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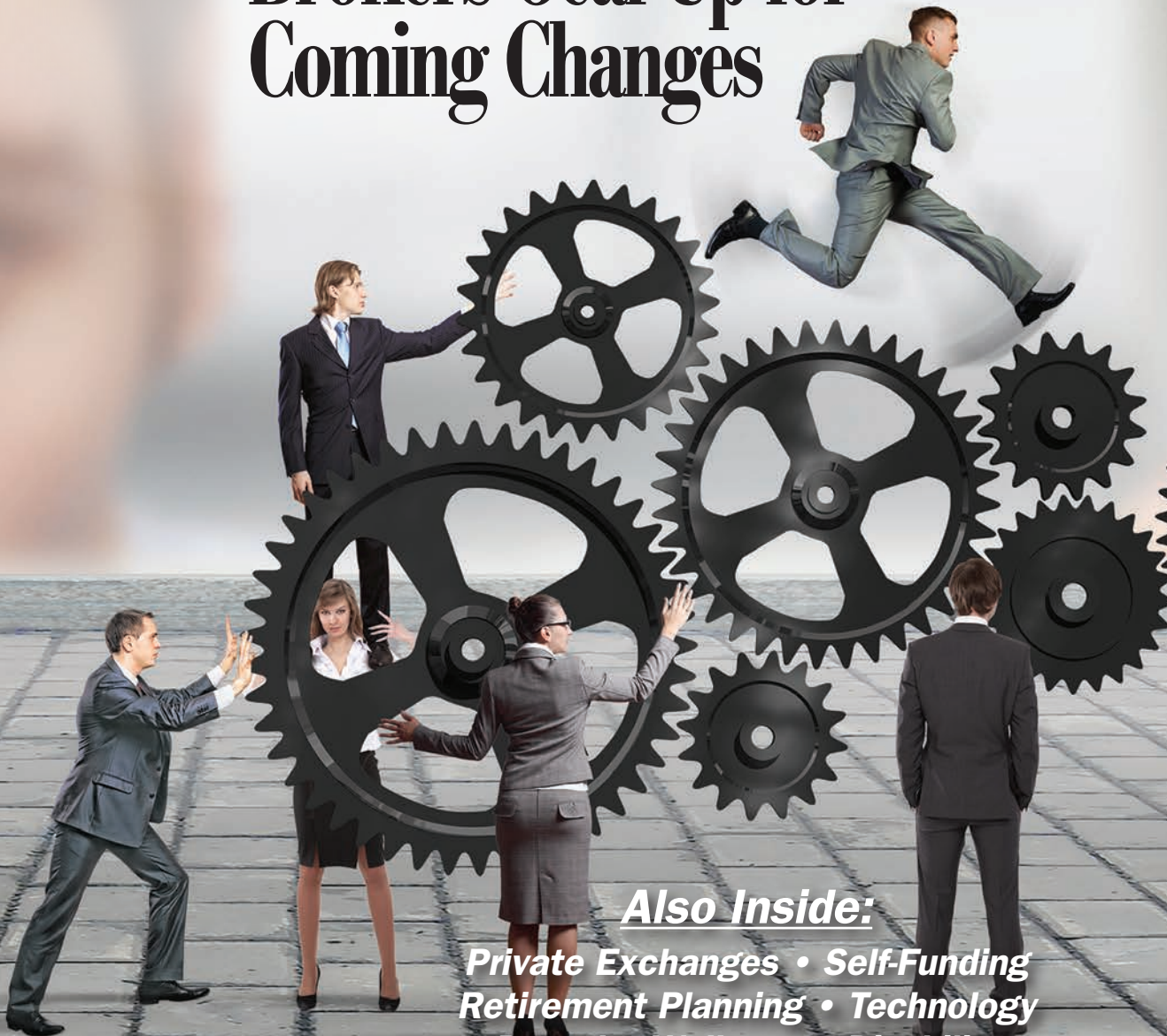
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SERVING CALIFORNIA'S LIFE/HEALTH PROFESSIONALS & FINANCIAL PLANNERS

FEBRUARY 2017

**NEW  
FEATURE:**  
Letter From the Editor P. 6

## Top GAs Help Brokers Gear Up for Coming Changes



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# 'I Feel Fine'

James Rodale was the founder of a publishing company dedicated to health and wellness. He was taping his appearance on the Dick Cavett Show in front of a live audience. The 72-year-old man told his host that he had never felt better and planned to live to 100. In fact, he felt so good that he had just fallen down a flight of stairs and laughed all the way. Then he gasped and he could not be awoken. "Is there a doctor in the audience?" Cavett asked. Alas, Mr. Rodale had just told his last joke.

I remembered that as I read this month's excellent article by John Denery of Stephens Insurance. He explains that the medical director of his company had warned three patients to take better care of themselves. "I feel fine," each one protested. Then died a short time later. Check out "Famous Last Words: 'I Feel Fine'" on Page 34.

This month's *California Broker Magazine* also features two great reads on what could be an evolution in the marketplace – the growth of private exchanges. Check out "The Future of Employee Benefits Is Now," Page 26 and "Failure to Launch," Page 28.

And Maxwell J. Schmitz's article, "How to Talk About Disability With Business Owners," on educating entrepreneurs of the need for them to carry disability insurance on themselves gives some great tips. See Page 14.

You'll also get a real kick in the pants out of Art Fries and his funny stories about wacky exams designed to deny clients their disability benefits. How about a prostate check to see about that neck injury? No thank you, kind sir. "Look for the 'Wow' Factors to Discover Problems With a Disability Exam" on Page 11.

\* \* \*

But now let's talk about my least favorite subject – me; and your least favorite subject – the Affordable Care Act.

It's an exciting time for me to join *California Broker Magazine*. The health insurance industry is going through a major upheaval as I type this and we now have the good for-

publisher Guest Informant, then at the *Los Angeles Business Journal*. I hope to bring everything I learned during those years to *California Broker* in order to best serve our community.

First, and most important, we want more of your news in our magazine, on our website and our forthcoming social media. Please email me with your hirings, promotions, awards, milestones and new contracts: We all know how inboxes overflow, so please put "Attn: Newsletter" in the subject line so I don't lose it. Oh, yes, one other thing to email me: Funny stories about your work with clients. This month *California Broker* is having a contest: Send your best funny client story to [editor@calbrokermag.com](mailto:editor@calbrokermag.com), with "Funny Client Story" in the subject line. Top funny stories will win valuable prizes.

\* \* \*

Back to Rodale for a moment. When Cavett's friend Katharine Hepburn heard that one of his guests died during a taping, she demanded that he come to her place and tell her the story.

Although Kate knew the answer, she wanted to know if he did, so she asked him: "Why didn't you say, 'Is there a doctor

in the house?'" Then she told him: "You knew it would get a laugh, didn't you?"

