	Standard Format Accepted
Medicare Supp	Must maintain an active license	Total Loss of Commissions	Complete bulk transfer form	Complete bulk transfer form	Depends on agreement
Medicare Advantage	Must maintain an active license and certify annually	Total Loss of Commissions	FMO restrictions	FMO restrictions	Depends on agreement
Kaiser					
Group	Must maintain an active license	Total Loss of Commissions	Complete bulk transfer form	Complete bulk transfer form	Standard Format Accepted
Individual	Must maintain an active license and be certified	Total Loss of Commissions	Complete bulk transfer form	Complete bulk transfer form	Standard format accepted
UHC					
Group	Must maintain an active license	Total Loss of Commissions	Complete bulk transfer form	Complete bulk transfer form	Standard Format Accepted
Medicare Supp (AARP)	Must maintain an active license	Total Loss of Commissions	Complete bulk transfer form	Complete bulk transfer form	N/A
Medicare Advantage	Must maintain an active license and certify annually	Total Loss of Commissions	FMO restrictions Successor agreement	FMO restrictions Successor agreement	FMO restrictions Successor agreement
Scan					
Medicare Advantage	Must maintain an active license and certify annually	Total Loss of commissions	FMO restrictions	FMO restrictions	FMO restrictions

the option to sell or transfer your book of business.

The first step is to build a plan to keep commissions coming as long as possible when a life event occurs. Life events will occur and knowing the options to pass as much value as possible on to loved ones after death is vital.

When no planning occurs, we know fate and chance are not great partners. Far too many agents who do nothing

make the default plan “ride out their commissions until they die at their desk.” Planning will create a far better result for loved ones. It is important to complete your planning. Many real life stories sound much like this: the agent lived to be over 80 and since his spouse was not licensed nor was a succession plan in place to continue the commissions after his death there was very little commissions paid to

her. The spouse did receive some of the Medicare supplement commissions, but lost most of the rest. She is now dependent only on social security and a small amount of commission from the Medicare supplements from one carrier. This result was not ideal and with planning followed by action a better outcome can result.

Sadly, these stories are more and more common and with education and



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"...in the event of death most carriers will no longer pay commissions. In the event of disability, commissions will stop if the license lapses. Also, if the license is renewed but certification exams are not completed, commissions will stop for most carriers."

proper planning there are viable solutions available. A recent LIMRA study outlined the average age of a life and health producer to be 56 years old, while a white paper from McKinsey & Co. puts the average age of insurance agents at 59 year old. These results show how there will be hundreds of agents at the age where planning for their commission future becomes a priority.

Planning to protect or sell your book begins with knowing what your ideal result is. "Agents looking to develop a plan to protect their book of business create the first win when they just make the decision to do the research into the options. Understanding all

the options to maintain commissions is helpful but denial is the worst enemy to business succession planning. We can deal with father time but can't avoid the eventual outcome," says Danniell J. Wexler, an attorney and estate planner who specializes in helping business owners plan for succession.

CARRIER COMMISSION POLICIES

The first step to develop a plan to keep commissions coming is to know what the carrier's policies are for paying commissions when a life changing event occurs. While many carriers do not continue commissions upon the agent's death or disability, in some cases it is possible to extend commissions. The table below outlines for each carrier how they handle disability or death of an individual agent, as well as how the transfer or sale of cases to another agent or agency is handled. It's important to know how the various carriers handle either the sale of cases or the commission transfer process. The information in the table below was sourced from carrier-broker agreements.

Remember that this information was based on agent/broker agreements with carriers and could vary from one agent/broker to another so it is important to review your agreement and verify with each carrier.

As you can see, in the event of death most carriers will no longer pay commissions. In the event of disability, commissions will stop if the license lapses. Also, if the license is renewed but certification exams are not completed, commissions will stop for most carriers.

WHAT TO DO NOW

With the knowledge of the carrier commission guidelines outlined above, it is important to develop a plan to address the loss of commissions under situations of disability and death. In part two of this two-part article, which will run next month, we'll cover how doing nothing, selling, or transferring commissions each compare in regard to net income, tax friendliness, the impact of disability or death and the relative value of each option. Part Two gives a broker an outline of their options to address the facts presented in the previous tables. These options include a method to continue commissions called a Commission Continuation Plan (CCP). For those considering the sale of their book of business, Part Two also reviews options to sell or transfer a book of business either at a time they choose or in the event of a life changing event. ★



Phil Calhoun, MBA, is life and health licensed, owns and operates Calhoun & Associates Insurance Services, has sold and acquired insurance agencies and insurance cases, and is the managing member of Lambda Insurance Services, a CCP. Phil can be reached at phil@integrity-advisors.com.



Maggie Stedt is the current President of the Orange County Health Underwriters, is the owner of Stedt Insurance Services and specializes in Medicare plans. Maggie has served many roles with OCAHU and she is the originator of the Annual Medicare Summit held in Southern California. The following people also contributed content to this article: Danniell Wexler, attorney and estate planner at dwexler@, Shelley Smith, Certified Valuation Analyst. Shelley@skywoodpartners.com and David Ethington, an Economic Partner of Lambda Insurance Services and Integrity Advisors.



