

# CALIFORNIA BROKER

VOLUME 36, NUMBER 3

SERVING CALIFORNIA'S LIFE/HEALTH PROFESSIONALS & FINANCIAL PLANNERS

DECEMBER 2017

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Long Term Care • 401(k)s • InsureTech • Employee Benefits • Dental

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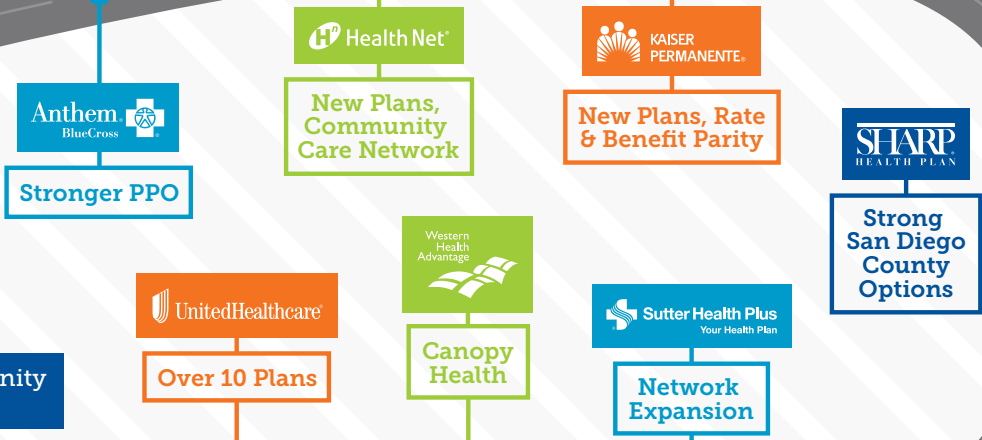
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### PUBLISHER

Ric Madden  
email: publisher@calbrokermag.com

### EDITOR-IN-CHIEF

Kate Kinkade, CLU, ChFC  
email: editor@calbrokermag.com

### SENIOR EDITOR

Victoria Alexander  
email: editor@calbrokermag.com

### ART DIRECTOR/PRODUCTION MANAGER

Steve Zdroik

### ADVERTISING

Scott Halversen, V.P. Mktg.  
email: scotthalversen@calbrokermag.com

### CIRCULATION

email: calbrokermag@calbrokermag.com

### BUSINESS MANAGER

Lexena Kool  
email: lex@calbrokermag.com

### LEGAL EDITOR

Paul Glad

### EDITORIAL AND PRODUCTION:

McGee Publishers, Inc.  
3727 W. Magnolia Blvd., #828  
Burbank, CA 91505  
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email: calbrokermag@calbrokermag.com.

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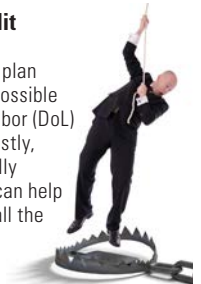
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# How I Would Fix Health Care

## *(Well, sort of fix...)* By ALAN KATZ

If you spend any time writing or speaking about health care reform, eventually you're asked the magic wand question: what would you do? Well, there's an idea I've been thinking about. It's not a Big Fix. It's merely something that would improve whatever system is in place – I think – by making the system more simple and transparent. I'm sure it's riven with problems. And maybe it's a hot topic, but I've missed those articles. In any event, here it is. Please let me know what you think I'm missing.

### THE MECHANICS

The idea is to have providers (physicians, hospitals, clinics, laboratories, etc.) publicize what they charge using a multiple of what Medicare pays. If Medicare pays \$100 for a procedure and a doctor charges \$300 for the same procedure, this doctor is a 300 percent provider.

Carriers, meanwhile, will set what they reimburse providers as a percentage of what Medicare pays as well. If an insurance policy pays up to \$250 for this same procedure, it's a 250 percent policy.

The key is that this percentage doesn't vary based on the procedure. Once a provider or carrier sets their multiple, it defines the cost for all treatment and services. Consumers gain two bits of information they lack today: what their provider is charging (300 percent of Medicare in this example) and what their health plan pays (250 percent of Medicare here).

There are two advantages to using Medicare as the benchmark for pricing. First, it's already in use today. Second, it assures both providers and payers are using the same measurement. When you say "300 percent of Medicare" doctors and insurers know what you mean whether they're in San Francisco or San Antonio. (If you're from elsewhere, it means take the Medicare rate and multiply it by three).

Compare this today when all they

know is that the carrier pays in-network services on a mysterious discount and out-of-network services based on an unknowable formula. What is reasonable and customary? Under this proposal, however, the consumer knows what the carrier will pay and what they're responsible for before they walk through the door for medical care.

If implemented today, a number of things remain unchanged. Deductibles, co-insurance and co-pays: still allowed. The Affordable Care Act's essential benefits: covered. Preventive care: not subject to deductibles and co-insurance. How emergency treatment is reimbursed will need to change to a standard multiple of Medicare for all payers regardless of the facility's usual percentage so consumers aren't subject to balance billing.

### SIMPLICITY AND TRANSPARENCY

As noted, this idea overlays the current system; it's not a substitute. This is an overlay, however, that delivers substantial simplicity and transparency. Consumers know up front which providers they can afford. There would be no networks so there would be no surprises from out-of-network charges. Consumers choose any doctor fully aware of how much of their bill is covered by their health insurance. If they want more covered, they simply choose another provider.

Physicians wouldn't have to guess what carriers will pay them. They'll reduce their costs as a lot of unnecessary paperwork goes away. However, they'll also have to compete with other providers in their community. If a doctor is going to charge 500 percent more than everyone else, she better have a good reason.

Hospitals could no longer hide behind their charge masters— a menu of prices they charge for services that no one ever sees and few hospitals can explain or justify. These inflated costs are the starting point for pricing negotiations with carriers, so few people ever see them. (Steve Brill wrote a story in Time

magazine in 2013 that explains charge masters and should be required reading for anyone attempting to reform American health care: <http://time.com/198/bitter-pill-why-medical-bills-are-killing-us/>).

Consumers and their brokers will be able to compare the value of plans on an apple-to-apple basis. If a 400 percent policy is more expensive than a competitor's 500 percent policy, the carrier better be able to explain why. Consumers won't face unexpected charges, either. They'll know if their policy will cover all of a given provider's expense or if they'll need to pay a portion of the costs. And they can choose their providers accordingly.

Carriers benefit from this proposal, too (unless you're employed in the networking department). Actuaries will have more certainty in determining the reimbursement required under each plan, regardless of whether the provider is in or out-of-network. With better information on their exposure, carriers can price more accurately. The simplicity of the system will also reduce operating costs and that's critical for carriers needing to meet a legally required medical loss ratio.

### AN IMPROVEMENT, NOT A REVOLUTION

I know this idea doesn't fix America's health care system. The goal is to inject greater simplicity and transparency into whatever system is in place. If transparency advocates are right, this will revolutionize health care. I'm not sure I buy into the idea that transparency is all that game changing, but to the extent it is, this proposal dramatically increases transparency throughout the health care system.

Single payer advocates will not be impressed by this idea. However, I believe, in spite of its current momentum, single payer is a long way away. Single payer proposals cost too much, impose too much centralized control and are too disruptive. The ACA cost Demo-

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crats Congress (and arguably the White House) and Obamacare is far less radical than any single payer plan out there. Imagine the political blow back for government-run insurance by voters who are already fearful of death panels and distrustful of Washington?

ACA supporters should like this approach. A common criticism is that the ACA doesn't do enough to make health care or health care coverage affordable. Simplicity saves money. Transparency empowers consumers to reduce their health care costs. The ACA plus a Medicare-pegged health care system

will help the ACA keep its affordability promise.

Advocates of reference-based pricing should also be happy. I'm proposing reference-based pricing on a nationwide scale with everyone using the same reference: the Medicare reimbursement schedule. This goes further than most of the reference-based pricing proposals or implementations I've seen, but it's a logical expansion of the concept. And because both the provider and the payer are referencing the same benchmark, litigation — a too common result of current reference-

based efforts — is unnecessary.

This proposal isn't a panacea. The question is, is it a practical improvement? Please let me know what you think — and what I'm missing.

**Editor's note: This article originally ran on the The Alan Katz Blog (<http://alankatzblog.com/>), where Alan offers perspectives on health care reform, politics and more. Email your comments to [editor@cal-broker.com](mailto:editor@cal-broker.com) and we'll make sure Alan receives them. ★**

*Alan Katz is the cofounder and CEO of Take 44, the company behind NextAgency.*

▶ ANNUITY SAMPLER **NOVEMBER 1, 2017**

Company Name	Ratings			Product (Qual./Non-Qual.)	Type SPDA FPDA	Initial Interest	Guar. Period	Bailout Rate	Surrender Charges	Mkt. Val. (y/N)	Min. Contrib.	Comm. Street (May Vary)
	Bests	Fitch	S&P									
American Equity	A-	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 11/9/17. 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	2.50%** 2.80%**	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	1.45%** 2.45%**	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 8/7/17 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	S	2.45%** 3.45%**	7 yrs.	None	9%, 8%, 7%, 6%, 5%, 4%, 2%, 0%	No	\$5,000 (NQ)	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 <sup>st</sup> year. a (less than \$100K) b (100K or more)												
Great American Life	A	A+	A+	SecureGain 5 (Q/NQ)	S	2.15%	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 11/6/17 Includes .25% first-year bonus and is for purchase payments over \$100,000. Escalating five-year yield is 2.40%. For under \$100,000 first-year rate is 1.90%. Escalating rate five-year yield 2.25%.												
Great American Life	A	A+	A+	SecureGain 7 (Q/NQ)	S	1.70%	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 11/6/17. Includes 1.00% first-year bonus and is for purchase payments over \$100,000. Escalating seven-year yield is 2.59%. For under \$100,000 first-year rate is 1.50%. Escalating rate seven-year yield 2.49%.												
Great American Life	A	A+	A+	Secure American (Q/NQ)	S	1.55%*	1 yr.	N/A	9%, 8, 7, 6, 5, 4, 3	No	\$10,000	5.75% 0-70 4.65% 71-80 *Effective
8/7/17. Eff. yield is 2.57% based on 1.55% 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 1.55%. Surrender value interest rate 1.55%. Accepts additional purchase payments in first three contract years. COM12255												
North American Co. for Life and Health	A+	A+	A+	Guarantee Choice II (Q/NQ)	S	2.25%** 2.50%**	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 11/1/17 - a (less than \$200K) b(200K or more)												
Reliance Standard	A+	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	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	3.10%*	7 yrs.	N/A	8%, 8, 7, 7, 6, 5, 4, 0	No	\$10,000	Varies
*Effective 10/10/17. 2.60% base rate with no guaranteed return of purchase payments. Plus 0.50% bonus for \$250,000 and above.												

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# CHRONIC ILLNESS PROTECTION LEVERAGE A SMART SOLUTION TO OFFER THIS PRODUCT

by PAUL CASPERS



**H**ave you heard about the senior living facility in Los Angeles that uses Amazon’s “smart” Alexa technology to help staff respond quickly to residents’ needs for care? As CNBC.com reported recently, a related app also helps keep family caregivers in the loop.