Cavett watched his word choice because he didn't want his audience laughing while there was a dead man on his couch. Pretty smart, huh? May we all aspire to and achieve such excellence. ★

Steve Silkin  
[editor@calbrokermag.com](mailto:editor@calbrokermag.com)



tune to track it for you. We will be providing updates via our website, our weekly email Insurance Insider News, our print and online magazine publication and our nascent social media platforms. It's going to be a great year and all of us at *California Broker* are confident that your fortunes will improve under the changes to come.

I started my career in journalism at the *International Herald Tribune* in Paris, returned to California where I grew up and worked at newspapers in Ventura County, then travel guide

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# THE BIG QUESTION OF REPEAL AND REPLACE: Will Obamacare Become TBD Care?

By ALAN KATZ

**T**here's politics then there's governing. As former New York Governor Mario Cuomo put it, "You campaign in poetry. You govern in prose." Republicans have been campaigning against the Affordable Care Act since its enactment with rhetorical flourishes along the lines of "repeal and replace" and "end Obamacare on Day One." That is poetry (or at least what passes for poetry in politics). Now Republicans will need to prove they can handle the prose part. That won't be easy.

Repealing the law outright would cause chaos in the health insurance marketplace and take medical coverage away from millions of consumers. However, doing nothing would break a promise central to the GOP's electoral successes in the past four congressional elections, not to mention the most recent presidential campaign. Either path could lead to voter retribution that would be devastating to the short- and long-term interests of the Republican Party.

A GOP strategy may be emerging that aims to avoid this rock and that hard place. The idea involves passing repeal legislation as close to President Trump's first day in office that is legislatively possible, but delaying the effective date of that legislation by a year or two. This enables Republicans to keep their promise to repeal Obamacare "on day one," yet gives

them time for the more difficult task of working out a replacement to the ACA. It's a political two-step Joanne Kenen has dubbed "TBDCare."

## WINNERS AND LOSERS

Yes, this would cast a dark cloud over the health insurance market for some considerable time and raises a host of questions: Is Congress capable of passing workable and meaningful health care reform? What happens if it doesn't? What would those reforms look like? Who would the winners and losers be under Republican-style reform? Not knowing the answers to these questions is terrifying. For GOP leaders trying to avoid the wrath of voters, however, living under a frightening dark cloud for a couple of years might look better than ushering in the health care reform apocalypse.

The repeal part of this two-step strategy is simple: Republicans in Congress eviscerate the financial mechanisms critical to the ACA through the budget reconciliation process. This type of bill requires only 51 votes, which means no Democratic support is needed. Meanwhile, President Trump dismantles other elements of the law by either revoking President Barack Obama's executive orders or issuing new ones. Both the legislation and executive orders become effective at the end of either 2017 or 2018 to allow for a "smooth transition."

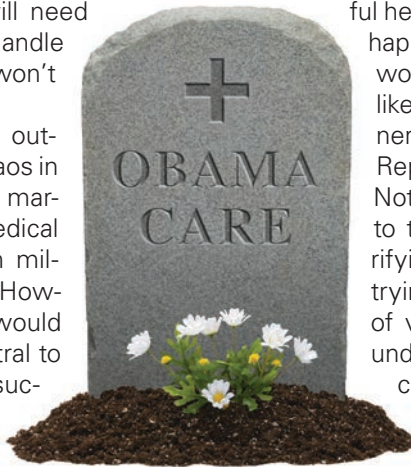
Then the "replace" portion of the program would begin. Much of any new health care reform legislation would need to go through the normal legislative process and be completed before the effective date of the repeal. Given the Senate's filibuster rules this means securing at least eight Democratic votes in the upper chamber. Meanwhile, opposition to TBDCare is already building.

## REDUCING COSTS IS KEY

What should not be overlooked in all this pain aversion is that the Affordable Care Act was neither the cause nor the solution to America's deep-seated health care problems. Long before Senator Obama became President Obama everyone knew the key to successful health care reform was reducing medical costs. A few provisions in the Affordable Care Act address costs, but the legislation focused primarily on health insurance reforms because, well, reforming the health insurance market is a lot easier than reducing health care costs. If you were a politician, who would you rather take on, insurance companies or doctors, hospitals and pharmacy companies?

Whether using poetry or prose then, it would be nice if, once they get past the politics of health care reform, Congress and the new administration addressed the substance of health care reform. Let's hope that's not asking too much. ★

*Alan Katz is a consultant specializing in health insurance. His firm, the Alan Katz Group, helps carriers and agencies develop sales and business strategies. [www.alankatzgroup.com](http://www.alankatzgroup.com).*





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		ICC13 MYGA (Guarantee 7) (Q/NQ)	S	2.70%*	7 yr.	None	9%, 8, 7, 6, 5, 4, 3, 0	Yes	\$10,000 (Q) & \$10,000 (NQ)	3.00%, age 0-75 & 2.10%, age 76-80** 1.50% age 81-85**
*Effective 1/9/17. 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	2.40%** 2.60%**	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 11/28/16. 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	1.60%** 1.80%**	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 12/19/16. Includes 2.00% 1st year bonus, 1.00% base rate subsequent years. a (less than \$100K) b (100K or more)										
American General Life Insurance Companies	A A+	A+ American Pathway Fixed 7 Annuity (*Guarantee Return of Premium) (Q/NQ)	S	2.10%** 2.30%**	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 12/19/16. 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	2.25%	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)
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Great American Life	A A+	A+ SecureGain 7 (Q/NQ)	S	2.55%	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)
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Great American Life	A A+	A+ Secure American (Q/NQ)	S	1.65%*	1 yr.	N/A	9%, 8, 7, 6, 5, 4, 3	No	\$10,000	5.75% 0-70 4.65% 71-80 4.40% 81-89
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The Lincoln Insurance Company	A+ AA	AA MYGuarantee Plus 5	S	1.80%** 1.95%**	5 yr.	None	7%, 7, 6, 5, 4, 0	Yes	\$10,000 (Q/NQ)	
*Rates Effective 11/22/16 (a-for premiums less than \$100K, b-for premiums \$100K or more), and are subject to change										
The Lincoln Insurance Company	A+ AA	AA MYGuarantee Plus 6	S	1.90%** 2.05%**	6 yr.	None	7%, 7, 6, 5, 4, 0	Yes	\$10,000 (Q/NQ)	
*Rates Effective 11/22/16 (a-for premiums less than \$100K, b-for premiums \$100K or more), and are subject to change										
The Lincoln Insurance Company	A+ AA	AA MYGuarantee Plus 7	S	2.00%** 2.15%**	7 yr.	None	7%, 7, 6, 5, 4, 3, 2, 0	Yes	\$10,000 (Q/NQ)	
*Rates Effective 11/22/16 (a-for premiums less than \$100K, b-for premiums \$100K or more), and are subject to change										
The Lincoln Insurance Company	A+ AA	AA MYGuarantee Plus 8	S	2.10%** 2.25%**	8 yr.	None	7%, 7, 6, 5, 4, 0	Yes	\$10,000 (Q/NQ)	
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North American Co. for Life and Health	A+ AA- A+	A+ Gaurantee Choice (Q/NQ)	S	2.45%** 2.70%**	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)
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*Effective 12/2/16. Includes 1.50% 1st yr. bonus. Min. guarantee is 1.00%. **Reduced 20% ages 76-80, and 40% ages 81-85										
Reliance Standard	A+	A Apollo MVA (Q/NQ)	S	4.45%*	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 12/2/16										
Symetra Life, Inc.	A A	A Custom 7 (Q/NQ)	S	3.20%*	7 yrs.	N/A	8%, 8, 7, 7, 6, 5, 4, 0	No	\$10,000	Varies
*Effective 1/3/17. 2.70% base rate with no guaranteed return of purchase payments. Plus 0.50% bonus for \$250,000 and above.										