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Morningstar Releases Major HSA Assessment

STUDY SAYS THERE'S ROOM FOR IMPROVEMENT

By VICTORIA ALEXANDER

Morningstar, a provider of investment research, recently published a study assessing plans from 10 of the nation's largest Health Savings Account (HSA) providers: Alliant Credit Union, Bank of America, BenefitWallet, HealthEquity, HealthSavings Administrators, HSA Bank, Optum Bank, SelectAccount, The HSA Authority and UMB Bank. The plan authors looked at the HSAs as both an investment vehicle to save for future medical expenses and as a spending vehicle to cover immediate medical costs. The plan authors say the results show there's room for improvement. Morningstar positively assessed only four of the 10 plans as an investment vehicle and three of the plans for use as a spending vehicle. Only one plan rated a positive assessment on both fronts.

The company assigned each plan an overall assessment of positive, neutral, and negative. For accountholders looking to invest their HSA funds, the study analyzed the quality and cost of mutual funds offered as part of the plan's "investment menu." The evaluation of HSAs as a spending vehicle focused mostly on the charged maintenance fees.

HSAs are becoming increasingly popular. According to research by the Employee Benefit Research Council, last year enrollment in high-deductible, HSA-eligible health plans was estimated to be between 20-22 million policyholders and their dependents. Furthermore, more than four in five HSAs (85 percent) were opened since the beginning of 2011. But Morningstar points out that consumers have few resources at their disposal to navigate the available plans.

"Our study establishes metrics that investors should consider when

choosing an HSA," Leo Acheson, Morningstar's lead research analyst for health savings accounts, said in a statement. "Participants using HSAs to invest and save for future medical expenses should seek plans that offer a well-designed investment menu of cheap, high-quality funds. HSA plans from four providers—Bank of America, Health Equity, Optum, and The HSA Authority—came closest to attaining that high standard."

Now that the Republican-led House and Senate have introduced healthcare reform bills that would double HSA contribution limits as well as allow health insurance premiums to be paid from HSAs, look for much more analysis of HSA plans. The Morningstar report provides context to understanding the HSA as an investment vehicle but also utilizing it as a spending vehicle, according to Jake Spiegel, senior analyst for policy research at Morningstar. Of course, brokers know that clients using HSAs to cover current medical expenses must

pay attention to maintenance fees, which vary by provider and can eat into savings account balances. (See the chart on this page for Morningstar's overall assessment for each plan.)

Morningstar's manager research group evaluated HSA plans by assigning positive, neutral, and negative scores to various criteria, and aggregating those scores to reach an overall assessment for each plan as both an investment vehicle and spending vehicle. As an investment vehicle, a plan must earn two positive scores and no negative scores for menu design, quality of investments and price to earn an overall positive assessment. An overall negative assessment means a plan would have scored negative in two of the three areas. As a spending vehicle, an HSA plan with no maintenance fee received an overall positive assessment, while a plan that charged fees regardless of the balance received a negative assessment. ★

HSA Plan Provider	Overall Assessment as Investment Vehicle	Overall Assessment as Spending Vehicle
Alliant Credit Union	Negative	Positive
Bank of America	Neutral	Negative
BenefitWallet	Neutral	Neutral
HealthEquity	Positive	Neutral
HealthSavings Administrators	Neutral	Negative
HSA Bank*	Neutral	Neutral
Optum	Positive	Neutral
SelectAccount	Neutral	Positive
The HSA Authority	Positive	Positive
UMB Bank**	N/A	Neutral

*HSA Bank is Morningstar, Inc.'s HSA plan provider.

**UMB Bank did not provide an investment menu and is therefore excluded from the investment vehicle evaluations.

Get The Complete Study

You can view and download the complete Morningstar Health Savings Account Landscape study at this link: <http://corporate1.morningstar.com/ResearchLibrary/article/813893/2017-health-savings-account-landscape/>

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"COLLEGE" FOR ADVANCED

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1:15 - 3:15 TWO "HIGH SCHOOL"
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COURSES PENDING APPROVAL

What Impact Will the New Proposed Healthcare Legislation Have on HSAs?

The most recent proposed health care legislation may impact HSAs. What do some of our Cal Broker contributors think of this idea?

“A new provision in The Better Care Reform Act (BCRA) will offer millions of Americans who don’t have access to employer plans the ability to pay their health insurance premiums on a pre-tax basis if they enroll in a health savings account (HSA). The Affordable Care Act (ACA) harshly penal-



Douglas Hessel

ized individual policyholders who were not eligible for subsidies by disallowing or severely limiting individual policy pre-tax premium deductions. The new provision in BCRA would sweeten the incentive for people to move to HSA qualified plans by lowering an individual’s taxes significantly with the ability to pay insurance premiums on a pre-tax basis. This change along with the other HSA changes in the bill will bring welcome relief to many, a clear win for the little guy.”

– Douglas Hessel

Partner with Johnson & Dugan Insurance Services, a UBA Partner Firm



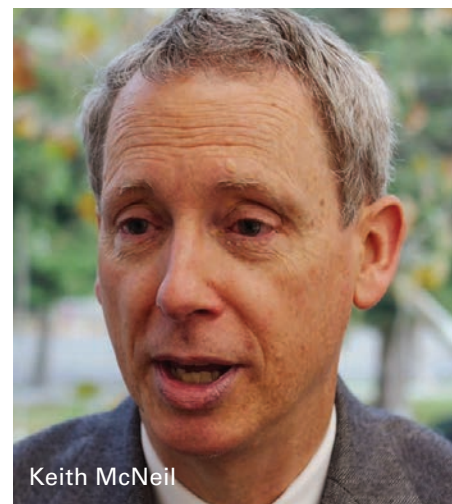
Michael Lujan

“This is one of the better provisions of the amended BCRA. The provision to allow HSA funds to pay for premiums is interesting and would be a welcomed market enhancement, especially for those who do not qualify for premium subsidies. That said, many middle to lower income people purchase high deductible plans without the means to create or fund the accompanying health savings account. The provision may be helpful for higher income consumers who understand HSAs and can afford to fund their accounts. This HSA provision could be less popular with some senators as it also makes high-deductible health plans ineligible for HSAs if they cover abortions --except where necessary to save the life of the mother or in cases of rape and incest.”