It’s no secret many families need help addressing the challenges of caring for loved ones who no longer can live independently. The physical and financial tolls of aging often are compounded when a chronic illness leads to the need for long term care.

However, like smart technology offerings, innovative life insurance solutions may be a boon when people become stricken with a chronic illness or a severe cognitive impairment. The key is ensuring that the effective date of the life insurance protection is prior to cer-

tification by a physician that the policy holder no longer can perform two or more of the six activities of daily living – bathing, dressing, eating, toileting, maintaining continence and transferring (walking or transitioning between a wheelchair and a bed and back again).

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**RESPONSIVE TO NEEDS**

An accelerated benefit rider designed to mitigate the financial impacts of chronic illness offers clients nominally priced protection, whether it is integrated into a permanent life insurance contract or available with it. For the client to receive the living benefit, his or her mortality must be significantly decreased; however, this type of solution also may help facilitate the insured’s access to high-quality care, including in his or her own home.

As a financial professional serving the California market, you probably have ample opportunities to engage with clients about chronic illness protection. Indeed, California Broker shared recently that the state has a growing population of adults who have healthcare insurance, but whose plans don’t meet their needs.

The reality is, chronic illness may trigger a significant unplanned expense for clients. On average, an American turning age 65 is projected to incur \$138,000 in future long-term care services costs, according to the Centers for Disease Control (CDC).

**A SOURCE OF RELIEF**

Some consumers expect to be able to self-fund the costs, while others think federal/state programs will pick up most of the tab. In fact, the Associated Press (AP) reported recently that 57 percent of people ages 40 and older plan to rely on Medicare “quite a bit or completely” if they’ll need ongoing living assistance, even though Medicare doesn’t cover most nursing care or home health aides.

Clients can’t count on having in-home care from family members or friends to help manage costs. Not everyone has the emotional or physical stamina to provide continuing care. Also, by 2050, when the youngest baby boomers reach age 86, the number of available family caregivers is projected to be 59 percent less than it was in 2013, according to the AARP Public Policy Institute.

A life insurance policy with a chronic illness rider may resolve multiple issues. This solution is designed to help clients protect their remaining assets and ensure a financial legacy for loved ones, and it also has the potential to alleviate challenges for family members.

**PRACTICAL PROTECTION**

A chronic illness rider on life insurance allows the insured to accelerate a portion of the policy’s death benefit, albeit with a corresponding decrease in the death benefit, when the conditions of the rider are met. No longer does the qualifying illness or impairment have to be permanent for the insured to go (or stay) on claim; it’s now possible to offer clients a chronic illness rider that does not have a permanency requirement.

Also, when a chronic illness rider is incorporated into a guaranteed universal life (GUL) insurance policy or purchased with it, the cost of the rider is

***“...if you can help consumers understand the value proposition of living benefit riders for chronic illness, you’ll be positioned to meet more needs, and in ways that truly exemplify the word “smart.”***

fixed. Furthermore, chronic illness riders on life insurance pay eligible policy holders on an indemnity basis. There’s no need for the insured to incur expenses, then submit receipts and await reimbursement; when the benefit is triggered, it’s paid monthly.

**FLEXIBLE STRUCTURE**

Chronic illness riders that feature a choice of payout options, such as 2 percent or 4 percent of the face value of the life insurance policy, offer flexibility. Solutions that also offer the IRS maximum per diem (an amount updated annually by the IRS) as a payout choice are designed to provide even more flexibility.

Regardless of the rider’s payout structure, clients can use the benefit for virtually anything, even if the expense is not related to their illness. Think of the benefit as a pool of money designed to offset not only direct costs of long-term care, but also other outlays, such as for alternative medical treatments or for

home modifications to accommodate a wheelchair. The ability for clients to use the benefit as they wish can be invaluable to them and their loved ones.

A chronic illness rider that includes a waiver of premium while the insured is on claim also has the potential to help the client cope better with his or her serious health condition. Although additional costs may be associated with the inclusion of the waiver, no one wants to be concerned about money while seriously ill.

**A HOLISTIC APPROACH**

As most people still lack sufficient life insurance coverage, a fact that LIMRA underscored in a recent blog post, they also may be unprepared for the financial impacts of chronic illness. Take a holistic approach to clients who need life insurance and educate them about the availability of chronic illness riders.

Such riders may be particularly attractive to generation X consumers and late baby boomers. Living benefit riders typically are more affordable for people in their 40s through their early to mid-60s than for older clients, and many solutions are tailored to the middle market. Also, in some cultures where death is a taboo topic, explaining the role of living benefit riders may help facilitate a culturally sensitive approach to life insurance.

**THE BOTTOM LINE**

You probably can think of people who would love to be the beneficiary of their own life insurance policy, if it was needed, and still have an opportunity to leave a financial legacy. Despite the commoditized nature of the life insurance business, if you can help consumers understand the value proposition of living benefit riders for chronic illness, you’ll be positioned to meet more needs, and in ways that truly exemplify the word “smart.” ★



*Paul Caspers serves as western divisional vice president, AIG Life Brokerage, AIG Financial Distributors. He is responsible for driving sales and recruitment efforts in the western division of the AIG Life Brokerage distribution channel. He has served with AIG since June 2012.*



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# THE GENOMICS REVOLUTION

By PHIL SMALLEY

## Discovering Benefit Sales DNA in Your Client's Chromosomes

*Why You Should Be Offering Them Genomic Testing!*

**T**he genomic revolution is upon us. Genetic testing is now affordable and widely available, allowing employers to capitalize upon this movement and improve employee wellbeing.

“Genomics is not tomorrow. It’s here today,” said Professor Dame Sally C. Davies, the United Kingdom’s Department of Health chief medical officer. Davies made this statement in her 2016 annual report entitled “Generation Genome,” where she said in an accompanying video posted on the Telegraph, “Please can we now move from talking and experimenting around genomes and put it into practice for patients.”

Genomics can now be added to employee benefit programs and wellness programs to further champion this noble cause. This will allow individuals to take a more proactive stance working with their doctors to prevent disease, avoid drug side effects and improve survival outcomes through personalized therapies for cancer. Also, this direction will rapidly accelerate research as more people get into much-needed clinical trials.

Employers have already started offering genetic testing services to employees in the United States and internationally. Whole genome sequencing, pharmacogenomics and cancer genomic profiling are a few of the genomic programs that companies have made available to their employees in the U.S.

### **VALUE OF WHOLE GENOME SEQUENCING**

Even though all humans are 99.5 percent the same genetically, we all carry various genetic variations and alterations that put us at either an increased or decreased risk of developing various diseases. Whole genome sequencing is the process of determining an individual’s complete DNA sequence at a single time. This type of sequencing can identify genetic variations and potential risk factors. In the “healthy” population, there are many individuals with incidental actionable genetic variations that, if known, could allow their doctors to take measures to prevent disease. Some researchers have questioned the value of routine genetic testing of the public, but researchers still report that genetic testing uncovered patients who had undiagnosed medical conditions. Research has also found that primary care providers are able to manage the results of genetic testing appropriately.

### **VALUE IN OFFERING PHARMACOGENOMIC TESTING**

Many employees take prescription medications. Unfortunately, many medications that doctors prescribe are ineffective. In the U.S., serious adverse drug reactions are estimated to occur in about 2 million Americans a year and these cause about 100,000 deaths per year, making adverse drug reactions the fourth leading cause of death.

Pharmacogenomics is the study of how an individual’s genes affect their personal response to drugs, and pharmacogenomic testing allows doctors to prescribe the right drug, at the right dose to the right patient. More than 91 percent of people carry at least one actionable drug-gene mutation that if known would mean a doctor should use a different drug or altered dose to treat that person. Truly, one size does not fit all. Genetically guided prescribing makes drug therapy more effective and helps avoid serious drug side effects.

### **VALUE IN OFFERING CANCER GENOMIC PROFILING**

Everyone has been touched by cancer in some way. On

average, in the USA, we have a greater than 40 percent chance of developing cancer in our lifetime and cancer causes more than 22 percent of all deaths. Genetic testing allows doctors to better prevent and treat cancer.

Cancer is a genetic disease and deserves a proper genetic diagnosis to allow the use of the most appropriate therapy, which leads to new knowledge and better drugs through clinical trials. Genomic profiling identifies the underlying DNA alterations that are driving the tumor's growth.

Many studies have shown that personalized cancer therapies based on tumor genetic biomarkers improve patient outcomes. In May 2017, the FDA took a novel direction by approving the use of a cancer immunotherapy drug based solely on the cancer's genomic profile regardless of where the cancer originated. There are also drugs today that are indicated for one form of cancer that could be applied to other forms of cancer once the genomic profile of a cancer is known. Equally, other therapies such as immunotherapy can be targeted where they can be most effective.

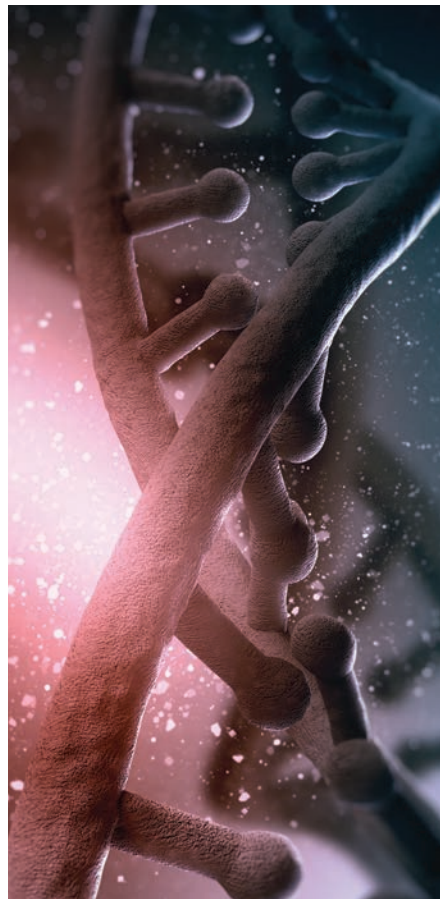
Even in end-stage cancer patients, some studies show that cancer genomic profiling guided targeted therapies can benefit patients. For example, a study published in 2015 in the *European Journal of Cancer* showed that genetic testing influenced treatment decisions in 53 percent of patients and targeted therapies based on cancer genomic profiling extended life expectancy by 1.1 years. Application of genomic profiling earlier in the disease process might lead to an even more favorable impact on cancer survival.

Getting cancer genetic profiling testing also allows some patients to take part in various clinical trials such as large national cancer agency sponsored trials such as NCI-MATCH and ASCO-TAPUR trials and many more.

Cancer genetic profiling can also help a doctor to avoid the use of expensive and toxic chemotherapy in some settings. For example, in early stage breast cancer, genetic testing of clinically high risk patients could lead to a 46 percent reduction in the number of patients needing additional post-surgery chemotherapy.

### HOW WILL GENETIC TESTING IMPACT COSTS?

The impact on healthcare costs depends on the circumstance and test. Pharmacogenomic testing can lower health care costs. For example, one study in patients with depression, found that genetic testing guided therapy could save an estimated \$1,035



per person per year in drug costs. Genetics guided therapy in the elderly polypharmacy patients can get patients off of medications and can save an estimated \$621 per patient per year.