# Look for the 'Wow' Factors to Discover Problems With a Disability Exam

By ART FRIES

**F**or those of you not familiar with disability insurance claims, an I.M.E. is the abbreviation for Independent Medical Examination. One of the tools that insurance company claim departments use to try to get a better picture of the claimant is to have them examined by a physician with an expertise in a particular area. This could involve an exam by an orthopedic physician or a psychiatrist or any one of a number of specialists who can offer an opinion on the claimant's medical symptoms.

That examiner might be fair and objective or have a bias in favor of the insurance company or they may even have an agenda that goes well beyond that of the I.M.E. Following are three "war stories." Each one includes a "wow" factor.

The first: My client, an orthopedic surgeon, had a pending claim for cervical issues. An I.M.E. was set up with an orthopedic surgeon hired by the insurance company. Upon entering the office for his scheduled appointment,





my client noticed that all employees were male and all were wearing jewelry on visible parts of their bodies (ears, tongues, etc.). I always tell my clients to observe the office atmosphere, and this was an interesting observation.

In the exam room, the physician proceeded to close the door and then put a latex glove on his right hand. My client then asked the doctor what he was planning to do and the response was, "I'm going to do a rectal exam."

My client asked, "What does a rectal exam have to do with my cervical issues?"

"We do a rectal exam on everyone who comes into this office."

A definite "wow" factor. At that point my client indicated that he wasn't going to subject himself to this invasive type of exam. The examining doctor said, "That's OK, it's voluntary on your part."

Since a request for a rectal exam did not seem very professional in this particular scenario, I had my client send a letter to the insurance company indicating as such, and that of course damaged the credibility of the examining doctor in challenging the denial of benefits.

The second: In this claim my client suffered from major depression. An I.M.E. was scheduled with a psychia-

trist who happened to be the president of his state psychiatric association. That sounded like a pretty good credential.

But I always recommend that my clients do an Internet search on the examining doctor to see if we can find any "wow" factor. After some reading my client called me and said he found a "wow." He referred me to doctor's the web site. It was clear to me after reading the material on the site that this doctor performed a lot of Q.M.E.'s – Qualified Medical Evaluations – which are common in worker compensation cases and are forerunners to an I.M.E. From information shown on the website it appeared that the psychiatrist did not even have any personal patients. Here is the "wow." A statement on the website said the following: "If you are coming into my office for a Q.M.E. I know that you are a liar so don't lie." After telling my client how to secure a copy of the I.M.E. and having a copy sent to me, we were of the opinion it was a boilerplate report provided to the insurance company by the psychiatrist that was a piece of crapolla, and once we advised the insurance company of the stupid statement on the examiner's website, his credibility was destroyed.

The third: My client in this last case

was an injured practicing oral surgeon, a D.D.S., and also an M.D. An I.M.E. was set up by the insurance company. A subsequent e-mail to me by the client describes the exam:

"The doctor listened to all my complaints but may not have heard what I said, since he seems to be a little scatter brained. He kept asking his assistant what he needed and said, 'She does everything but I get the credit, and if she retires then I will too.'" He did a perfunctory physical. He did not look at the MRIs or the radiographs that I brought with me and said he did not need these. He seemed to be intrigued by my degrees and education. I left the office but returned to get copies of the paperwork I had filled out and I heard him say from the back room (without him knowing I was there). 'I never examined someone who knows more than me'...and laughed out loud."

The wow factor can certainly help you to challenge the results of an I.M.E. or Q.M.E. that became a justification for a denial of benefits. ★

*Art Fries is a disability claim consultant in Nipomo, Calif., with a national client base. For more information, visit [www.wafries.com](http://www.wafries.com), email [friesart@hotmail.com](mailto:friesart@hotmail.com) or call 800-567-1911.*

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# HELP YOUR ENTREPRENEUR CLIENTS: How to Talk About Coverage With Business Owners

By MAXWELL J. SCHMITZ

**T**here are some people out there who love to work, and there are others who live to work. If you are reading this at the dinner table or during your “off-hours” then you may be one of the live-to-work ilk. And there is nothing wrong with that.

I enjoy asking business owners what they love more – their business or their family. Then watch them think about it. Some entrepreneurs even describe their business as their “baby” because they have seen it grow from an idea to a living, breathing, adaptable being. Their business is their passion, purpose, and pride in life.

Business owners feel tied to the company they have built and therefore want to meet professional obligations before they can take care of their other issues.

When a business is the source of happiness, pride, purpose for a client or prospect, it is imperative to insure the financial security of the company against the risk of illness or injury – the most common cause of bankruptcy.

Below I’ve outlined four key points that our top disability advisors have used to start the conversation about disability planning.

## MAKE IT IMPORTANT.

There are many factors that can affect a company’s success or failure. Don’t miss the opportunity to ask your client to identify those risk factors and what is truly at stake. It’s a fun exercise. Many external forces will come to mind – politics (particularly relevant right now), the economy, rising costs, etc. However, the success of any business is predicated on the performance of its leadership.

Ask the business owner to identify what risk factors could potentially threaten his effectiveness as a leader.

If the client does not mention it first, then don’t be afraid to ask about his health or the health of his employees.

If the client’s health is cavalierly cast aside as a non-issue, then you know you have an open door on underwriting. Try responding with, “I’m so glad to hear that. If everyone is healthy then that means this is the perfect time to take action and ensure that health will never be a problem for your business. Let’s set something up that keeps the business afloat if you or a key employee needs to step away.”