– Michael Lujan

Co-Founder and Chief Strategy Officer, Limelight Health, Inc. Current Board Member at Silicon Valley Association of Health Underwriters Past President of California Association of Health Underwriters. More of Lujan’s thoughts are posted here: <https://www.linkedin.com/pulse/repealing-obamacare-bcra-20-michael-lujan?published=t>

“At present HSA funds may be used to pay for COBRA premiums but not for employee contributions toward their premiums while actively employed. The Senate Republicans have proposed to extend that allowance for COBRA premiums to active employee premiums as well. This



Keith McNeil

makes sense, but it could result in the member having little or no money in the account when it comes time to pay for medical claims below the high deductible. Thus there are always trade-offs. If allowed in the final wording, the most efficient way to handle that would seem to be to pay the employee portion pre-tax through salary reduction and then allow the employee to deduct the same amount tax-free from the HSA.”

– Keith McNeil

Partner with Arrow Benefits, a United Benefits Advisors Partner Firm



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AN INCOME RIDER COULD BE HOLDING BACK YOUR CLIENT'S EARNING POTENTIAL

By Rich Lane

One of a client's chief concerns when selecting an asset for his or her financial plan is to ensure their money is in a safe place and has the ability to grow. Many clients choose a fixed annuity for this purpose, as it provides safety of principal with a guaranteed yield.

However, a secondary concern is when and how they will access his or her money. To help with this, many brokers will recommend the addition of an income rider to help ensure a client has access to funds whenever they need it.

A client may see this as the best of both worlds, as he or she will be getting the safety and growth potential from a fixed annuity with guaranteed access to their income. But this seemingly smart recommendation has a downside. While income riders can help deal with future income needs, they also can drag down a client's potential for accumulation.

An annuity purchase can be designed, without the addition of an income rider, to help a client have access to their money when they need it. As a broker, it's important to understand why money may be restricted in the first place and how to better structure an annuity to meet a client's financial goals and needs.

RESTRICTED ACCESS CAN BE PART OF THE MAKE-UP OF AN ANNUITY

For many clients, the thought of having a secure, stable income guaranteed for the rest of their lives is a huge draw. Though, as I mentioned above, any annuity — whether it's fixed, indexed or variable — is built to provide a client with earning potential as well as some measure of safety. To protect the financial integrity of the insurance carrier that is providing the safety, an annuity purchase often requires a time

commitment that restricts access to funds.

This means there could be surrender charge penalties for accessing money ahead of the scheduled time — depending on the initial setup of an annuity. Typically, the longer the time commitment that your client is willing to make without access to their money, the greater earnings potential that the annuity carrier can provide.

Some brokers try to overcome restricted access with the addition of an income rider. But the addition of an income rider to a base annuity contract, while adding some flexibility to a cli-

"Adding a rider may create a fee that eats up a significant portion of a client's interest crediting."

ent's income option, isn't free.

Adding a rider may create a fee that eats up a significant portion of a client's interest crediting. Paying a fee for more flexibility in an income option feature that already comes with an annuity contract drags down a client's potential for overall yield and accumulation.

So, while your client may be thinking that with an income rider, "I get income, plus accumulation," what they really get is an additional income option, with mediocre accumulation. If accumulation is one of their principal goals for selecting an annuity in the first place, this could leave a client confused and potentially frustrated.

POSITIONING AN ANNUITY FOR A CLIENT'S LONG-TERM FINANCIAL GOALS

Even though some annuities may have surrender charges, they can offer a client a guaranteed lifetime income stream or another type of payout

to match his or her specific income needs. That's because income options are part of every annuity contract and don't cost anything. As a broker, you just need to ensure the choice of timing for a client is based on their goals and needs.

For a client who is interested in a safe vehicle to accumulate money over time, especially in today's low-interest-rate environment, a deferred annuity without an income rider would be the right annuity to position. Especially as many clients buy annuities and never take a distribution from them, selling an income rider to this type of client could ultimately drag down their overall yield and prevent them from accumulating as much as they could.

On the other hand, a client who is looking for immediate income distributions should consider an immediate annuity, as it can provide an income stream that starts right away without the added cost. An immediate annuity is easy to understand, doesn't have any fees or charges, and likely offers a higher payout than a deferred annuity whose income rider is triggered early in the contract.

SUCCESSFUL SALES AND SATISFIED CLIENTS

Annuities can be structured so that your clients can have the best of both worlds, access to income when they need it and safety of yield. To do this, it's important to ensure you have insight into your client's financial goals to tailor the purchase in a way that makes the most sense for them. ★

Rich Lane is the second vice president of individual annuity sales and marketing for Standard Insurance Company. He has been in the fixed annuities industry for more than 20 years, with an emphasis on product and distribution development for brokerages, banks and broker/dealers. Rich currently serves on the board of directors for the National Association for Fixed Annuities (NAFA).



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How Telemedicine Value-Adds Can Enhance a Benefits Package

By GIL YOUMANS



"A doctor who is available on the phone or through secure video conferencing on computers, tablets or mobile devices can save employees from having to leave work for in-person appointments."