Also, as serious adverse drug reactions are a common cause of emergency room visits, hospitalization and increased length of stay in hospital, using genetic guided medication prescribing that decreases drug side effects should be able to lower overall healthcare costs considerably.

In some instances, whole genome sequencing may lead to a short term 30 percent increase in healthcare spend in the first six months after testing as patients see their doctors to change therapy and get follow-up testing performed. After this period, genetic test-

ing could lead to more disease preventative therapies and improved lifestyles. Of course, this should result in less time off of work with lower morbidity and mortality, which would save costs to the employer and health insurer.

As cancer genomic profiling is fairly new, the net impact on healthcare costs is unclear currently. The cost of genetic testing leading to the use of expensive targeted therapies is mitigated by the cost savings attributed to being able to withhold additional chemotherapy, avoid expensive high-grade treatment related toxicities that are more common in patients treated with conventional chemotherapy and lower the risk of cancer recurrences. Ultimately, the goal of cancer genomic profiling is to help the patient receive the most advantageous treatment and outcome.

### BENEFIT OF A PRODUCER ADVISING CLIENTS TO USE A GENOMIC ADVISOR

When companies use a genomic advisor—essentially an intermediary – instead of directly going to a genetic testing firm, they will be ensured privacy for employees at time of claim because no health or genetic information identifying the employee is given back to the employer.

A good genomic advisor also provides clients with expert counsel to educate the employer and employees about pros and cons of various types of genetic testing offerings and knowledge about good vendors that are appropriately vetted by experts. ★



*Dr. Phil Smalley, chief medical director for Wamberg Genomic Advisors, is an internal medicine specialist with 27 years of experience in insurance medicine. He recently retired from his position as senior vice president and global chief medical officer for RGA International Corporation. Dr. Smalley received his medical degree from the University of Toronto, Canada. He is a Fellow of the Royal College of Physicians and Surgeons of Canada and past president of the Canadian Life Insurance Medical Officers Association. Dr. Smalley was also managing director of the Longer Life Foundation, the not-for-profit research partnership between RGA and Washington University School of Medicine. Dr. Smalley currently lives in Toronto and consults for the insurance industry.*

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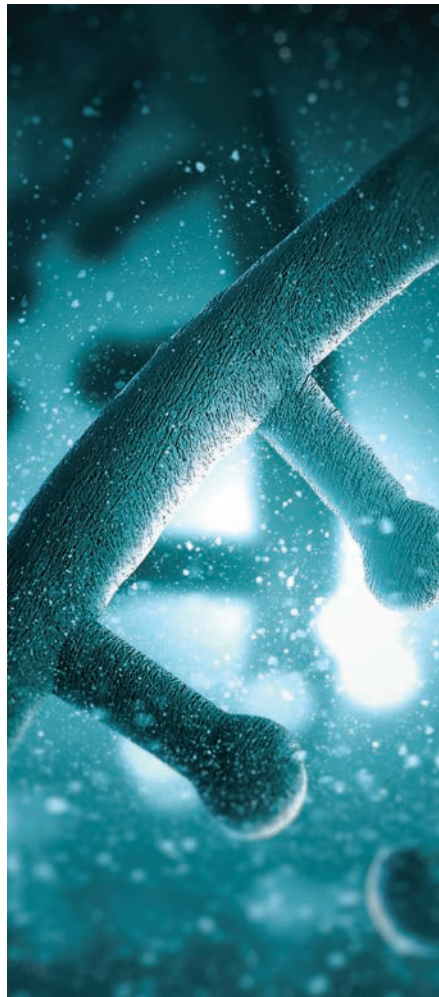


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# Craving More Info On Genomic Testing?

If you'd like to learn more about genomic testing, here are the references Dr. Smalley used:

1. Prof. Dame Sally C. Davies, Annual Report of the Chief Medical Officer 2016, Generation Genome, London: Department of Health (2017) [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/631043/CMO\\_annual\\_report\\_generation\\_genome.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/631043/CMO_annual_report_generation_genome.pdf)
2. Sarah Knapton, The Telegraph, Science, July 4, 2017 <http://www.telegraph.co.uk/science/2017/07/03/chief-medical-officer-every-cancer-patient-should-have-dna-tested/>
3. Amendola LM et al, Actionable exomic incidental findings in 6503 participants: challenges of variant classification. *Genome Res.* 2015 Mar;25(3):305-15
4. Vassy JL et al, The Impact of Whole-Genome Sequencing on the Primary Care and Outcomes of Healthy Adult Patients: A Pilot Randomized Trial. *Ann Intern Med.* 2017 Jun 27;167:159-169
5. Karczewski KJ et al, Chapter 7: Pharmacogenomics. *PLoS Comput Biol.* 2012;8(12):e1002817
6. Carere DA et al, Prescription medication changes following direct-to-consumer personal genomic testing: findings from the Impact of Personal Genomics (PGen) Study. *Genet Med.* 2017 May;19(5):537-545
7. Subbiah V and Kurzrock R, Universal Genomic Testing Needed to Win the War Against Cancer: Genomics IS the Diagnosis. *JAMA Oncol.* 2016 Jun 1;2(6):719-20
8. Schwaederle M et al, Association of Biomarker-Based Treatment Strategies With Response Rates and Progression-Free Survival in Refractory Malignant Neoplasms: A Meta-analysis. *JAMA Oncol.* 2016 Nov 1;2(11):1452-1459



9. Schwaederle M et al, Impact of Precision Medicine in Diverse Cancers: A Meta-Analysis of Phase II Clinical Trials. *J Clin Oncol.* 2015 Nov 10;33(32):3817-25
10. Massard C et al, High-Throughput Genomics and Clinical Outcome in Hard-to-Treat Advanced Cancers: Results of the MOSCATO 01 Trial. *Cancer Discov.* 2017 Jun;7(6):586-595
11. Spetzler D et al, Multi-platform molecular profiling of 1,180 patients increases median overall survival

- and influences treatment decision in 53% of cases. *European Journal of Cancer*, September 2015; Volume 51, Supplement 3, Page S44
12. ClinicalTrials.gov, A service of the U.S. National Institutes of Health NCI-MATCH: Targeted Therapy Directed by Genetic Testing in Treating Patients with Advanced Refractory Solid Tumors, Lymphomas, or Multiple Myeloma; NCT02465060 ASCO-TAPUR: Testing the Use of Food and Drug Administration (FDA) Approved Drugs That Target a Specific Abnormality in a Tumor Gene in People with Advanced Stage Cancer; NCT02693535 <https://clinicaltrials.gov>
13. Cardoso F et al, 70-Gene Signature as an Aid to Treatment Decisions in Early-Stage Breast Cancer. *N Engl J Med.* 2016 Aug 25;375(8):717-29
14. Winner JG et al, Combinatorial pharmacogenomic guidance for psychiatric medications reduces overall pharmacy costs in a 1 year prospective evaluation. *Curr Med Res Opin.* 2015;31(9):1633-43
15. Saldivar JS et al, Initial assessment of the benefits of implementing pharmacogenetics into the medical management of patients in a long-term care facility. *Pharmacogenomics Pers Med.* 2016 Jan 19;9:1-6
16. Haslem DS et al, A Retrospective Analysis of Precision Medicine Outcomes in Patients With Advanced Cancer Reveals Improved Progression-Free Survival Without Increased Health Care Costs.; *J Oncol Pract*, February 2017; Volume 13 (Issue 2): pp e108-e199
17. Reck M et al, Pembrolizumab versus Chemotherapy for PD-L1-Positive Non-Small-Cell Lung Cancer. *N Engl J Med.* 2016 Nov 10;375(19):1823-1833. ★

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# Group Health Captives Part 2

## SEIZING OPPORTUNITIES AND PREPARING FOR THE MARKETPLACE OF THE FUTURE

By STUART SLONIN



**W**e are witnessing major structural changes taking place in the economy. One example is the automotive industry. VOLVO announced that by 2019, it will stop manufacturing cars with internal combustion engines and transform their entire fleet to hybrids or



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cars powered solely by batteries between 2019 and 2022. In many ways, 2018 is also a transition year in health insurance. In the individual market, Congress has “cobbled together” an ACA “patch” for 2018, and proposed major changes for 2019. In the group market, it’s a little more complicated. With a better performing economy, there is ample planning time to structure programs for each size segment of the group benefit marketplace. Employers are no longer sitting, waiting for their renewal notices. They have become more proactive in their expectation of how their benefit program should be performing. Thus they are out in the marketplace – looking for new ideas, new tools and new consultants who are knowledgeable to bring these new techniques to their attention.

### **MANY DYNAMICS IN PLAY**

Risk and uncertainty is evident in the results achieved in the large employer marketplace (groups of 51+). There is renewed emphasis on technology, data, the use of risk management and predictive modeling tools to assure that pricing is adequate for all possible contingencies. There is a noticeable increase in out-of-pocket costs and cost shifting to employees. But there is also increased use of funding accounts to offset these costs. This structuring of group plans has achieved some measurable results. This is impressive when we see that there are at least

two to four generation groups working together at a single employer’s workplace – each with their own needs and wants in what they expect in an employee benefit program.

### **GROUP CAPTIVES REMAIN AT TOP OF LEADER BOARD IN GROUP MARKETPLACE**

Group captives are no longer the “new kid on the block” (their first use was in 1956 – almost making them a “senior citizen” in the group planning marketplace). It will be interesting to see how many employers will enter this market in 2018 and beyond. This “transition” as stated also applies to agents and benefit consultants. When will they begin to make use of this dynamic planning tool and get past their learning curve to reach that highest plateau? And will they become the trusted advisor employers will use to access these programs?

### **EMPLOYERS WILL BE MORE WILLING TO SWITCH TO A GROUP CAPTIVE PROGRAM**

The captive marketplace has remained strong and stable; producing better long term results than either the fully Insured or self-funded group marketplaces. This is not a surprise when you consider that by joining a group captive program, an employer is joining other like-minded employers who want to achieve better long term results, than

those available in retail programs. Instead of standing on their own claims experience, they are protected by the law of larger numbers in a group captive program.

Because of their unique construction, group captives are able to take in a more varied type of group risk. There are no SIC codes where either an extreme white collar or blue collar risk would not be able to be written. Captives are highly adaptive to any area in the U.S., and any group plan structure the captive program decides on. They are equally at home providing a PPO or Medicare allowable claims repricing structure with equally good results. The reason for these results is that the captive program is able to establish the parameters of the rules its member firms must follow. This includes: feasibility study, funding rules for entry, specific group benefit choices, reinsurance arrangements, rules for getting in and out of the program, compliance services, and a full roster of risk management tools the plan uses to effectively manage the program. Employers like the ability to save money on state premium taxes, and their ability to get continuous data about how the plan is functioning as well as their claims data showing how their employees are using the program on a monthly basis.

The ACA has designed preventive benefits to be part of any benefit plan. Thus in captives, we see combinations of wellness, telemedicine and preventive benefits packaged together with EAPs and shopping tools to make the benefit plan more consumer friendly. When employers concentrate on these tools that bring stability to this program, they see excellent long term results in bending the cost curve. As far as other observable results, employers are seeing their employee census becoming more steady (check their Quarterly Wage & Tax report Experience Modification factor on a year-to-year basis looking at the same quarter). Steady group plan designs with increased benefits and funding account opportunities are the reasons why employees are attracted to and stay with an employer for a long time. There are examples of this level of success in every community throughout the U.S.