The importance of continued health cannot be ignored, nor should it be taken for granted. This is something out of your control, out of the client’s control, and out of the company’s control. No one chooses when or how an injury or illness occurs. That is the whole point behind DI, and it must be conveyed.

One final best-practice to develop the importance of this coverage is to speak in terms of aggregate benefits as opposed to monthly benefits with annual premiums. Monthly disability benefits can sound like peanuts especially when sold alongside life insurance. An adviser may sell a \$1 million 30-year term life policy along with a \$10,000 DI benefit to a 30-year-old. Both cost \$150 per month. What’s the better deal?

Most people will try to do the math when put on the spot. Some might even say the life coverage at first glance. Realistically the DI has far greater potential benefit and a higher likelihood to be used during working years compared with term life insurance. So next time you are working on a \$10,000 per month DI case try selling \$4.2 million of potential benefit for the exact same price.

There are several exciting develop-

ments in the world of DI. Most of these updates make things infinitely easier for brokers and clients alike.

While these new solutions and advances might be endlessly fascinating to you (as they are to me!), your client might feel rather differently about DI in general.

Make a point to identify their interests by asking the business owner to rank the following list of concerns.

- I want to be financially secure if I become disabled.
- I want my company to be financially secure if I become disabled.
- I want my company to be financially secure if my business partner becomes disabled.
- I want my company to be financially secure if my key employee becomes disabled.
- I want my key employees to be financially secure if they become disabled.
- I want all my employees to be financially secure if they become disabled.
- I want to be financially secure if my business partner can no longer make the payments to purchase the business from me.

Here’s what to discuss in greater detail based on the list above: Individual Disability Insurance; Business Overhead Expense; Disability Buy/Sell; Key Person DI; Guarantee Standard Issue; Group Long-Term Disability; Loan Indemnity DI

## MAKE IT EQUITABLE.

Business owners bear a burden that their employees do not. An employee is guaranteed base wages per the terms of his employment contract. Most business owners don’t have the same luxury. A business owner’s compensation is the last thing in a long line of other financial obligations. Employee benefits such as workers’ comp and

group disability may be included on the list of regular monthly expenses.

Most entrepreneurs are simply unaware that there is a way to secure their income in the event of illness or injury. Typically, owners will exclude themselves from worker's comp because the premiums are too expensive for the low likelihood of the owner incurring an injury at work. A savvy insurance broker may find that individual DI policy has a comparable premium to a workers' comp policy, but it is important to highlight that individual DI covers the owner around the clock, at work and at home, for both injuries and illnesses. Owners would be smart to consider their DI options in lieu of a workers' comp plan.

Some business owners will understand the importance of having a group long-term disability plan for recruitment and retention of their best and brightest employees. Most of these plans will cover the management team, to include the owner. However, many plans are bought and sold as a commodity on a spreadsheet. That means these group plans can leave the higher income earners with significant holes in their disability coverage. An owner making \$10,000 per month will suddenly have to find a way to live on \$5,000 per month, which may be fully taxable as income. A commodity plan like this can leave a business owner with less than one third of his or her gross income, resulting in significant hardship. The employees effectively have a better disability contingency plan than the decision-maker. Help your business owners make their plans more equitable with supplemental individual DI policies.

#### **MAKE IT EASY.**

Guarantee Standard Issue (GSI) is the best thing to happen to the Individual DI market since the reassessment of the doctor market. The occupations that are best for this: attorneys, architects, CPA firms, pharmacists, programmers, scientists, small-animal vets, tech employees, and any executive groups you encounter. All it takes is five lives and an employer who is willing to pay a little more to protect their top employees. Incomes should be over \$100,000 and a group

long-term disability plan should be in-force on the first \$3,000-\$5,000 per month. Carriers have been very bullish in this market segment as they all scramble to compete for market share. These are individual policies issued on a group basis. Qualification is guaranteed as long as each employee has worked continuously for the past 180 days preceding the application date. Big discounts may be available as well.

If five lives and employer-paid funding is too difficult, or the occupations are medical or more hands-on in nature, then we may still be able to issue with massive multi-life discounts. These discounts can be as high as 25 percent and issued on a gender-neutral basis. That means women (who are priced to pay higher premiums) can walk away with a discount as large as 40 percent. That is nearly a two-for-one rate for some professionals.

Also, simplified underwriting is back in a big way. Your client can avoid financial documentation and medical exams as long as the applicant applies for \$6,000 per month or less and is under 45. Combine this with an e-application TeleApp and you can process a simple application. These simplified plans can also be sold with \$4,000 per month in future increase options, meaning the client can secure up to \$10,000 per month without ever doing a blood draw. This is the wheelhouse for sole proprietors who are too busy to return calls. Send a simplified quote with every inquiry.

DI is an exciting avenue with strong renewals. You can build a practice for the long-haul on the back of your DI business. Whether you are on the doorstep of retirement, thinking about a comfortable stream of income to carry you through, or you are a young producer, the renewal compensation from DI is unlike the life insurance world of the one-and-done commission transaction. The service work is about the same. Keep your options open by staying vigilant when you are working with business owners. And remember, most people don't buy DI because they don't know how to ask. Help them bridge that gap! ★

*Maxwell J. Schmitz is brokerage manager at DI & LTC Insurance Services in San Rafael, Calif.*



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# Top GAs Help Brokers Gear Up for Coming Changes

**T**he Affordable Care Act was the most in-your-face piece of legislation in decades, and it had produced a tectonic shift under the insurance broker industry – with devastating consequences. As soon as Donald Trump was elected and Republicans gained control of Congress, the repeal movement was ready for takeoff. So California Broker Magazine asked insurance executives how to be prepared for the next step in the process – whether that becomes “repeal and replace” or simply “repeal” – and how to face the opportunities and challenges of today’s climate.



## **Participating in the conversation:**

**Michael Wolff,**  
President, Dickerson  
Employee Benefits

**David L. Fear Sr.,**  
Shepler & Fear  
General Agency

**Hadley Weiler,**  
Executive Director  
of Sales, LISI

## **HOW SHOULD AGENTS PREPARE FOR CHANGES TO THE HEALTH INSURANCE MARKET?**

**Michael Wolf:** “Keep Calm and Carry On” comes to mind. The ACA is still the law of the land. Accordingly, we all must adhere to the stipulations of the law with all the penalties and compliance requirements. The avalanche of announcements and speculations about the future of the legislative environment may be very confusing. It is therefore very important to distinguish between facts, opinions and predictions.

It is highly advisable to stay informed and rely on trustworthy resources from our trade associations, as well as carriers and General Agencies.

Because of this confusing transition period, your clients need

your advice about their health care coverage more than ever. It is a good idea to communicate with them frequently about the news they are exposed to and that may make them insecure about their existing coverage.