When you want or need to buy something, you expect to do a quick search online, drop the item in your shopping cart and hit purchase. Whether it's next-day shipping or live streaming all the episodes of your favorite show's newest season, instant access is the standard.

WHY SHOULD IMMEDIATE ACCESS TO MEDICAL CARE BE ANY DIFFERENT?

Well, it's not. More employers are adding telemedicine to their health benefits package to help reduce costs

and improve access to care. In fact, 80 percent of employers will offer a telehealth benefit to their employees by 2018, according to a Towers Watson survey.

To help businesses keep their companies healthy and productive, more insurance companies are offering telehealth benefits and resources.

Partnering with the right employee benefits provider can help you stand out among the competition by providing services beyond just basic health and voluntary benefits.

TELEMEDICINE CAN INCREASE EMPLOYEE PRODUCTIVITY

When employees don't feel well, it may mean time out of the office at a doctor appointment or at home recovering. Time away from work can have a big impact on your customers' business when it comes to productivity.

Because many people don't have time or think they can't afford to be sick, they may put off a visit. Without seeking early medical care, something as minor as a sinus infection can get worse, which means your customers' employees must take time off work

and may be out of the office for longer than expected.

When your customers' employees have 24/7 virtual access to board-certified physicians, it can reduce unnecessary time away from work. A doctor who is available on the phone or through secure video conferencing on computers, tablets or mobile devices can save employees from having to leave work for in-person appointments. The more employees who avoid doctor visits and get an early diagnosis and treatment for an illness, the more money stays in the employers' pockets.

TELEMEDICINE CAN CONTROL COSTS

Telemedicine can help your clients cut down the cost of health care as it could potentially deliver more than \$6 billion in a year in health care savings to U.S. companies, according to Towers Watson's report *Current Telemedicine Technology Could Mean Big Savings*.

A quarter of Americans in a recent Bankrate survey said they have skipped medical attention because of the out-of-pocket costs. The survey found older millennials (ages 27 to 36) were most likely to avoid the doctor because of costs.

VIRTUAL CARE IS ACCEPTABLE CARE

But, you may be asking if people are okay with not seeing their physician in person? The answer is yes. Seventy-six percent of patients believe the access to care is more important than the need for human interactions with their health care providers, according to NTT Data's *Trends in Telehealth*.

ADDITIONAL WAYS TO OFFER PROTECTION

Your clients are always looking for ways to keep their employees happy and healthy while giving them added financial protection. In addition to telemedicine, here are some other value-added services and coverages a top benefits partner can help you can bring to your clients — many available at low or no cost under certain conditions:

- Legal Document Assistance. According to Rocket Lawyer's 2016 Make-a-Will-Month survey, more

than 64 percent of Americans don't have a will. The main reason why: They haven't had time to do it. Consider partnering with a company that offers complimentary legal document preparation. In addition to wills, this service includes power of attorney, health care directive and lease documents.

- Identity monitoring and restoration. According to Credit.com, an estimated 15.4 million consumers were affected by some kind of identity theft in 2016. Some benefits providers partner with ID theft protection companies that will offer free identity theft protection monitoring for one year.



- Financial education. When it comes to retirement savings, about one in four U.S. adults say they don't save any portion of their household income for retirement, according to the Harris Poll 2016 Consumer Financial Literacy Survey. Consider partnering with a company that offers a financial education program, budgeting tools and promotes free external websites such as WorkLife, which have a wealth of information on benefits and health.
- Discounts on drugs and medical services. Discount programs can complement coverage by helping pay for services that are restricted or not covered. This is especially important if your customers offer a high-deductible health plan that leaves employees with considerable financial exposure to out-of-pocket costs. Bankrate's Money Pulse Survey found that 56 percent of people say they're either somewhat or very worried they won't be able to afford health care coverage in the future.
- Flexible benefits plans. Encourage

your clients to talk with their employees about this valuable way to pay for some health care expenses and insurance premiums with pretax income. Not only can they make benefits more affordable, they can help your clients reduce payroll taxes, too.

- Benefits communication support. Encourage your clients to maintain year-round benefits conversations with their employees. Effective communication drives stronger participation in the benefits program and ensures your clients see the return on their investment. Some benefits providers offer communication tools and support at no addi-

"Telemedicine can help your clients cut down the cost of health care as it could potentially deliver more than \$6 billion in a year in health care savings to U.S. companies..."

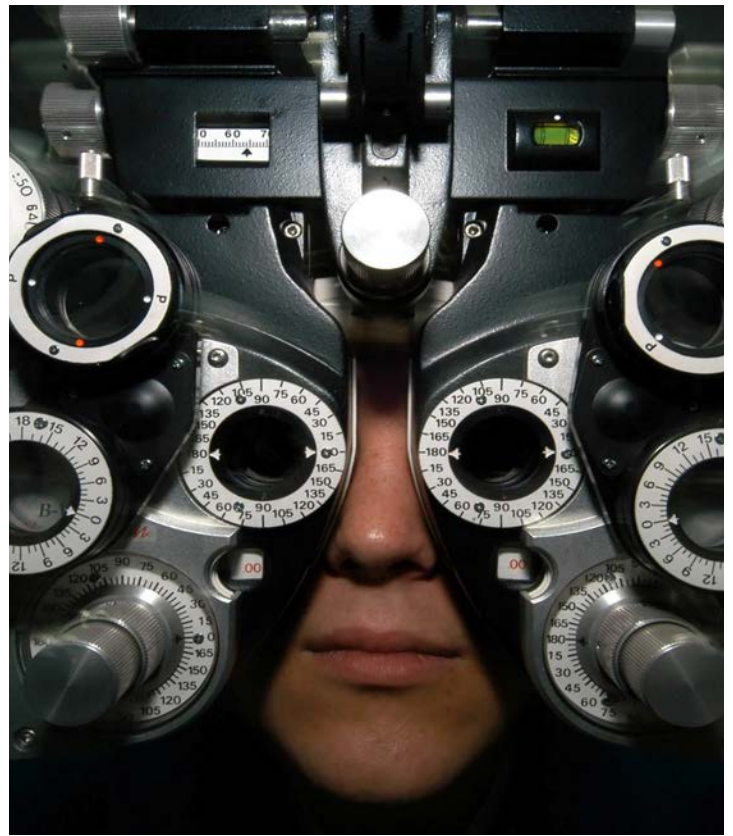
tional cost as part of their services.