## BENEFIT YEAR 2018: WHAT WE KNOW AND WHAT WE EXPECT

The large benefit consulting firm's data for 2017 is in and presents a mixed picture of where costs and preferences are going (Kaiser, UBA, Mercer, Gallagher Willis, Towers Watson, Aon, and the Milliman Medical Index). In the fully insured large employer market, we see negotiations producing lower renewal costs than those initially presented or movement into self-funding or captive structures. We see rising deductibles, rising out-of-pocket costs, changing prescription drug plans (moving from four to six tiers and to plans with co-pays or coinsurance models – based on increased costs of 8 percent or more) and plans using health risk assessments as part of their initial underwriting requirement. We see statistical increases of anywhere between 3.6 percent to 7 percent or more, depending on plan design and area of the country in 2018. We see PPOs and HDHPs as the most requested plan designs followed by HMOs and POS plans, as well as multi-option programs under the same administration package. With greater variance of provider reimbursement across the country, we are beginning to see movement from PPO reimbursement to Medicare allowable reimbursement. The pressure here is that more employers are requesting plans which allow their employees to go to Centers of Excellence across the country – when that level of treatment is required. This trend will continue to increase over the next few years.

## WHY GROUP CAPTIVE PLANS "ANSWER THE BELL"

When you view a group captive program, you see a remarkably mature structure that ticks all of the boxes of what an employer looks for in a benefits delivery system for their company. From 1956 through today, it has gone through all of the changes that group benefit planning has wrought during all of those years. It brings every available tool to manage the group risk effectively – giving the employer a flexibility they have never had before. It presents a financial opportunity to control plan utilization in a consumer friendly way that will be appreciated by all

those becoming a part of the program.

At a recent benefits conference, I was asked for more specifics about what makes captive plan arrangements so attractive to employers and professional practice groups. Here are a few answers to that question. An important part of managing risk in group captives is how diverse are their employer classes (what industries have they attracted into their captive pool)? How have employers come into the program (LOC's or cash)? How long has the average group been in the program? How have human resource professionals or CFOs adapted to the captive structure and gained in their knowledge and use of the program? In the past, state and federal regulations were the main issues. Now a current issue is how does an employer with multiple locations use the captive structure and remain in compliance with all regulations on a current basis?

In the past five years, more captive owners have asked about extending their structures beyond pure group health risk (specific and aggregate protection) and group risk sharing. They have inquired about blending with other lines and pass-throughs to reinsurance markets and other health insurance areas including disability and even life insurance. I suspect that once employer groups get comfortable with using the captive structure (and discover the dollars and cents justification for using it) they will put pressure on benefit consultants to explore other uses of the structure.

If we accept the idea that we live in an interconnected world, employers are slowly planning for the automation revolution by making small targeted investments in new technology. Like it or not, the way we work is changing right in front of our eyes and will become more concentrated within the next five years. The preparation for those changes will come from the employees they hire and their preparation for the new workplace. We will see that movement between: millennials, generation Xers and baby boomers. Along with their research into health benefits, employers will check on the quality status of the provider community by reviewing both The Leapfrog Group's Hospital & Safety ratings, as well as U.S. News

& World Report's Hospital rankings. There is more transparency information available today, and consumers in general are beginning to pay more attention to them than in past years in making their healthcare decisions.

Back to our analogy with the automotive industry today. That industry is in a period of massive disruptive change. Sales of autos became a commodity business at the retail level, with low margins and tough competition. They were pass-through mechanisms for the brand manufacturers. Buying a car is a big family purchase with an equally large price tag. The industry is now moving toward an autonomous driving experience in a sharing marketplace. That vehicle (with all the computer equipment) has a price tag of about \$200,000. The only way you can justify that level of expense per vehicle is to eliminate the individual driver, and move to a shared vehicle with several owners.

If we take those terms and ideas and applied it to group captive programs – my response would be the same as that good Italian sauce: "It's in there, it's already in there!" All of the elements of a gold-plated benefits program that any employer or professional practice would search for already exists in a turnkey well-constructed captive benefit program. The only limitation would be an employer's imagination in how far he wants to go with building and expanding his company's use of that program. The 2019 open enrollment marketplace will include many exciting options. Those include: a new Taft-Hartley Act program for groups of 1+, a new association health program (satisfying two segments of the group marketplace) and expanded group captive programs moving into new risk arrangement areas. This is a truly exciting time to be a participant in the group benefits marketplace. The ultimate question left for this audience is: will you be ready to bring this program and the other new ones to your new and existing clients? Be assured: if

it won't be you, it will be someone else! ★



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

# Marketing Your Business

## BUILD YOUR BRAND WITH COMMUNITY INVOLVEMENT

By EMILY DE LEON



**F**or many brokers, time is money. While getting involved at the local soup kitchen or assisted living facility seems like a great idea, you might put it off for another day or keep it on your to-do list.

It's understandable. You're so busy seeing clients, completing paperwork, chasing leads, and trying to keep up with family and friends that undertaking a volunteer project or other charitable

endeavor probably feels out of reach. But what if I told you making community involvement part of your integrated marketing strategy can win you new business?

### **BRANDING ON A BUDGET**

Marketing on a small business budget can be a difficult task. Community outreach allows you to gain visibility, build relationships and bring in new



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# HRAs 3 THINGS TO CONSIDER WHEN EVALUATING HRAs

By JOANN VERNON



**T**his is the season for pumpkin spice lattes, family gatherings and, if you're part of the insurance industry, open enrollment season. We all know what comes with that...long hours and lots of lattes. Many clients are looking to you, their brokers, for help and guidance with plan designs, cost saving mechanisms, education, compliance and the list goes on.

The consultant today isn't just focused on cost, either. They are being asked to be more of a business partner. As we meet with our broker partners around the country, compliance is al-

ways a hot topic, but controlling costs is still a large part of the discussion. In addition, we as consultants discuss providing efficiencies for HR and truly designing a plan that meets the needs

of their client's workforce.

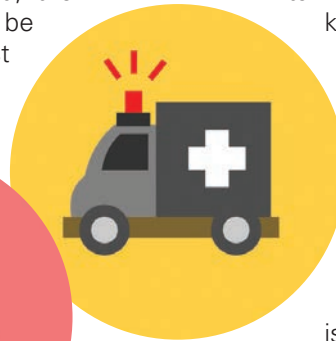
What are you doing today to help your employer clients? What about health reimbursement arrangements (HRAs)? Each year since 2006, the number of

employers that have incorporated a HRA/health savings account (HSA) as part of their overall solution has grown substantially.

A 2016 study by the Kaiser Family Foundation shows that the HRA/HSA adoption rate is up to 26 percent. This number will only continue to grow as the number of employers looking to make consumerism changes to their plan increases.

**BONUS: 2 HRA TIPS TO JOT DOWN**

**Tip 1:** Be sure to know what kind of valuation you are going to use for the COBRA premium, in regard to the HRA-eligible benefit. The first year valuation maximum is loosely set by the IRS. However, subsequent years can actually be set using the previous year's utilization numbers.



**Tip 2:** Education will be key to the success of the program. Whenever anything new is introduced, the dos and don'ts will need to be communicated. The worst thing that could happen is

an opportunity to get creative and consultative in your approach. I would love to know what California Broker readers are seeing in regards to trends with HRAs, HSAs and FSA strategies. I shared with you just a few options that are available. Please let me know more about what you are finding that is relevant and working with your clients! Email me at [jvernon@primepay.com](mailto:jvernon@primepay.com). ★

an employer implements one of these strategies (which is truly to benefit their employees) and no one uses it because they don't know how. Now more than ever, you have the



*For more than 20 years, Jo Ann Vernon has been helping brokers and employers develop strategies and benefit programs for their clients and employees. She takes a consultative, holistic approach to benefit design by providing relevant solutions for employees and ultimately cost savings for employers. She can be reached at [jvernon@primepay.com](mailto:jvernon@primepay.com)*

## 3 Trends in HRAs Today

### 1 HRA/FSA STACK (AKA COPAY REPLACEMENT HRA)

Perhaps your client is not ready to make the leap over to a high deductible health plan (HDHP), but still needs to figure out a way to reduce the overall costs. Increasing the copays, deductible and out-of-pocket is one of those ways. However, when copays are increased, the noise from the employees is heard. Consider a HRA/FSA combo program. The employer can reimburse the employee (for example, \$10 for each office visit) and the employee can still contribute to their FSA for the remaining portion of their copay. Of course, you'll want to set limits and make sure that the cost savings by moving to the higher plan design isn't eaten up by reimbursements through the HRA.

### 2 POST DEDUCTIBLE QHDHP

This works well when you need to increase the deductible of the qualified HDHP (QHDHP), but still want to provide a strong benefit for the employees. This strategy works when the employee is responsible for the first \$1,350/\$2,700 (minimum qualification for a qualified health plan in 2018), but will

reimburse the employee the difference up to the new deductible. For example, if the new deductible is \$2,000, the employee is responsible for the first \$1,350/\$2,700 and the employer for \$650 through an HRA. The number of employees that max out their deductible is a much lower percentage of the overall claims. However, the perceived value of the higher deductible is a startling number to the employee population.

### 3 PERCENTAGE SPLIT HRA/FSA

Let's say your client is ready to make the leap to an HDHP and needs a strategy to help the employees with the transition. Consider installing a percentage split HRA/FSA. You can choose any split that you and the employer feel makes the best sense. For example, let's use an 80/20 split. An employee seeks treatment and uses their HRA/FSA debit card to pay for the services. In this case, 80 percent of the charge will be paid under the HRA (employer money) and the remaining 20 percent will be removed by the employee's FSA (employee money). Again, setting up the plan design with limits will help the employer.

# GENWORTH SURVEY

# Consumer Insight

# About Long Term Care

By VICTORIA ALEXANDER

**G**enworth recently released results of its Long Term Care Consumer Sentiment Study. The data from the study was collected from online surveys conducted in July and September 2017.

According to the survey respondents, not having enough money to pay for care is the greatest fear they have about aging and their long term care needs. Despite this, only one in five have taken any action toward financing their long term care expenses. Moreover, only half of the respondents said they plan to take personal financial responsibility for their own care as they age. The others said they would leave that worry to the government, their children or family, community or faith-based organizations, or they had no idea who would provide their care.

California Broker got Genworth's LTC expert Larry Nisenon on the phone for a little more info about the survey and public sentiment toward long term care.

**CB: Were your survey findings surprising?**

**Nisenon:** I'd say what we found cer-



tainly supported what we knew to be true. In a nutshell, the greatest fear about aging is not having enough money to pay for it and the overwhelming majority of people are not planning ahead for aging.

According to our survey, boomers are the least likely to think they will be one of the 70 percent of Americans who will eventually require care. That may be a little surprising or counter intuitive. And some readers might find it a bit surprising to know that millennials are the most likely to have taken action toward planning for LTC expenses.

### **CB: When you say “taken action,” what counts?**

**Nisenson:** It includes a lot of things. They could’ve talked to a family member about a plan of care, they could’ve gone online to find out about long term care costs or they could’ve talked to a financial or insurance professional about LTC. We count it as an action if the person isn’t just thinking about long term care, but has also done something to find out more about it.