As we learned from our experience with the ACA legislation, many provisions of the new law may be phased in, delayed or challenged by courts. Significant changes may be delayed beyond 2017 and may be implemented in subsequent years.

**David L. Fear:** Agents will need to prepare for new rules and regulations coming out from the federal government. Keep your clients posted on the inside information you obtain and don't rely on cable TV networks to predict how the ACA will change any better than they predicted the outcome of the last election. The National Association of Health Underwriters is non-partisan and that point of view will be very valuable over the upcoming six to 12





months. Visit the NAHU website and listen in on the update that Chief Executive Janet Trautwein has provided recently. Her insight has proven to be valuable and I trust that it will continue to be very accurate.

I think the next thing an agent should do is register to attend this year's NAHU Capitol Conference in February because I expect that we'll be hearing directly from Congress and the administration about where things are going at that point in time. This may be the most important Capitol Conference ever held given the results of the election.

**Hadley Weiler:** We all have been preparing since the days we studied for the license exam. It should be in our very nature to prepare for that prospect, for that meeting, for that RFP, for that sale, for that question, for that renewal, for that change and for that new law. We are consistently hit from every angle. We wouldn't be in this business if we didn't wear that badge daily. Some are more prepared than others. Preparation can work in levels or degrees. You need to decide what degree you exist in and then grow your circle of influence to expand your degree. What we need to remind ourselves is that change takes place every year. It's the reaction to the change that defines who we are and how we succeed.

#### **ARE THERE OTHER MARKET TRENDS TO CONSIDER?**

**David L. Fear:** One trend that concerns me are proposals to get employers out of the loop in regard to providing health benefits for their employees. For years the far right has promoted eliminating employer-based coverage and simply allowing individuals to buy coverage for themselves. Congress wants to make reimbursement of individual plans legal again for small employers. While the National Federation of Independent Business was a big proponent of this, I couldn't disagree more with them about where this may lead. It's true that many small employers have a tough time making participation requirements in the group health arena. And one solution is to simply allow employees to buy their own coverage and the employer can reimburse them for that.

But the effect of this may be to have small employers completely abandon group health benefits. That would be very bad for our system, given the adverse selection that is rampant in the individual market but greatly tempered by employer group offerings. This trend towards individual coverage concerns me and should concern all agents who sell group health coverage. Frankly, the employer based system has created stability in the mar-

ket and trashing it would continue to make a greater mess out of the private health insurance system.

One other thought: Just because something changes in Washington, D.C. doesn't mean that it will change in California. We seem to dance to our own music out here and if given the opportunity, I think California will ask for block funding and say we will do it our way, similar to what we've done with Medi-Cal and more recently, Covered California.

**Michael Wolff:** The technology advances in our industry continue to have a big impact on how quickly and efficiently we can serve our clients. This is especially important considering the downward pressure on agent commissions. Electronic enrollment, employee management software, quoting technology and presentation techniques are only some categories that are being improved at a rapid speed. To stay competitive, agents need to make informed decisions about using these tools. Our company has done extensive research on many platforms and continues to invest in these tools on behalf of its agents. Our employees are always available to be a technology resource and to consult with agents.

Coinciding with our industry's tech surge, the emergence of millennial workers as a stronger workplace in-



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fluence will continue to shape digital tools to enroll, organize and maintain workforce data and benefits management.

Also, the 21st Century Cures Act was signed into law by the outgoing President on Dec. 13. It provides a legal way for small employers to reimburse their employees for premiums paid for individual healthcare coverage on a pre-tax basis. This law may have a big impact on how small group coverage is presented or renewed. As part of their due diligence, group agents now should point out that the employer has the choice between a group health plan with all its advantages and a Health Reimbursement Arrangement that allows the reimbursements of premiums on a pretax basis for individual plans, purchased by the employees.

Some small group health plans may dissolve and take advantage of the new regulation that allows reimbursement of individual premiums on a pretax basis. Group agents therefore need to educate themselves on how to move employees to individual plans in an efficient manner.

**Hadley Weiler:** Any changes under the new administration could have an impact on market trends and enhance the role we play with our clients. While there are still a lot of unknowns, one consistent fact remains certain: our

value. The value we play as educators, mediators and leaders has not changed. It's our duty to our clients, to the industry and to ourselves to keep driving for excellence and consistently staying ahead of all the curves out there.

#### HOW CAN AGENTS INCREASE SALES IN THIS CLIMATE?

**Hadley Weiler:** Many will grow organically from within; many will grow by acquisition and many will grow by merger. This year will bring all of that and much more. Decide now where you want to go and who can assist you in order to get there, then go! As agents of today, be aware of the landscape and don't let opportunities to grow pass you by.

**David L. Fear:** Continue to act as trusted advisers to their clients, not just sell them products. Look beyond the traditional and consider alternative products such as self-funded medical, HRAs and voluntary ancillary benefits. Work closely with property and casualty and life insurance agents and agencies to assist them in advising their clients with regard to employee benefits and compliance issues. Take advantage of industry opportunities to network with other agents and new carriers bringing new products to the

market. Learn about supplemental benefits and how they work.

**Michael Wolff:** As we have seen with the ACA, the agents that stayed on top of the legislative changes and compliance requirements gained market share. In addition to major medical coverage, it is important to present products that help with out-of-pocket exposure in a high deductible health plan – for example, critical illness and accident policies. Ancillary products such as dental, vision, life and disability insurance remain important coverage products for clients and provide an additional revenue stream. Workers' compensation coverage presents an opportunity for life and health agents to partner with a property and casualty agent and provide clients with a comprehensive, competitive package. Dickerson has assisted agents with each of these coverage types and continues to do so through its partnerships with leading carriers.

Access to one or more broker-friendly payroll companies that offer a comprehensive software solution for employee management – onboarding, time and attendance, and document management – can also add to an agent's bottom line. ★

*Compiled by Steve Silkin, managing editor, California Broker Magazine.*

Demanding clients?  
Increasing competition?  
Narrowing networks?  
Really bad hair day?

# We can solve all (but one) of these problems!

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

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

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## BOOSTING EMPLOYEE ENGAGEMENT

# Helping Clients Get Workers More Involved in Their Self-Insured Health Plans

By DAVID ZANZE

**W**ith more employers of all sizes moving toward self-insured health benefits, it's important for brokers to help clients maximize the healthcare savings that this type of arrangement provides. A customized benefit design, the right employee offerings based on utilization, and a team of business partners to help manage the program are only part of the self-insured success formula.

Your clients need to engage employees to take an active role in their care and make more informed decisions. While the healthcare system certainly has its problems, it has been shown that an educated healthcare consumer has a better chance of having a positive experience, both physically and financially. When employees maintain their health and wellness, it can help the company's bottom line. Here are four moves your clients can make to encourage their employees get proactive in their self-insured health plan.