As the world continues to do more business online, and the insurance industry continues to upgrade technology, consider telemedicine for your clients. It's a fast-growing trend that can save employers and employees time and money. And it's just one of many low- or no-cost services and benefits you may be able to add to your portfolio to provide greater value at a time when your clients are struggling with benefits costs. By partnering with the right benefits provider, you can bring much more than insurance products to help your clients get the most out of their benefits program. ★



Gil Youmans is director, growth markets, Colonial Life & Accident Insurance Company, a market leader in providing financial protection benefits through the workplace, including disability, life, accident, dental, cancer, critical illness and hospital confinement indemnity insurance. Contact Gil at: JYoumans@coloniallife.com or 803-678-6574.

The Eyes Have It



EMPLOYEES ARE WILLING TO PAY MORE FOR ACCESS TO PREMIUM VISION COVERAGE

By JOHN A. MURRAY

Amid recent health care uncertainty, employers who offer competitive health benefits have a clear advantage when it comes to recruiting and retaining top talent. The smartest employers are offering more than just the basics—they're also providing access to ancillary benefits, like dental and vision, that today's employees need and want.

When it comes to offering vision benefits, in particular, "going premium" can have a positive impact. In fact, according to the 2017 Transitions Employee Perceptions of Vision Benefits survey, 87 percent of employees said they would be more likely to stay at a company offering vision benefits that cover premium lens and frame op-

tions. Millennials—who represent the largest generation in the workforce—are more likely to strongly agree with this statement.

However, "going premium" doesn't have to come at a hefty price tag for employers. Vision benefits, in general, have long been known to have a phenomenal return-on-investment—with employers gaining back an average of \$7 for every \$1 spent, according to The Vision Council. Additionally, new research confirms that employees are willing to help share the cost. Eight in 10 employees are willing to pay more for a vision plan that fully covers premium eyewear products and two-thirds are willing to pay more than \$3 extra per pay period, according to the survey.

SELECTING THE IDEAL VISION PLAN

Today's workers want the best when it comes to their vision coverage. They're looking for fashionable frames, and they want the right lens options to help them see and perform their best. Offering a comprehensive vision benefits package that covers these premium options can help employers boost employee satisfaction—and stand out in the crowd. In fact, nine out of 10 employees agree that offering coverage of premium lens options makes a vision plan more competitive. This is likely the result of an increase in demand for stylish eyewear options—ranging from frame choice, to lens color and tint, to the latest in eyewear technology. Additionally, the technol-

ogy behind the lenses should not be ignored, considering nearly one-third of employees believe that “lens technology” defines stylish eyewear.

But with so many options available, how can brokers best leverage and tailor premium vision coverage to meet the needs of their customers?

As a broker, it’s important to help employers select a vision plan that best aligns with the needs of their specific workforce—whether it’s better access to fashion, function or both. The VSP EasyOptions Plan is unique to the industry because it is the only plan that allows employees and their dependents to actually choose their own covered option at the time of their eye exam—rather than at the time of enrollment.

For example, if an employee or their dependents want to increase their allowance for unique frame or lens options during the eye exam visit, they are able to do so. This allows brokers and employers to offer employees and their families the ability to select eyewear options that better meet their lifestyle needs, while limiting unnecessary out-of-pocket costs and extra administrative paperwork. For example, employees who spend a lot of time in front of a computer—or who have a job that requires them to go from inside to outside frequently—may want to try photochromic lenses. Photochromic lenses are clear indoors,

and darken and adapt outdoors to help protect the eyes from ultraviolet (UV) rays and harmful blue light, while reducing eyestrain and fatigue that can drastically diminish an employee’s productivity.

It’s up to the broker to help employers choose the best possible vision plan offering based on the demographics and needs of each particular workforce. Partnering with a managed vision care provider that can assist in providing insights into various demographics and their unique wants and needs—including desire for premium eyewear options—can help brokers and employers design plans that will deliver the best value to their clients.

PROVIDING ONGOING EDUCATION

It’s also important for brokers to provide ongoing education to employers about the overall value of vision benefits and the eyewear options available through a particular vision plan—so that they can, in turn, share this information with their employees. Consider that 95 percent of employees want their employer to proactively reach out to them with information on lens technology, new innovations and general eye health topics. Additionally, more than half (58 percent) of employees want to be contacted several times per year.

Many vision plans and optical companies offer a variety of resources

on different lens options so that employees can better understand what’s available. For example, an eye health-centric newsletter with articles related to eye health and nutrition, beauty tips and tricks, eyewear technology and health and fitness. Some newsletters also includes information on member-exclusive special offers—including discounts on fashionable eyewear, LASIK and more.