### **CB: Does it make any sense that baby boomers are the least likely to believe they’ll need LTC?**

**Nisenson:** I don’t think anybody wants to believe they’ll be part of the seven out of 10 Americans who eventually require long term care. Baby boomers are showing us that they are more fearful as they get closer to the real possibility of needing LTC. Millennials are still far enough away that it’s not uncomfortable – they are preparing and looking at the information. Of course, generation X is sitting in the middle and we found that they are the most fearful about having the lack of money. They’re also the group that has reacted the worst. Gen Xers are the least likely to have done anything about LTC.

But this also makes a lot of sense. Remember that gen X is the sandwich generation. They are the most likely to be taking care of kids and parents at the same time. So they may be paying for all the typical costs of children while also supporting their own parents physically and/or financially. If you’re in this situation, you’re immersed in the today and now. You may not feel as if you have the time and money to think about the issue that might effect you down the road.

### **CB: Are there also commonalities among the generations?**

**Nisenson:** Yes, there’s general confusion among all three generations on what LTC is and where the government steps in or doesn’t. A general lack of education about health insurance, Medicare, Medicaid and LTC only adds to the confusion. You would think all the news about health insurance lately would provide additional clarity, but that doesn’t seem to be happening yet. So a lot of people don’t even understand LTC is on top of health care. A lot of people think the government will pay for their LTC at some point. As you know, Medicare and Medicaid are both coming under funding pressure. A benefit that exists today might not even be there in 15 or 20 years.

Our survey clearly shows the need for more general awareness. Producers are in a position to start this con-

versation about LTC costs, both for older clients and even the children of clients. You should be talking about financing options. And misconceptions about government programs. Also the the notion that LTC is unaffordable.

## **DATA POINTS FROM THE GENWORTH SURVEY**

Consumers’ inaction may be partially explained by additional survey findings that showed glaring misunderstanding about what care costs and what costs are covered by various funding sources, including government programs.

- Two out of three adults expect government programs to partially or fully cover the costs of their long term care services, despite the fact that Medicare pays for only limited care and Medicaid has strict financial eligibility requirements. In addition, both programs have come under increasing funding pressure.
- Confusion exists about government programs and what they cover: 45 percent of respondents either confused Medicare for Medicaid or admitted they didn’t know the difference between the two programs.
- About 40 percent underestimated the hourly cost of professional care in the home, which is where most people prefer to receive care, and 52 percent of respondents did not know that this service can be covered by a long term care insurance policy.
- 62 percent of respondents incorrectly defined what long term care insurance covers.
- 61 percent of respondents did not know that long term care insurance usually provides care coordination services such as personalized care plans and help finding quality care providers as part of the policy benefits.

### **Generational Differences**

- Baby boomers, who are closest to the age at which people typically begin needing long term care services, are the least likely to think they will be among the 70 percent of people that will require long term care services at some point. (52 percent compared to 64 percent for millennials and 65 percent for generation X).
- Gen X is the most fearful about lacking the money to pay for long term care, but is the most likely not to have taken any action toward paying for future long term care expenses.
- Millennials are most likely to have taken action toward paying for future long term care expenses, which may be tied to another finding revealed in the study -- that they are the most likely not to expect the government to cover any part of their long term care services.

**CB: Okay, what about affordability?**

**Nisenson:** The truth is that regardless of budget there is an LTC policy out there that can help defer a client's needs. No matter which generation the client is in. Even for those clients that can't qualify for LTC, we have a solution available to them. For example, an immediate needs annuity will provide lifetime income to defer costs.

We typically don't expect a lot of 30-year-olds to buy an LTC policy, but I think millennials should be asking their employers to offer group LTC. Because the great thing is that it's very affordable now and they can add to it over time as budgets allow. In fact, on the group LTC side we just completed a study that says 68 percent of those polled would prefer to buy LTC through an employer. So there's certainly an interest. Group policies are portable and affordable. This certainly speaks to a younger generation. And employees can invite immediate family members to apply under that policy—including parents.

**CB: Any last thoughts about your survey?**

**Nisenson:** What this study really screamed to us loudly and clearly is that the LTC conversation is not occurring often or early enough. It's incumbent on us in the industry to reach out to clients and to have those LTC conversations -- as difficult as they may be. There's so much confusion out there about how to finance long term care expenses. That means there's a lot of opportunity for agents to help clear up the confusion and offer a solution. ★

## RESOURCES TO GET A CONVERSATION STARTED

Understanding who pays (or doesn't pay) for care and how to bridge any gaps in financing can help ensure that consumers will have the financial resources to receive the quality care they deserve. Here are resources from Genworth to get the conversation started:

- Genworth provides tools for people to develop a plan at: Let's Talk: "Conversations that Matter" at [www.genworth.com](http://www.genworth.com).
- To compare long term care costs in different care settings across various cities and states, download Genworth's Cost of Care App on the App Store for iOS devices.
- To find out what long term care services are covered by Medicare and Medicaid: [longtermcare.gov](http://longtermcare.gov).
- To explore long term care financing options, please visit [genworth.com/longtermcare](http://genworth.com/longtermcare)
- Beyond traditional insurance products, an underwritten single premium immediate need annuity can be purchased by older, less healthy Americans or their families to provide a guaranteed lifetime source of income that can be used for any purpose, including to pay for care or other expenses. Learn more here: [www.genworth.com/products/immediate-need-annuity.html](http://www.genworth.com/products/immediate-need-annuity.html).

## LIMRA WEIGHS IN: COMBINATION PRODUCTS GIVING LIFE BACK TO LONG TERM CARE MARKET

Even though people value long term care insurance, LIMRA research shows stand-alone individual long term care insurance sales have declined 60 percent since 2012. Declining sales are mainly due to cost concerns from the consumer perspective and profitability concerns from the carrier perspective. Fewer carriers are willing to take on the risk associated with the stand-alone products now than when they first appeared in the market.

Yet, while this product declines, the need for long-term care services will increase as more people enter retirement. According to LIMRA data, there will be 82 million Americans in retirement by 2040, and federal government data estimates that 52 percent of those 65 and older will need long term care services during their lifetime.

Today, LIMRA estimates that less than 7 percent of consumers over age 50 have long term care coverage. What is going to fill this void?

One way is through combination products—life insurance and annuity products that have a long term care rider.

LIMRA research shows that life insurance combination products have seen growth over the last eight years. Total premium sales in the combination market hit \$3.6 billion in 2016 and represented 17 percent of industrywide premium sales (excluding excess premium). According to LIMRA research, one of the top reasons consumers find these products appealing is because they receive a benefit even if they don't need long-term care. Six in 10 consumers say they would consider a combination product to mitigate long term care costs.

Similarly, sales of annuity with long term care riders have increased over the past five years. Despite that the number of companies offering the combined products has declined, sales of the annuity/LTCI combination products have increased 23 percent on average annually since 2011. The draw to the annuity/LTCI combination products is unlike a stand-alone LTC product; the consumer owns the benefit and purchases it upfront. If needed, the funds for long-term care are there. If not, the value of the product will go to heirs in the event end of life care isn't needed either.

While LIMRA doesn't expect to see a rise in individual LTCI sales soon, combination products are a great way to fill the gap the declining individual long-term care insurance sales has left while still meeting at least a portion of consumers' long term care needs.

# HOPE FOR THE CALIFORNIA PARTNERSHIP FOR LONG TERM CARE?



The California Partnership for Long Term Care, a great concept, has fallen upon hard times. Sales are almost non-existent because the insurance carriers have priced 5 percent compound inflation, heretofore a unique California Partnership requirement, to dizzying heights. Five out of the original seven carriers have withdrawn their membership, and only CalPers and Genworth remain.

By LOUIS H. BROWNSTONE

But finally, some stakeholders have gotten together to revive the Partnership. Senator Liu of Glendale enthusiastically sponsored SB 1384, which was passed and signed by Governor Brown in September 2016. SB 1384 had three important elements:

1. It allowed for inflation options in Partnership policies besides 5 percent compound;
2. It created a new type of Partnership policy at lower cost which covers care in all settings except a nursing facility;
3. It required the formation of a Task Force of interested stakeholders to advise and assist in implementing reforms to the Partnership.

The Partnership proposed several inflation options as alternatives to 5

percent compound inflation, all built around 3 percent compound inflation:

- a. A plan with a choice of 3 percent, 4 percent, or 5 percent compound inflation;
- b. A plan with age-based inflation rates, starting at 5 percent compound and reducing to 3 percent compound inflation at age 70;
- c. A hybrid product which would in-

clude 3 percent compound inflation. d. A new home and community plus plan without nursing facility coverage which would include 3 percent compound inflation.

At this point, these are merely proposed plans. The Partnership has promised that it will be flexible in approving different structures of plans. One such flexible idea is to approve as low as 2 percent compound inflation for home health care only policies. There will be less emphasis on all carriers conforming to a specific structure in their plans, so that some of the unique concepts in their non-Partnership policies can be brought over to Partnership policies.

These structures could include a total pool of money benefit, rather than a monthly benefit. It could also include a dollar elimination period, rather than a daily or monthly benefit with an elimination period calculated in days. Another idea is to have a pool of money which could cover many non-essential benefits in one bucket. Carriers would be encouraged to file structures currently in their non-Partnership plans in order to ease their filing process and obtain speedy approval.

On the new home and community plan, the minimum daily benefit would be 50 percent of the cost of a nursing facility, now \$150/day. This would reduce the cost of a Partnership policy by about 30 percent from its minimum daily benefit of \$210. One possible structure would reduce the home care benefit to as low as about \$100/day while keeping other community care at the higher daily benefit level. Actuaries may find that the cost of the coverage may not be much different from the cost of a comprehensive policy, but the premiums at \$ 150/day could be more affordable for the middle class. Remember that the purpose of the Partnership is to provide lifetime coverage through a private/public partnership that would be affordable for the middle class. People are increasingly avoiding nursing facilities, and this policy covers them where they want to be covered.

In addition, a Senate spot bill has been introduced which would give new Partnership plans "urgency status." This would create a swift path for plan approvals, which have still been very slow in California. There are at least

15 insurance policies with long term care benefits available in virtually all states which have not been approved in California. "Urgency status" would eliminate this logjam for Partnership filings, so that approvals would hopefully happen in several months rather than several years or not at all.

The Department of Health Care Services is now putting its finishing touches on revised regulations. These will soon be open for public review before they are finalized. However, insurance carriers will be invited now to file Partnership plans in order to speed up the approval process.



The Task Force had their first meeting on April 3, and have had two additional meetings as of September 27. About 20 enthusiastic people attended each meeting, either in person or remotely, and there was good analysis by Brenda Bufford of the Partnership and others who participated. New proposals have been offered with 3 percent compound inflation with premiums as low as \$100/month per person. This would make premiums affordable for people with moderate income and assets.

Even better, these plans would in effect offer lifetime protection for this target audience, unlike previous buyers with substantial assets and income. For example, if a person had \$ 100,000 in assets, he or she could purchase a partnership plan with a benefit limit of \$100,000. Once that person became sick, he or she could use up the benefits in the policy, apply for Medi-Cal, protect the \$100,000 in assets, and be

covered for the rest of his or her life. With Medi-Cal waivers, he or she may be able to stay at home for at least most of the period of care. What a bonanza! Lifetime protection, preservation of assets and possible home care. That's what we all want in a long term care insurance policy!