### CONSOLIDATE BENEFITS CONTACT INFORMATION IN ONE PLACE

With a self-insured plan, employers have the flexibility of hiring vendors of their choice to provide benefits that specifically meet the needs of their employee population. While this can provide a more customized solution, it can sometimes be disconcerting to an



employee who is confused on where to go for certain services or doesn't have all the numbers handy when he needs them. Here are some suggestions:

- Fit all contact information on the employee medical ID card. If there is too much information to provide on one card, an employer may consider printing a refrigerator magnet or additional wallet card that has all the information in one place.
- Use an employee portal to consolidate all benefit information. Whether it is set up through the HR Department, offered by a third-party administrator as part of their service, or set up through another channel, an online portal gives employees access to their benefit information on their smartphone, tablet or computer. Some portals can provide an employee's benefit summary, explanation of benefits statements and allow them to print a temporary ID card.

### CUSTOMIZE COMMUNICATIONS

Unless all of your client's employees come from one generation (for example, a startup tech company composed of only millennials), employers should avoid a one-size-fits-all communications approach when discussing health plan options; otherwise some employees may tune out. Here are some ways to do it:

- Give real-life examples representing different generations. Provide scenarios and suggested plans



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that relate to employees in different stages of their lives. Examples include employees starting out in their 20s; those in their 30s and 40s supporting families; and older workers concerned about retirement benefits.

- Use the right communication channels to reach all audiences. It's best that your clients disseminate their messages through a variety of channels so that each generation will receive it in the manner they are most comfortable with. For example, studies show that older employees tend to prefer their communications delivered through email or printed materials and younger workers typically feel more comfortable receiving their information online or in face-to-face meetings.
- Provide questions that encourage employees to evaluate all plan options. Your clients should help their employees to think beyond the obvious, so that they don't choose the same plan year after year without thorough evaluation of each option. For example, some employees might choose an expensive zero-deductible plan each year, even though the cost for the plan continues to increase annually. By helping them understand that a mid-range plan with a \$1,000 deductible offers low co-pays for office visits and most prescriptions, they may decide that the mid-range plan is a better fit. Or if they know how a high deductible medical plan and a health savings account work together, it may encourage them to think beyond the standard plan option and save money for both themselves and their employers.

### HELP EMPLOYEES TO THINK MORE LIKE HEALTHCARE CONSUMERS

According to a 2014 Aflac survey, more than 40 percent of people spent less than 15 minutes reviewing materials and choosing a health insurance plan during the previous year's open enrollment period. That is far less time than other big purchase items. Studies show that the typical American spends four to 10 hours on average shopping for a new car, computer, TV, or planning a vacation.

The study also found that 73 percent of workers surveyed said they don't understand what is covered in their policies and 42 percent reported that they waste up to \$750 on mistakes with their insurance plan. With the average worker spending up to \$5,000 a year on out-of-pocket costs toward their employer's \$17,545 average cost for a family health plan (according to the 2015 Kaiser Family Foundation report), it makes fiscal sense to help employees better manage their health benefits for higher satisfaction and engagement. Here are some suggestions:

- Create materials to show employees how to effectively use their health benefits. Employers can include infographics and more visuals in their benefit materials to help employees understand the ways they can save on healthcare costs. For example, if an employee needs a standard procedure like a hip replacement and is on a high deductible health plan, they can comparison shop among providers and hospitals, just as with other big-ticket items. Publicizing reference tools such as Healthgrades.com can assist employees in finding a provider or hospital with the best medical outcomes for their procedure and a reasonable price. Just by asking, an employee can sometimes receive a discount by letting the provider know that they are paying cash.
- Encourage employees to review every doctor bill. Providers and hospitals can make mistakes and sometimes double-bill, so employers need to remind employees to routinely review all their medical charges. For example, if a claim was denied, did the employee check that it was billed to the right insurance company? Problems can occur when a medical plan uses a well-known network and the doctor sends the bill to the network provider and not the medical plan or third-party administrator. This can result in charges being denied and the provider going after the employee for full payment.
- Remind employees of annual doctor visits and screenings. Employees

need to get their annual wellness exams done as well as age-appropriate preventive screenings. At this time, many preventive screenings are still covered under the Affordable Care Act and are no cost to the employee.

### SHARE INTERACTIVE TOOLS TO HELP EMPLOYEES CHOOSE PLANS, DOCTORS AND SERVICES WISELY.

Encourage employers to find tools that assist their employees in choosing and utilizing their benefits more effectively. This can help boost employee engagement in your client's health plan. Here are some examples:

- Steer them to open enrollment tools that are interactive and can deliver personalized information and recommendations based on self-reported data.
- Look for tools that allow employees to enter information such as location and treatment needed, and compares local providers in the network. An employee can see how the providers or hospitals rate against each other regarding estimated costs, medical outcomes, patient reviews, etc.
- Publicize free mobile apps such as GoodRx.com, which gives instant access to the lowest prices for prescription drugs nationwide and alerts users of when their desired prescription has been reduced or a coupon is available. This app also provides tips on how to save on prescription costs, side effects of each drug, pharmacy locations and more. Other websites such as CDHPcoach.com, offer information to help employees become better healthcare consumers.

The more engaged and satisfied an employee is with his or her company-sponsored, self-insured plan, the happier the company client will be when the plan successfully manages costs while keeping its employee population healthy and productive. And the more satisfied the company will be with you as the broker of record! ★

*David Zanze is president of Pinnacle Claims Management Inc., a third party administrator, and Pinnacle Rx Solutions, a pharmacy benefit manager. Visit [www.pinnacletpa.com](http://www.pinnacletpa.com) or call (866) 930-7264 for more information.*



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# PRIVATE EXCHANGES: THE FUTURE OF EMPLOYEE BENEFITS IS NOW



By SIMA REID

**O**ur world has changed – you can use your smart phone for research, dating or online shopping. And our world will continue to change – you will always remember your first trip in a driverless car. To stay current, employee benefits must keep up with the times as well. Many employers see the value in structuring their programs to meet the needs of their multigenerational employee population. A private exchange helps employers toward that goal and helps employees select the right benefits.

Offering a private exchange to employees is not just about moving to a defined contribution model or promising a silver bullet to reduce benefit costs. A private exchange should bring value to the employers and their employees independent of the products or pricing of those products.

For employers who understand the value of giving up some of the benefit decisions to their employees, a private exchange provides the employer with a way to give more choice, but with tools to help employees make good decisions based on their wants and needs.

More choice is good, but too much choice is not better. It is important to include choices that make sense for the particular workforce that include traditional medical, dental, vision as well as voluntary benefits. A meaningful line up of choices will help employees fill gaps they may have in the areas of legal services, ID Theft, Chiropractic Care, additional life insurance or disability.