Additionally, vision plans may offer a wide range of materials online for both employers and employees. VSP offers a Vision Plan Savings calculator that employers can use to determine the estimated prevalence of eye health issues within their workforce, as well as money they can save by offering a comprehensive vision plan. All of these are worth investigating. ★



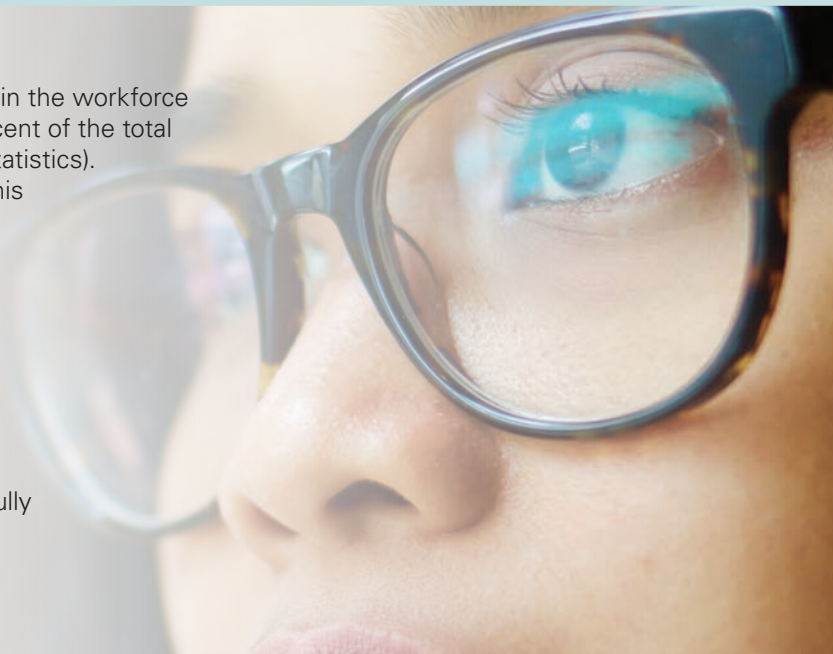
John A. Murray is a senior vice president in the employee benefits division at Risk Strategies Company. John has been in the industry for over 25 years helping employers to help build, maintain and improve their employee benefits programs. John has expertise in managing plans from both a strategic and financial perspective. He has worked with employers with 100 to several thousand employees throughout his career and still has a passion for this challenging and complex industry. Risk Strategies is a top 25 national broker specializing in all lines of insurance.

Millennials Matter

Millennials comprise the largest generation in the workforce today, and are projected to make up 75 percent of the total workforce by 2025 (U.S. Bureau of Labor Statistics).

When it comes to attracting and retaining this group, access to premium vision benefits matters.

- 88 percent of Millennials agree—and 49 percent agree strongly—that they would be more likely to stay at a company offering high quality vision benefits, such as coverage of premium lens and frame options.
- 83 percent of Millennials are willing to pay more per pay period for a vision plan that fully covers premium eyewear products.
- Lens technology is more important to Millennials than other generations when considering what makes eyewear stylish.



METLIFE ANNOUNCES BENEFIT TREND STUDY

MetLife’s 15th Annual U.S. Employee Benefit Trends Study found that demographic shifts are disrupting the workplace and redefining employees’ workplace expectations.

Download the full study at <https://benefittrends.metlife.com/us-perspectives/work-redefined-a-new-age-of-benefits/>

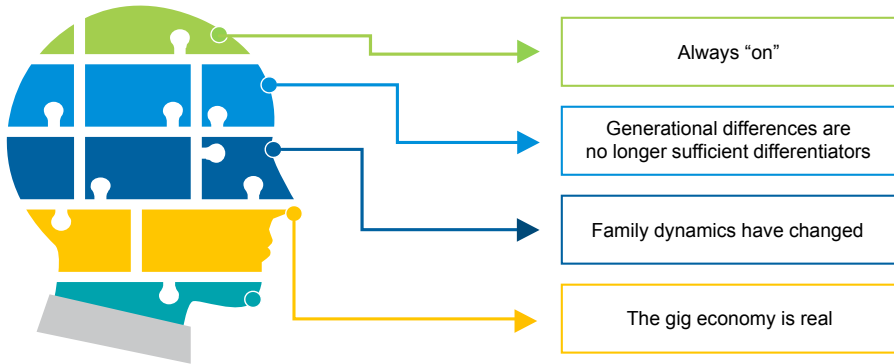
COVERED CA: BCRA RECIPE FOR DISASTER

The National Academy of State Health Policy, in consultation with Covered California, released an analysis of the value of health coverage and subsidies across the nation that compares current law under the Patient Protection and Affordable Care Act and the Better Care Reconciliation Act (BCRA), which at press time is under consideration in the U.S. Senate. The analysis, “Barely Covered: Initial Analysis of Coverage and Affordability Impacts to Consumers Under the Proposed Better Care Reconciliation Act,” is available at: <http://nashp.org/wp-content/uploads/2017/06/Barely-Covered.pdf>. The analysis looks at what consumers would need to spend to keep comparable coverage to what they have today, given the reduction in subsidies proposed in the BCRA. The analysis describes the coverage available on the individual market in California, Ohio and Pennsylvania. “While the Congressional Budget Office (CBO) analysis makes clear that 22 million Americans would lose coverage under the Senate’s proposal, this report puts a spotlight on the fact that for the millions of Americans who would remain insured, the skimpier benefits are coverage in name only,” said Peter V. Lee, executive director of Covered California. “Many consumers would face huge financial hurdles to get needed care. The term ‘high deductible’ would take on a staggeringly high new meaning under the BCRA, with subsidies tied to a benchmark plan that would mean families would need to meet a deductible of more than \$14,000 before most, if not all care, was covered,” Lee said. “Consumers would be stuck with thousands more in out-of-pocket costs — and 100 percent of the cost of their medications — if they enroll in the benchmark plan being proposed in the BCRA as it is written.” Under current law, health insurance products offered through Covered California are linked to a “benchmark” product with an actuarial value tied to a Silver-tier plan, which has a 70 percent actuarial value. Actuarial value is a measure of the expected health care costs a specific health plan will cover for a standard population. Higher actuarial value generally means lower cost sharing for enrollees. The