Will carriers file? Their reception to the Partnership has been pretty cold with the exception of Genworth, the one carrier that's still in the Partnership. The five carriers that have withdrawn from the Partnership have done so because either sales were extremely low, costs were extremely high, or because

they exited the industry. There's a great deal of bad experience that has to be overcome in order for the carriers to come back to the table.

I believe they should file. Urgency status would greatly reduce their filing cost. Policies would be saleable even with 3 percent compound inflation. Lower premiums and some education money will help galvanize agents and the public. A private/public partnership continues to be the most viable solution to our growing long term care crisis. Washington, D.C., won't provide a solution. California is in the best position to lead the nation. ★



*Louis H. Brownstone is chairman of California Long Term Care Insurance Services, Inc. and ex-chairman of the National LTC Network. He can be reached at [louis@cltcsurance.com](mailto:louis@cltcsurance.com).*

# How to Avoid a DoL 401(k) Audit

By ROBERT C. LAWTON

**T**here are many reasons for plan sponsors to do everything possible to avoid a Department of Labor (DoL) 401(k) audit. They can be costly, time consuming and generally unpleasant. If brokers can help clients avoid this, they are all the more valuable.



The DoL in its Fact Sheet for fiscal year 2016 indicates that the Employee Benefits Security Administration (EBSA) closed 2,002 civil investiga-

tions with 1,356 of those cases (67.7 percent) resulting in monetary penalties/additional contributions. The total amount EBSA recovered for Employ-

ee Retirement Income Security Act (ERISA) plan participants last year was \$777.5 million.

In my experience, if a company re-

ceives notification from the DoL that it has an interest in looking over the 401(k) plan, the company needs to be concerned. Not only do the statistics above support the fact that DoL auditors do a

good job of uncovering problems but, in my opinion, they are not an easy group to negotiate with to fix deficiencies.

As a result, I believe the best policy to follow to ensure your clients don't re-

ceive a visit from a DoL representative is to do everything possible to avoid encouraging such a visit. Here are some suggestions that may help clients avoid a DoL 401(k) audit:

### 1. Always respond to employee inquiries in a timely way.

The most frequent trigger for a DoL 401(k) audit is a complaint received from a current or former employee. These complaints can originate from employees you have terminated who feel poorly treated or existing employees who feel ignored. Advise clients to be particularly sensitive to employee concerns and respond in a timely way to all questions. They should also keep copies of any correspondence and be very professional in how they treat those individuals who are terminated -- even though in certain instances that may be difficult. Terminated employees who feel they have been mistreated often call the DoL to "get back" at an employer.

### 2. Improve employee communication.

Often employee frustrations come from not understanding a benefit program -- or worse, misunderstanding it. Tell clients that if they become aware that employees are frustrated with the plan or there is a lot of behind-the-scenes discussion about it, you must schedule an education meeting as soon as possible to explain plan provisions.

### 3. Promote a "fix the plan – now" mindset.

If the DoL decides to audit a company's 401(k) plan, as shown above it frequently finds something wrong. Many times, plan sponsors were well aware that a certain provision in the plan was a friction point for employees. Or worse, they knew the plan was broken and no one took the time to fix it. Be proactive. As a benefits consultant, encourage your clients to communicate with you regularly. Tell them you always want to tackle trouble spots as a preventive, before any employee calls the DoL.

### 4. Encourage a mock DoL 401(k) audit.

Many 401(k) plan sponsors have found it helpful to conduct a mock audit of their plan. A mock audit can make management more responsive to concerns about addressing a plan issue, especially if it offers evidence to share with them that shows an audit failure.

### 5. Remind clients of the 5500 filing.

The second most frequent cause of a DoL 401(k) audit relates to the annual Form 5500 filing. The most common 5500 errors include failing to file on time, not including all required schedules and failing to answer multiple-part questions. Ensure that your clients' 5500 is filed by a competent provider and that it is filed on time. Most plan sponsors either use their recordkeeper or accountant to file their plan's 5500.

### 6. Counsel promptness with contribution submissions.

Surprisingly, many employers still don't view participant 401(k) contributions as participant money. They are, and the DoL is very interested in ensuring that participant 401(k) contributions are submitted promptly to the trustee. Clients should be very consistent and timely with deposits to the trust. Participants will track how long it takes for their payroll deductions to hit the trust. If they aren't happy with how quickly that happens, they may call the DoL. If clients have forgotten to submit a payroll to the trustee or think they may have been late, have them call their benefits attorney. There are procedures to follow for late contribution submissions.

DoL audits are generally not pleasant. It wouldn't be too strong to say that they are often adversarial. Because these visits are typically generated by employee complaints or Form 5500 errors, auditors go in with a pretty good idea that something is wrong. Consequently, it's smart business to do all you can to help

clients avoid a DoL 401(k) audit. ★

*Robert C. Lawton, AIF, CRPS is the founder and president of Lawton Retirement Plan Consultants, LLC. Lawton is an award-winning 401(k) investment adviser with over 30 years of experience. He has consulted with many Fortune 500 companies, including: Aon Hewitt, Apple, AT&T, First Interstate Bank, Florida Power & Light, General Dynamics,*



*bob@lawtonrpc.com.*

*Houghton Mifflin Harcourt, IBM, John Deere, Mazda Motor Corporation, Northwestern Mutual, Northern Trust Company, Trek Bikes, Tribune Company, Underwriters Labs and many others. Lawton may be contacted at (414) 828-4015 or*

**A**s consumers increasingly move their lives online, and experience good – and bad – service from a multitude of companies, their expectations are naturally rising. This puts the notoriously digital shy insurance industry at an important juncture. Younger entrants to the insurance market probably developed with strong online offerings from the outset, but many older firms continue to stall on this, still reliant on back-end systems that stop them from developing a single customer view or integrating channels. However, the need to change customer communications strategies to include a strong digital focus is growing in urgency in the insurance industry as well as every other industry.

# PRODUCERS MUST ALIGN WITH INSURERS DETERMINED TO MEET CUSTOMERS' DIGITAL EXPECTATIONS

By GIULIANO ALTAMURA



U.S. online sales are forecast to reach \$459.07 billion this year. The online world's share of total retail sales is, in fact, rising every quarter. It's clear that insurers need to learn to fully leverage

this channel and fast. The benefits are clear-cut. Having a detailed view of customer behavior and interactions with an insurer will help brokers make more relevant and informed suggestions that

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also help them increase sales through leveraging potential cross-sell and up-sell opportunities. For the customers, it means better service through more relevant offers and communications.

Technology is there to enable all of this. User friendly and intelligent interfaces are vital for both brokers and direct customers, and with brokers often sharing screens with customers, tools such as scenarios or customization of policies can and should be set up in a way that works for both parties.

And, with consumers increasingly at ease with mobile purchasing and total mobile payments in the U.S. reaching approximately \$8 billion in 2016, insurers also need to ensure familiarity with this channel and how people use it so they continue to meet customer requirements. Consumers spend more time using apps each day than on the mobile web: over three hours compared to 50 minutes, so offering apps and mobile optimized sites should be standard. There is a real cost-efficiency value here for the insurance market too – apps can be particularly useful for delivering add-on services such as support for reporting claims, issuing renewal reminders, and ‘find my nearest’ for any variety of services related to the insurance coverage.

Other digital technologies are also increasingly coming into play. Social media is becoming increasingly important with solutions such as Facebook Messenger allowing conversations to start over social media and then be transferred to the website where the client can access additional information and eventually buy their coverage. In the same way, the use of chatbots is common across many sectors to let potential customers ask questions via the web, and these can also add value in the insurance industry in allowing consumers to talk to a company about cover options before they make an ultimate decision.

Integration of digital channels and technologies is of course vital: how many of us as consumers start the buying process on one channel before completing the purchase on another? Insurance customers are no different. Too often in conversations with clients, brokers have no single view of all the policies that person has taken out, or



of the interactions they have had with them, making it impossible to offer timely and relevant offers, and wasting opportunities for cross- and up-selling.

Albeit slowly, the insurance market is starting to switch to a model that requires this up-to-the-minute overview of the customer to enable it to move from providing single coverage with an annual renewal, to offering an overall insurance service based on consumers’ needs. There is a real need to keep up or risk losing out and, while customer information in back-end systems – often legacy systems – tends to be held in different formats for the use of single, separate departments, it is possible to collect all of this data into one location where it can be used to create a complete single customer view.

There is significant cost and time involved in integrating back-end systems into a single customer view, of course, but creating new modern front-ends and integrating them with the different back-ends holds immense value. It allows far easier collection and pooling of all types of structured and unstructured data from various systems, with the inclusion of an organization’s big data further adding to this to create a unique data repository. Add to this the contribution that artificial intelligence (AI) can both add now and will likely do in the future, and you have some hugely valuable business intelligence tools that can improve strategy and decision making organizationwide.

In a world empowered by big data, AI may for example be able to provide predictive analysis and make suggestions as to which segments of clients insurers should target for a more profitable and lower risk investment, for cross- or up-sell opportunities, or it may be able to automatically respond to specific trigger behaviors by consumers.

Rather than using algorithms to create quotes, for example, underwriters will be able to profile prospects on the basis of particular risks in their area, such as crime and geo-environmental. This will allow insurers to identify where there are lower chances of insurance being claimed on, so enabling them to provide these prospects with offers at very little risk.

Achieving digital innovation even at the more basic level can be challenging, however. This is especially true if a company is relying on current staff to have the right technological skills and counting on there being enough capacity in-house to carry out tasks. This is where working with a third-party consultant can help, not just to map out the process of improving user experience via greater digitalization but to also help implement or indeed outsource the process.

The bottom line is that insurers know they will lose the loyalty of direct customers or of brokers if they are stalling on digitalization. The good news is that we’re seeing more and more insurers understanding the importance of bringing their systems and processes up to speed with the multichannel customer. More insurers are embracing new digitalization-enabled business models. Those are the insurers with which to align yourself. ★



*Giuliano Altamura is the financial services business unit manager for Fincons Group, a company dedicated to assisting clients in IT strategy and design and development of technological and organizational tools. Before joining Fincons Group, Altamura worked at Accenture for almost a decade, gaining a strong foundation in integration architecture, multi-channel architecture and application development. He joined Fincons Group in 2004 and in 2011 took responsibility for the financial services business unit, which focuses on the banking and insurance fields.*

# DentaCoin: IS THIS THE FUTURE OF DENTAL INSURANCE?

By MARIAM NISHANIAN

*Editor's note: This article was contributed by a representative of DentaCoin. It doesn't represent the views of California Broker magazine. We're offering up the article in the interest of keeping readers aware of potential insurance industry disruptors.*

Living in a transaction-based economy, it is not hard to see why some professionals may lose motivation to help their clients receive better care. The problem has persisted the medical industry for decades, especially in North America where two-tier medical systems are struggling to provide preventative care. In the dental industry, the same problem persists: dentists are not motivated to help their clients prevent issues with their teeth unless the client has comprehensive dental insurance. It's not the dentist's fault: that's how the system has been designed. They get paid for work they do, but only if the client has dental insurance, or is willing to pay out of pocket. Isn't there a better way to motivate dentists to provide comprehensive dental care in order to prevent the need for further treatments without having to rely on traditional dental insurance and coverage? Well, there will be soon.