## RIGHT-SIZING

When employees are allowed to select plans that make sense for them from a benefit/cost perspective, many employers see a right-sizing of their benefit program providing them with savings. If an employer only offers one health plan that has low out of pocket, they are overpaying for many employees. If an employee would rather pay lower premiums and higher co-pays, choice

allows them to do so. This brings value to the employee and the employer.

Being self-insured does not mean you eliminate employee choice. For many employers, self-insured plans make more sense than a fully insured plan. A private exchange should be able to accommodate either financing mechanism.

Private exchange is not just a benefits administration system. Private exchange technology provides critical education and tools available to employees for all the plans and programs offered. Gone are the days of trying to include all the information in an employee enrollment communication that the employees likely won't read. The process for human resources is streamlined through the private exchange using a modern, inviting and attractive online platform.

How companies engage and retain employees has changed. The need exists for a year round platform focused on life's experiences and challenges. Tools to help employees work on wellness whether it is health or financial will provide value to the employee. Messaging employees during the year encourages them to go to the private exchange outside of open enrollment.

## CALCULATION TOOL

While decision support helps personalize employee decisions, it is important for a private exchange to help people not just pick which medical or dental plan, but also voluntary benefits offered. If you ask most people how much life insurance they should have, not many can tell you. A tool that helps someone calculate, based on their circumstances, how much life insurance they may need so they can decide if they want to buy additional life insurance above what the company provides can be valuable to many employees.

How many consumer purchases today have us searching on line for information telling us the best products at the best cost? More and more employ-

ees find value in this same approach for their benefits. Private exchanges that provide employees with side-by-side comparisons in summary and in detail along with costs can bring value to the employee.

Many employers value a positive, friendly platform for the delivery of their employee benefit program. A private exchange brings modern technology to education and enrollment of benefits. How many employees within a company do you think watch YouTube? Whether we think this is an acceptable method of communication or not, it is a powerful, current method of communication. Using videos and other educational tools on the private exchange adds value for many employees.

## EMPLOYEE SHOPPING

Allowing employees to shop for their benefits takes the insurance enrollment process to a very different level. It bridges the often disjointed, confusing process of benefit enrollment with our normal daily activities of how we approach buying goods and services. A private exchange allows employees to walk down the aisle of a virtual store of benefits.

About 38,000 employers are using a private exchange. The greatest growth that we have seen is in middle market – companies between 100 and 2,500 employees.

Can't we just make life easier? A private exchange makes life easier for the employer and their employees by using technology, a modern approach, enhanced educational tools and resources, focused on the employee experience. Private exchanges are the future of employee benefits. ★

*Sima Reid is the president of Reid Group Enterprises, which includes Twentytwenty Insurance Services and Broker Self Insurance Solutions. For more information on self-insurance and private exchanges, Reid can be reached at (562) 429-6038.*



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# Failure to Launch:

## CAN PRIVATE EXCHANGES LIVE UP TO THEIR HYPE?

By RYAN GLUSHKOFF

**N**ot only did the arrival of the Patient Protection and Affordable Care Act of 2012 bring more work for human resources and benefits professionals nationwide, but it also put the spotlight on insurance exchanges. Private exchanges had been successfully used for employer-sponsored Medicare retirees for years, but until the launch of the ACA, they never reached the active employee segment of the benefits market.

Under Obamacare, both the federal marketplace and state marketplaces for individual and small business coverage were modeled on the private exchange concept. But with Obamacare's future now in question under a Trump administration, it is a good bet that both the federal and state marketplaces will disappear. To understand whether private exchanges can live up to their hype despite this shifting landscape, it is necessary to explore why they have not performed so far and what it will take to make them perform going forward.

Under the ACA, the market for pri-



ivate exchanges was forecast to explode. In 2013, Accenture predicted that private exchanges would have 40 million members by 2018 and Aon Hewitt predicted that one-third of employers would offer their group-based health benefits via a private exchange in the next three to five years. The value proposition of private exchanges

seemed to have the right ingredients: more employee choice, assistance with decision-making through online technologies, less administrative burden, and more cost savings due to increased carrier competition. To meet these rosy forecasts, new vendors rushed in from all corners of the employee benefits market. From technol-



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ogy providers to carriers to brokers to consultants, everyone put together a private exchange offering. But the reality didn't live up to the hype.

The reality is that there are now between 5 million to 8 million total enrollees covered by private exchanges, according to Mike Gaal at Milliman. But under Accenture's forecast, there should be 19 million enrollees on private exchanges by now. That means the original estimates were off by more than half, raising the obvious question: Why are private exchanges suffering from failure-to-launch syndrome?

First, the current model of customized employee benefits on a per-employer basis works just fine for most organizations. From an employer's perspective: It's not broke, so why rush to fix it?

Second, the initial catalyst for driving interest in private exchanges is that it would drive down healthcare costs and insurance premiums. The idea was that health plans and insurance companies would compete side by side in a marketplace setting, and that would lead to lower costs. But this situation never materialized in the private sector. Since health plans refused to compete with one another, the underlying promise of lowering healthcare costs evaporated along with employer interest.

Third, the concept is still not completely understood, and private exchanges aren't helped by their association with public exchanges. Several state exchanges have reported operational difficulties in the last year, and some insurance carriers have withdrawn their participation. As news of public exchange woes came out, the "insurance exchanges" brand – whether public or private – suffered.

In many ways, exchanges are a feasible solution without an urgent problem. But despite these headwinds for private exchanges, there are some notable tailwinds. Even though the model of custom benefits is not broken, it's far from perfect. Having each private employer craft a set of benefits for the employee population is extreme customization and doesn't take advantage of size and potential similarities. And this kind of customization doesn't exist in other industries, so there is little

reason it should exist in the employee benefits market.

Today's model of custom benefits for each employer is the equivalent of every family having its very own grocery store with only products that it will buy. That would hardly be logical or economical. And the grocery store model works well because many families need the same detergent, sugar, coffee and bread. The same is true in



healthcare, because different families can use the same products and plans. In other words, there are economies of scale that can be harnessed through proven methods of mass marketing. That's effectively what exchanges are. They are collections of common benefits products that different populations can buy for common prices, very much like shopping at a grocery store.

What will it take for the tailwinds to exceed the headwinds and deliver on the lofty promises originally made by private exchanges? Or more plainly, how do you move people from a model in which benefits are customized per employer to one where benefits are customized for groups of employers? And get those employers to abandon their old ways and embrace a new approach? After all, the idea of a private exchange is a sound one and not exactly controversial – offering a common set of products that different customers want and would buy in a com-

mon marketplace. It all comes down to marketing, product, economics and a small, yet very impactful change to the tax code.