Working doesn’t look like it used to

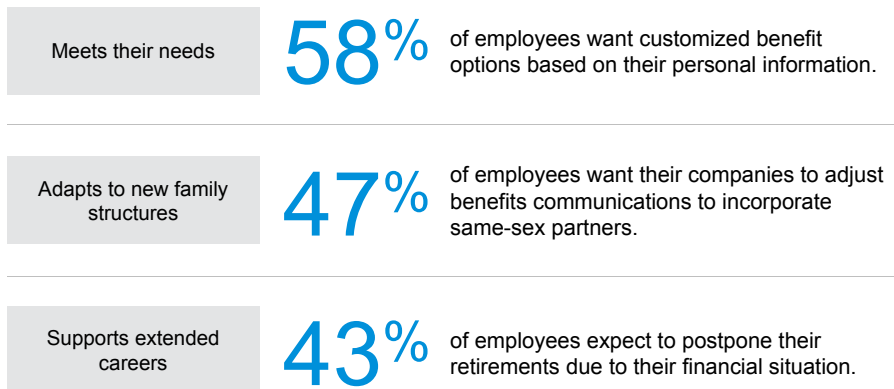
Big shifts mean greater needs

New ways of working and increased diversity are fundamentally changing companies and their employees.



A need for diverse benefits experiences

Employees want benefits that reflect their changing lives



Better Care Reconciliation Act (BCRA) sets the benchmark product at an actuarial value of 58 percent, which means the plan designs would need to have deductibles of \$7,350 for an individual or \$14,700 for a family — leaving consumers on the hook for huge out-of-pocket costs when they access care. “Covered California has worked hard to make sure benefit designs are patient-centered, with primary care, specialty visits, needed tests and prescription drugs that are not subject to any deductible,” Lee said. “Putting wildly high deductibles between patients and the care they need is a recipe for disaster.”

MASSMUTUAL STUDY FINDS SIGNIFICANT ‘ADVICE GAP’ BETWEEN MILLENNIALS, OTHER GENERATIONS

When it comes to investing, age seems to play a factor in impulsivity and in advice seeking, according to a recent MassMutual Retirement Savers Survey. The study, based on 450 respondents, found that millennials tend to make more risky investment decisions compared to other Americans by reacting to short-term market volatility yet they are less likely to rely on professional financial advice. “MassMutual’s research finds a real ‘advice gap’ exists between younger workers and other generations,” said Tom Foster, national spokesperson for MassMutual retirement plans. “We discovered that those who rely the least on professional financial advice are most likely to react to shorter-term market trends by making potentially harmful decisions to reallocate their retirement savings investments.” Research by Morningstar and Standard & Poor’s indicate that bad timing decisions account for markedly reduced earnings. A third of millennials (32 percent) said they were moving more of their retirement savings into stocks and equities to benefit from future growth, MassMutual found. Meanwhile, a quarter of millennials said they are moving more of their savings into fixed-income investments such as bonds or money market accounts due to recent stock market activity. The study pinpointed profound differences in how -- or if -- Americans receive financial advice. Overall, 32 percent of Americans polled said they relied on a financial advisor to

guide them in making decisions about investments. However, older respondents were much more likely to use an advisor, with 62 percent of those ages 65 or older relying on professional money advice as compared to 8 percent of Millennials. Women (36 percent) are also more likely to rely on an advisor than men (29 percent), the study found. For more info on the survey, go here: <https://www.massmutual.com/about-us/news-and-press-releases/press-releases/2017/05/05/17/14/massmutual-retirement-savers-survey-april-2017>

AM BEST AFFIRMS DELTA DENTAL OF CA RATING

A.M. Best has affirmed the Financial Strength Rating of A (Excellent) and the Long-Term Issuer Credit Ratings of “a” of Delta Dental of California (DDC) (San Francisco, CA) and its affiliates. The rating affirmations reflect growth trends in premium volume, profitability and risk-adjusted capital levels reported on a consolidated and individual company basis. The organization’s trend of strong operating results was driven by increased membership; disciplined pricing; benefit design; continued efficiencies realized from major system upgrades positively impacting expenses; and favorable dental trends, according to AM Best. The organization continues to focus on streamlining operations and investing to modernize its information and technology infrastructure, which has resulted in improved efficiency, cost savings and increased market penetration in both insured and self-funded businesses. Furthermore, earnings have been accretive to capital, which has allowed the enterprise to improve its level of risk-adjusted capital.