DentaCoin is trying to disrupt the dental industry's feedback and ratings systems; but what's more, DentaCoin has a plan in the works to provide an insurance-like model whereby anyone can gain access to smart contract-based agreements between clients and dentists. This model will place the responsibility of quality dental care on both sides of the industry: dentists will be more likely to provide preventive treatments, which can save the client money in the long run, and the client will be better positioned to follow advice from their dentists because of the contracts in place.

Dentists, like many other profes-



sionals, struggle to find the time and resources to ensure each and every client they see gets the preventative treatment they need to reduce the likelihood of costly procedures in the future. What DentaCoin is planning could blow the whole system wide open because there will be transparent, verifiable records of transactions showing a dentist's history with preventative treatment and this can motivate the dental industry to work harder to provide excellent services to the people who need it. With DentaCoin's transparent and reliable feedback systems, clients can have better access to information regarding their options for dentists and dental treatments; this system will create a need for dental professionals to take a hard look at their practices to ensure they are providing the best care possible for their clients. And with the eventual introduction of an insurance-like model, DentaCoin can provide a full circle experience for clients seeking

dental treatment, preventative measures and more.

When it comes to creating transparency and accountability of the dental industry, there are a number of concerns that arise when surveying the current systems. Even if dentists are taking stock of their own practices, that information never sees the light of day beyond that dental office. With more shared information and more access to that information, clients can make informed decisions about their dental health and overall wellbeing. And with the introduction of insurance-like models to guide the transactions between client and dentist, the industry will shift for the better. ★



*Mariam Nishanian handles communications for Netherlands-based DentaCoin Foundation. She can be reached via email at: [mariam.nishanian@dentacoin.com](mailto:mariam.nishanian@dentacoin.com).*

# MANAGING BENEFITS – TO OUTSOURCE OR NOT TO OUTSOURCE?

By MIKE EHRLE



**S**hould my company outsource benefits administration? You may have clients ask this question. It's a legitimate question to ask when considering ways to streamline your business operations. Human resources departments are often considered overhead, so outsourcing one or more responsibilities in this area can open up that highly valuable department and improve return on investment.

## OUTSOURCING BENEFITS – A DEFINITION

Before weighing in on whether or not a company might outsource benefits administration, let's get a general understanding of what we perceive as outsourcing. When deciding to outsource benefits, a company partners with an outside firm to take on specific human resources responsibilities, such as payroll and/or benefits administration.

The outside firm acts as an extension of the existing HR department, relieving them of these time-consuming responsibilities in order to focus on managing processes, meeting compliance requirements and improving the quality of the employee experience with the company.

**ADVANTAGES OF OUTSOURCING**  
Selecting an outside firm to manage

benefits administration means you're bringing in HR experts willing to share their best practices with employees, ensuring they understand and appreciate their own benefits package. With the right information, employees make more informed decisions regarding benefit options from the start. Not only that, but they're more likely to appreciate the benefits they're able to get, as well as their employer who's providing them.

Additionally, outsourcing a certain set of tasks gives the existing HR department the ability to evolve into a more efficient and effective team, regardless of the resources available to them. They can focus on the tasks best handled internally while making the employee experience their top priority. HR teams already have enough on their plate, and outsourcing provides them with

company to leverage the services offered by the outsourcing firm in the most effective way.

### OUTSOURCING VS. CO-SOURCING

Outsourcing benefits is a rapidly growing and popular option for companies with limited resources that are looking for an efficient and cost-effective solution to managing their benefits. But it isn't the only option. For companies that wish to stay more involved with the benefits administration process, but still need additional help, co-sourcing is worth consideration. Co-sourcing often means the company retains access to review and make changes to existing processes handled by the outsourcing firm, while the firm manages things like benefits enrollment, new

that offer services that can be customized to the needs of a company. When researching firms, companies must ask the right questions. For example:

- What is your benefits strategy today? In the next three years?
- Do you work directly with my employees or solely through my HR department?
- What specific dynamics are most important to you across HR and your organization?

If a company has reached a point where it is considering benefits administration outsourcing, it pays to do the research to find a partner that will not only educate and support employees through the benefits process, but will improve the efficiency of the HR department so that everyone has a high-quality experience as a co-source. ★



the flexibility to turn their focus back to their employees.

### THE TRANSITION

Deciding to utilize a benefits administration outsourcing partner requires an initial period of transition as the outsourcing firm learns about the company and prepares a customized solution based on existing operations. This cooperative period allows the

hire onboarding and data transfers. Co-sourcing also allows for an existing HR employee to become an "internal expert" on the processes managed by the outsourcing firm, handling time-sensitive and high-priority issues directly.

### SELECTING AN OUTSOURCING PARTNER

There are a variety of outsourcing firms



*hodgesmace.com.*

*Mike Ehrle is senior vice president, sales, for Atlanta-based Hodges-Mace. Hodges-Mace we leverage a variety of technology and service options to implement positive changes to a company's delivery of benefits. To learn more, go to [www.hodgesmace.com](http://www.hodgesmace.com).*

**Products**

**Voluntary benefits.** Aflac, a provider of voluntary insurance sales at the worksite in the United States, is enhancing its benefits offerings through the launch of its BenExtend product. As the first release in an evolving life stages coverage line, BenExtend is a group insurance product that combines accident, hospital indemnity and critical illness benefits into one simple plan design. For employers seeking more creative solutions to manage health care costs while also trying to help employees manage out-of-pocket expenses, BenExtend delivers an innovative alternative. According to the Society for Human Resource Management, 84 percent of employers have begun to offer consumer-directed health plans. In 2017, high-deductible health plans (HDHP) range from \$1,300 to \$6,550 in out-of-pocket costs for an individual policyholder and \$2,600 to \$13,000 for a family. BenExtend helps employees mitigate these costs and limit exposure to financial risk. Aflac's initial BenExtend release is available on an employer-paid basis for businesses with 100 or more benefits-eligible employees. To learn more, visit Aflac.com.



**Genomic testing.** Employee Benefit News recently reported that a small Illinois-based law firm has added cancer genomic testing to its benefits package off-cycle. This is one of the very first employers to make the offering. Kelleher & Buckley LLC, a law firm located in the suburbs of Chicago, now offers a cancer genomic profiling program to its 48 employees. Employees receive a certificate for genomic testing through Wamberg Genomic Advisors,

a California-based firm that works with U.S. labs to conduct therapeutic tests. The law firm pays between \$8 and \$15 per employee per month. The cost depends on the age of the employee, who doesn't pay for the benefit. Editor's note: Dr. Phil Smalley, chief medical director for Wamberg Genomic Advisors, has contributed an article to this month's California Broker.

**Events**

**LAAHU Holiday Party** – Dec. 19, Tarzana (change of venue). LAAHU, with support from Health Net, will host a holiday cocktail party at Chablis food +wine in Tarzana Dec 12 from 4:30 pm-7:30 pm. Cost of admission is an unwrapped toy or \$15. Note the new location! Register here: <https://events.r20.constantcontact.com/register/eventReg?oeidk=a07eepkc8ng2d1bfb45&oseq=&c=&ch=>

**LAAHU: Save the date!** LAAHU Annual Conference at LA Convention Center will be April 11th & 12th, 2018. Sponsorship & exhibitor information coming soon.

**IICF Casino Night** – May 17, San Francisco. Join the Insurance Industry Charitable Foundation for a fun night of gambling and insurance industry networking while also raising money for community grants. The event takes place at The Rotunda, Union Square, San Francisco. Registration and sponsorship info available at [IICF.com](http://IICF.com).

**News**

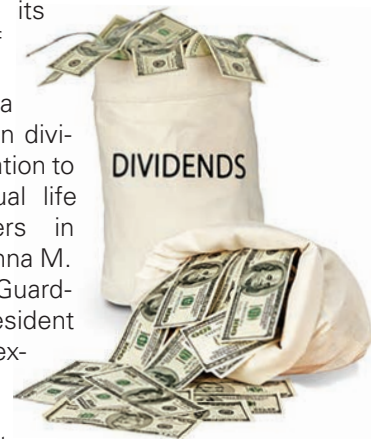
**BIG I'S PREZ LUKEWARM ON TAX CUTS & JOBS ACT**

Amid the House's passage of the Tax Cuts and Jobs Act, Bob Rusbuldt, president and CEO of the Independent Insurance Agents & Brokers of America (IIABA or the Big "I") released a statement saying he was appreciative of the U.S. House of Representatives' effort to grow our economy and create new jobs through a modernized tax code, but the Big 'I' "remains concerned that the bill passed by the House of Representatives today would place a number of Big 'I' member businesses at a competitive disadvantage with

their C Corporation counterparts and would create a new tax disparity between different types of pass-through businesses." Rusbuldt said Big 'I' will continue to work with Congress and interested stakeholders to improve the provisions of the legislation. More info at <https://www.independentagent.com/default.aspx>.

**GUARDIAN MAKES HISTORIC ANNUAL DIVIDEND PAY OUT**

Guardian, one of the nation's largest mutual life insurers and a provider of employee benefits, announced its board of directors approved a \$911 million dividend allocation to its individual life policyholders in 2018. Deanna M. Mulligan, Guardian's president and chief executive officer, said the pay out was the largest annual dividend pay out in the company's history. The dividend interest rate, which is the investment component of the dividend, will remain 5.85 percent in 2018. For more information, visit [www.GuardianLife.com](http://www.GuardianLife.com).



**TEENS ALSO MORE EXPENSIVE TO INSURE**

Kaiser Health News reports that the cost of insuring teenagers will spike in 2018. The price surge stems from a change in federal regulations that allows insurers to recalculate the health risks of children within a family's premium bill. Despite the policy change for kids, they will still be considerably cheaper to cover than their parents. Find the whole story at [www.khn.org](http://www.khn.org).

**SUTTER HEALTH PLUS PLANS EXPAND TO SANTA CRUZ COUNTY**

Not-for-profit HMO Sutter Health Plus announced plans to offer health care coverage to employers and consumers in Santa Cruz County. The health plan will begin its sales and marketing efforts now with coverage effective as

early as Jan. 1, 2018, pending regulatory approval. Once approved, the Sutter Health Plus network in Santa Cruz County will include Palo Alto Medical Foundation and its care centers throughout the county, Sutter Maternity & Surgery Center and Watsonville Community Hospital. Members will also have access to El Camino Hospital in Los Gatos, a Sutter Health Plus participating provider since 2015. The move into Santa Cruz County will mark the third geographic expansion since the health plan's launch in 2014. Today, Sutter Health Plus has grown to serve nearly 70,000 members. Go to [www.sutterhealthplus.org](http://www.sutterhealthplus.org) for more info.

### COMMONWEALTH FUND POST SAYS ACA DEALT A ONE-TWO PUNCH

The Trump administration dealt a one-two punch to the Affordable Care Act's health insurance marketplaces and the Americans who buy their health plans through them, according to The Commonwealth Fund's Sara Collins. In a new To the Point post, she explains that the first blow was an executive order to federal agencies to write new

regulations allowing the sale of insurance that doesn't meet the ACA's consumer protection standards. The second was the administration's decision to end payments to insurers for the ACA's cost-sharing reductions (CSRs). The second punch has the power to be a knockout, Collins says, one that could trigger premium spikes and ultimately a mass exit of insurers from the marketplaces by 2019. Read Collins' entire blog entry on [commonwealthfund.org](http://commonwealthfund.org).