PRODUCTS

Whole life. Guardian Life Insurance introduced Guardian EstateGuard Whole Life Insurance. The product offers a tax-advantaged financial strategy for protecting, conserving and transferring wealth to heirs who would otherwise incur high estate taxes. This type of policy offers preservation strategies that: accelerate the issuance of death benefits, have two people insured un-

der one policy with survivorship benefits and increase the policy cash value after the first death. For more info, go to <https://www.guardianlife.com/news/new-guardian-estateguard-whole-life-insurance-offers-tax-advantaged-financial-strategy-helps>

Credit monitoring benefit. MetLife has added credit monitoring services to its group legal services employee benefit plan, MetLaw, which is provided by Hyatt Legal Plans, a MetLife company. The new credit monitoring service, available to employers with 1,000 or more employees, strengthens the product’s identity theft protection services for participants. The new credit monitoring service, provided by CyberScout, scours the internet and major credit bureaus to help uncover and minimize fraud in the early stages and provides members with a dashboard of credit reports to monitor their credit scores. If identity theft is uncovered, fraud specialists work to restore the member’s identity. Participants who experience an identity theft incident can also be reimbursed up to \$1 million for reasonable and necessary expenses related to the incident, such as lost wages and unauthorized electronic fund transfers. Visit www.metlife.com or www.legalplans.com.

Disability. Standard Insurance Company has launched a guaranteed standard issue (GSI) version of its new income protection product, Platinum Advantage. GSI allows employers to offer highly compensated employees individual disability insurance coverage that can help ensure they can maintain their way of life after experiencing a disabling illness or sickness. Coverage provides employees with monthly benefits that can be used to pay bills, take care of their families and maintain their current lifestyles if they become ill or injured and can’t earn a paycheck. Advantages also include: No medical underwriting, no need to submit financial documentation beyond the company-provided census, portable policies that are individually owned, identical premium rates for men and women and coverage for employees up to age 99. For more information on Platinum Advantage and a full list of features, producers can visit www.standard.com/di. ★

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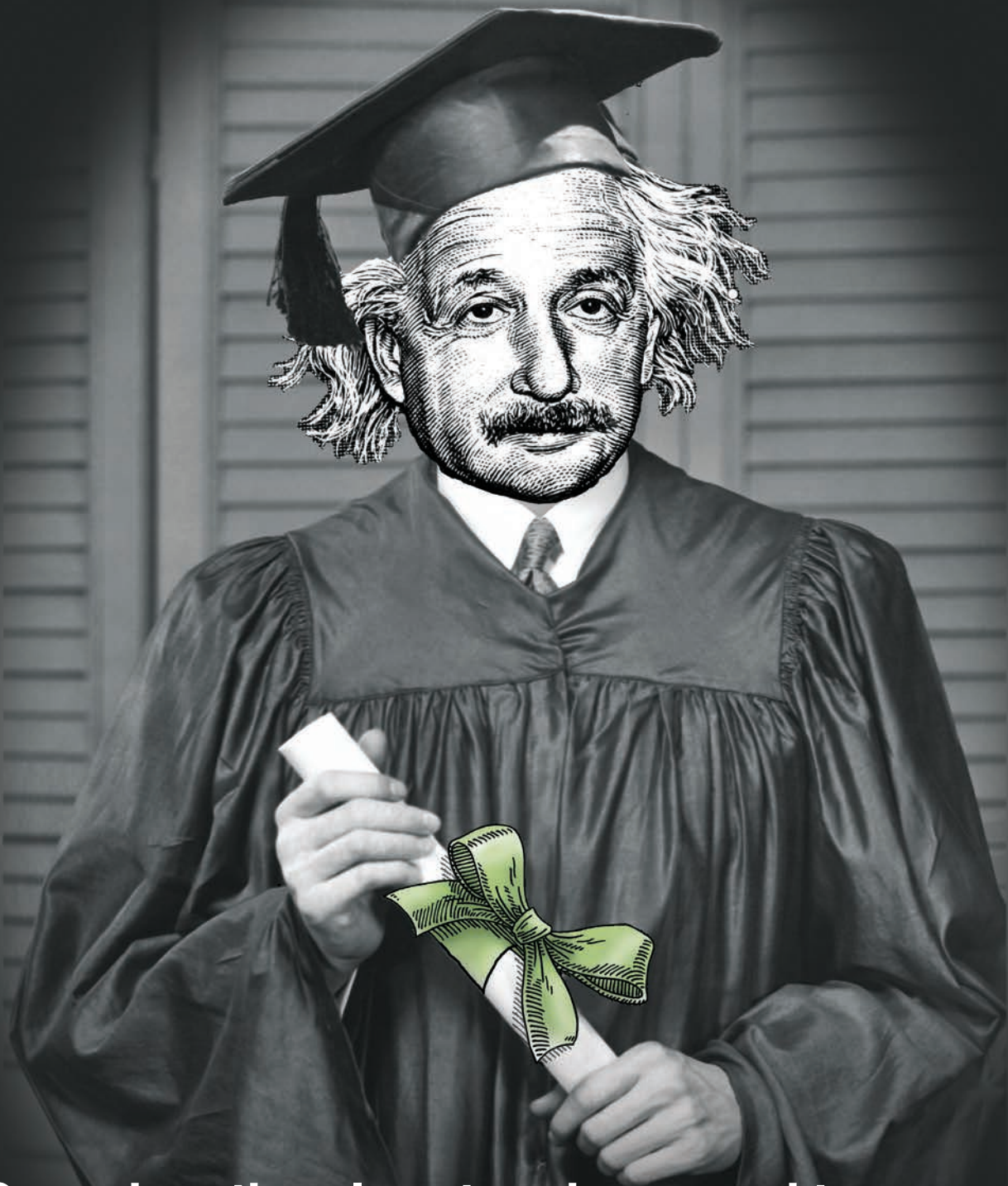
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