### BEST REPORT: MEDICARE ADVANTAGE SECTOR BALLOONS, MARGINS REMAIN SQUEEZED

A new A.M. Best special report says that net premiums written in the highly competitive Medicare Advantage sector nearly tripled to \$187.5 billion in 2016 from \$69.9 billion in 2007. Double digit growth rates have been the norm for the past decades, reaching as high as 22 percent in 2011 and 20 percent in 2014. The MA market is fairly concentrated, as the top players -- UnitedHealth, Humana and the Kaiser Foundation-- account for 50 percent of

MA enrollment, and the top 10 players account for over two-third of the segment's enrollment. Access the full report at [AMBEST.com](http://AMBEST.com).



### MOODY'S UPGRADES CNA

Moody's Investor Services announced that it had upgraded the CNA Financial Corporation insurance financial strength rating to A2 from A3, with a stable outlook. In addition to the upgrade of CNA's insurance financial strength rating, Moody's affirmed the debt ratings of CNA Financial Corporation. For more information, visit [CNA.com](http://CNA.com).

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**INSURANCE CEOS MAKE HARVARD BUSINESS REVIEW LIST**

Congrats go out to a few insurance industry execs. Aflac’s chief executive officer Daniel P. Amos was named to the Harvard Business Review’s 2017 list of the 100 Best Performing CEOs in the World. Amos makes the list this year at #33. Joining him are Aetna’s Mark Bertolini (#75) and United-Health’s Stephen Hemsley (#78).



**MASSMUTUAL STUDY: AFRICAN AMERICANS WELCOME FINANCIAL GUIDANCE & EDUCATION**

According to a new study by Massachusetts Mutual Life Insurance Co., African Americans are more likely to face greater financial difficulties than other middle-income Americans, including saving for retirement, and would welcome more financial education and guidance through their employers. While 63 percent of middle-income Americans overall say they feel “very” or at least “somewhat” financially secure, only 51 percent of African Americans say the same, according to the Mass Mutual African American Middle American Finances Study. The study, which surveyed 492 African Americans with annual household incomes of between \$35,000 and \$150,000, found that even higher earners expressed financial misgivings: 45 percent of African Americans with annual household incomes of \$75,000 or more say they feel less than financially secure compared to just 28 percent of other Americans in the same income category. Access the study at: <https://www.massmutual.com/-/media/files/mm-2017-african-american-fin-sec-study>

**COLONIAL LIFE RESEARCH SHOWS VALUE OF ENROLLMENT TECH**

Most U.S. businesses still use old school pen and paper to enroll employees in benefits and conduct HR tasks and requirements, but a strong benefits provider who can bring along a trusted technology vendor can help employers save time and money, according to a new white paper released today by Colonial Life. “High-Tech Benefits: A strong carrier can be an invaluable partner during enrollment season – and the rest of the year” uses industry and internal company research to illustrate solutions available to help employers not only survive enrollment season but also to streamline HR responsibilities the rest of the year. The white paper explains the market opportunities available to insurance agents and brokers, the improved enrollment experience technology can provide to workers and the benefits a one-stop shop can give to businesses throughout the year. Access the white paper at [coloniallife.com](http://coloniallife.com).



**DMHC FINES ANTHEM BLUE CROSS \$5 MILLION FOR SYSTEMIC GRIEVANCE SYSTEM VIOLATIONS**

The California Department of Managed Health Care (DMHC) has taken enforcement action including a \$5 million fine against Blue Cross of California (Anthem Blue Cross) for systemic grievance system violations. According to DMHC, Anthem Blue Cross has demonstrated a pattern and practice of failing to identify, timely process and resolve enrollees’ grievances. DMHC says Anthem Blue Cross has also failed to fully and timely provide information to the Department during the

investigation of member complaints. The full complaint can be downloaded here: <http://wpso.dmhc.ca.gov/enfactions/docs/2990/1510765385688.pdf>.

**AFLAC LAUNCHES DUCK CHAT ON FACEBOOK MESSENGER**

Aflac recently announced its latest innovation, DuckChatSM via Facebook Messenger. It’s a new 24/7 platform that will aid consumers in understanding questions that are often asked during benefits enrollment. Aflac says DuckChatSM plays a central role in its campaign to help consumers from feeling overwhelmed and deterred from enrolling in, or applying for, the types and amounts of insurance they may need. To learn more, search for the Aflac Duck on Facebook Messenger or visit [Aflac.com](http://Aflac.com).

**NOW OUT: BEST BRIEF ON TRUMP EXECUTIVE ORDER**

A.M. Best recently published a brief on President Trump’s health care executive order and its directive to consider changes to short-term medical policies, association health plans and health reimbursement accounts. To access a copy of the briefing, titled “President Trump’s Executive Order – More Changes Impacting Health Insurer,” visit [AMBEST.com](http://AMBEST.com).

**IT’S VIDEO FOR THE INSURANCE INDUSTRY**

Embedded video technology provider Vidyo, in collaboration with Efma, an association of 3,300 retail financial services companies in more than 130 countries, recently released its 2017 research study documenting the insurance industry’s turn to video-enabled services. The study polled 84 insurance services professionals from 34 countries. Responses indicate that video has emerged as a critical channel for interacting with customers, delivering advisory services, selling insurance and more. Visit [Vidyo.com](http://Vidyo.com) to access the full report. ★



# NEWS ABOUT EMPLOYEE BENEFITS! 7TH CIRCUIT AND THE ADA – LET’S KEEP IT IN PERSPECTIVE

By TERRI L. RHODES

In 1997, the EEOC filed suit alleging that Sears Roebuck & Co. discriminated against a salesperson by refusing to provide her with a reasonable accommodation under the Americans with Disabilities Act (ADA). After Sears's refusal to accommodate her, the employee gave up her job. The EEOC alleged that Sears "maintained an inflexible worker's compensation one-year leave policy which does not provide for reasonable accommodation of employees with disabilities."

The U.S. District Court for the Northern District of Illinois ruled in favor of Sears. The EEOC appealed, the 7th Circuit Court of Appeals decided there was enough evidence for a jury trial and sent the case back to the District Court. In 2010, the case (*EEOC & Keane v. Sears Roebuck & Company*) settled for \$6.2 million.

With the 7th Circuit's focus on "inflexible" leave policies, the case was generally interpreted as a victory for the EEOC's position that long-term leaves of absence may be a reasonable accommodation. It is what appears to have led EEOC Commissioner Chai Feldblum to refer to the ADA as an "inadvertent leave law."

Fast forward to September 2017. In *Severson v. Heartland Woodcraft, Inc.* <<http://www.lawandtheworkplace.com/files/2017/09/Severson.pdf>> the 7th Circuit affirmed a district court's ruling that an employer did not violate the ADA by failing to provide an employee with a long-term medical leave of absence.

The plaintiff, a former employee of Heartland Woodcraft, developed chronic back problems and became unable to work. After exhausting his Family and Medical Leave Act (FMLA) leave, he informed Heartland that he needed surgery, which would require him to be out of work for two to three additional months. Heartland told him his employment would terminate at the end of his FMLA leave, and he could reapply when he was able to return to work. Af-



ter recovering from surgery and being cleared to return to work, the former employee didn't reapply. He instead sued, alleging that Heartland failed to reasonably accommodate him under the ADA. The district court granted summary judgment in favor of Heartland, and the plaintiff appealed.

This time, the 7th Circuit affirmed the district court's ruling. As notable as the ruling itself is some of the language in it. The court stated that "a long-term leave of absence cannot be a reasonable accommodation" under the ADA. In *Heartland*, "long-term" was defined as multi-month. The court took issue with the EEOC's position that the length of the leave is irrelevant in determining the reasonableness of the accommodation, concluding that this would transform the ADA "into a medical-leave statute—in effect, an open-ended extension of the FMLA."

The 7th Circuit bluntly stated: "The ADA is an antidiscrimination statute, not a medical-leave entitlement." So much for the "inadvertent leave law?" Not necessarily. While the 7th Circuit's different ruling could indicate a more widespread judicial approach, it also may not. The 7th Circuit is a single court. Circuit courts in other jurisdictions have reached differing conclusions on this issue. In addition, the EEOC continues to take the position that leaves of absence may constitute reasonable accommodation in certain circumstances. Which means that

employers could still face EEOC suits over "inflexible" leave policies.

Most important, it's not clear that the 7th Circuit's ruling would stand up to challenge. A multi-month leave might be reasonable or it might not be reasonable. It all depends on the relevant facts in a given situation. The court offers no statutory citation for its conclusion. Nor does it offer any real guidance for employers on what length of leave is reasonable. One month? Forty days? It's left open to interpretation.

There is a real risk that employers could see more in this ruling than is there. But what can employers do to reduce the risk of an employee or EEOC action on an "inflexible" leave law?

- Wait for additional court rulings. Since the 7th Circuit case is a single ruling and provides no concrete guidance, it would increase risk to incorporate it into absence and disability management processes. HR should not jump to conclusions about maximum absences to accommodate employees under the ADA. The EEOC has certainly made it clear it has not jumped to those conclusions. It would not be unusual for it to locate a case to try to obtain a different ruling or, at the very least, clarify what length of time does constitute a reasonable accommodation.
- Focus on individual employees. The ADA requires an individualized (case-by-case) assessment to evaluate whether a particular form of accommodation would be reasonable for an employer to provide to a particular employee. This assessment takes into account the job in question, the facts relevant to the employer, and the facts relevant to the employee. Adopting a blanket bar on multi-month leaves is not the kind of individualized assessment understood to be required by the ADA. Engaging an employee in the interactive process does not obligate the employer to provide the requested

accommodation (such as a multi-month leave extension). The best practice is to engage in the interactive process and determine whether it is or is not reasonable to grant the requested accommodation or some other form of accommodation. It is critical that the interactive process is well documented.

- Seek out peer guidance. Leave laws are increasingly complex. The interaction among them, as with the FMLA and ADA in the Heartland case, makes them that much more so. Many employers have invested time and resources in developing and implementing best practices.

As it's in all employers' interests to minimize employee recourse to the legal system, these employers are happy to share what they've learned with others. Encourage HR and other leaders to avail themselves of the conferences, workshops, webinars, and other resources available to keep up with the ever-changing leave landscape. In today's environment, continuous learning is essential for effective risk management in leave, absence, and disability. Leave policies intended to accommodate employees' legitimate needs can become a source of risk and unnecessary cost. That can be avoided

through caution, an appropriate focus on individual circumstances and seeking out and learning best practices. The EEOC doesn't view the 7th Circuit's recent ruling as the final word on reasonable accommodation under the ADA.

Neither should employers and all those with an interest in risk reduction. ★

*Terri L. Rhodes is CEO of the Disability Management Employer Coalition (DMEC). Terri was an absence and disability consultant for Mercer, and also served as director of absence and disability for Health Net and corporate IDM program manager for Abbott Laboratories.*

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