First off, let's talk marketing. Let's delete the word "exchange" from our vocabulary and come up with something else. There is too much baggage associated with the word.

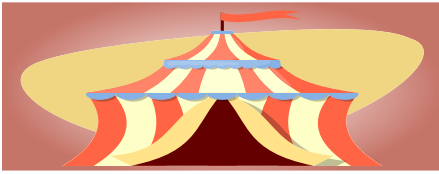
Second, the right collection of products needs to be offered that address the needs of the people who will buy them. And those products need to be just as good, if not better, than the products that employers already have access to.

Third, the price of those products needs to be more affordable than they are today when offered by employers. If this price to the employer and their employees isn't substantially lower, what incentive is there to make a switch?

And finally, tax incentives need to change. Today, employers are incentivized to provide benefits because they're tax deductible to them and tax-free to their employees. And current law allows individual employees to avoid taxes on money spent on insurance premiums only if their employers purchase insurance on their behalf. In other words, the employee benefits model is structured so that employers are rewarded for spending more on healthcare and employees are not heavily incentivized to track the costs. Instead of this approach, what if the law instead allowed employees to deduct that spending from their taxes? This idea was recently proposed by professors at Harvard, Duke and UCLA in a New York Times op-ed.

These suggestions – in regard to marketing, product, economics, and incentives that motivate the market players – are market-based principles proven to rectify inefficiencies. With less regulation (which will likely arrive under a Trump administration), market forces need to run their course in the U.S. healthcare market, which will give us what we all want – choice, affordability and, above all, quality quality of care. ★

*Ryan Glushkoff is senior director of marketing at PlanSource and has spent his career in mass-market and enterprise technology. Twitter: @NoMoreGuff; Email: Ryan.Glushkoff@PlanSource.com*



# HOW TO HELP EMPLOYER GROUPS PLAN A WELLNESS FAIR

By KYLE J. PICKETT

**B**enefits professionals: By now, the implementation of your employer groups' 2017 health and wellness initiatives are underway and most likely, a wellness fair is on their calendar.

If you're not thinking the right way about wellness fairs, you will not be able to grasp their impact fully. Many might think they are a thing of the past, but I'm here to tell you that is not the case. Not only are there multiple benefits your groups can gain from hosting a wellness fair, but now there is free, online technology that can streamline the process for you and your groups, making it easier to plan an event than ever before. You no longer have to set up planning committees, contract with expensive third parties, or any of the other unnecessary planning headaches you're accustomed to experiencing. So, keep in mind the true benefit and value you provide your employer groups when you're able to offer assistance.

Below are some key benefits to your groups from hosting an employee wellness fair. Also some tips on how to make the planning process easier.

## PREVENTION HELPS YOUR GROUPS SAVE MONEY

There are many excuses people can have for not getting their yearly physical, flu shot, etc. Finding time is usually the biggest factor. You can make it easier and eliminate this issue by bringing these options directly to them. Not to mention that the employees don't have to take a lot of time out of their work day because they do not have to leave work.

And by tying them in with a fun and interactive wellness fair, you can increase the employee participation rate and turnout for flu shots and screenings. A case study of wellness fairs showed nearly a 25 percent increase of employees who received their biometric screening at the employers' first wellness fair. Help your groups keep in mind their audience – male, female, white collar, blue collar – when

including vendors. This is going to help draw their employees to the wellness fair and increase the walk-ins for screenings.

Even if your employer groups are not doing biometrics at their wellness fair or the fair is not during the flu-shot season, there are still other healthcare providers that provide preventive options: blood pressure screenings, hearing screenings, vision screenings, etc.

I recently attended a wellness fair and spoke to a representative who conducts blood pressure screenings at more than 200 corporations a year. She stated that on a weekly basis, they identify high blood pressure in folks who don't know they have it, even folks who are in the danger zone of stroke level. "Simple screenings can go a long way," she said.

## INCREASE EMPLOYEE AWARENESS

When planned right, an employee wellness fair can bring your group's employees' health to the forefront of their mind. Employees already have enough to worry about such as meetings, deadlines, family obligations, etc. Rarely are they focused on their health and well-being, but you can help move the needle here.

A wellness fair helps employees become more health conscious, as different vendors can educate employees on topics and issues that may have never crossed their mind.

Think of a wellness fair as an event that ties it all together, providing health and wellness education to employees, helping them make connections from different types of local providers if ever needed.

I've been at plenty of wellness fairs, chatting with the HR team, when an employee comes up asking, "Where is such-and-such insurance provider? I have a question regarding my coverage."

You can invite the insurance carriers to your wellness fair so they'll be there to answer those questions. Changing insurance carriers, or adding/removing coverages can lead to numerous ques-

tions from your group's employees, some of which you might struggle to answer. Benefits professionals: This can take a lot of pressure off you (and your HR contact of the group) not only during the wellness fair, but throughout the year. Not to mention, most carriers have onsite reps who specialize in attending employee wellness fairs for their clients, so don't hesitate to ask them to attend.

Jason Andrew, CEO of Limelight Health, said: "According to a MetLife survey, about half of American employees still don't understand all of their benefit options and the value of supplemental health benefits." That is why it's so important to have a wellness fair and include the insurance carriers. Some employees might attend the wellness fair specifically to get these types of questions answered.

## COMBINE A HEALTH FAIR AND OPEN ENROLLMENT

Open enrollment season can be a hectic time for HR and benefits professionals. However, ever thought of knocking out a huge portion of your open enrollment during your employee wellness fair? It's a perfect time as you'll have all the employees in one venue.

You or the medical insurance provider can attend the event and bring a laptop to set up at your booth, and assist employees with completing their open enrollment, online. Having open enrollment available during your wellness fair gives you the opportunity to knock out a huge portion of your employee population all in a few hours. This is only recommended if your employer group has the space and you or the carrier can provide the staff to help make it a smooth process. ★

*Kyle J. Pickett is co-founder at Health Fair Connections, which offers a free application, <https://app.healthfairconnections.com> to automate the health fair planning process. For more information, visit [healthfairconnections.com](http://healthfairconnections.com). or email: [kylepickett@healthfairconnections.com](mailto:kylepickett@healthfairconnections.com).*

# 7 Mistakes to Avoid When Choosing a Wellness Portal

By DEREK KREN



**C**ompanies are turning to wellness portals to help control healthcare costs and improve the overall health of their employees. There are so many wellness portal options on the market that it's becoming even more important to sort through the abundance of providers to find the ones that offer the right features for you.

With a multitude of factors to consider, the process of choosing a wellness portal that best suits your company's needs may initially seem overwhelming. In order to help make your decision easier, consider this list of the seven most common mistakes that people make when choosing a wellness portal and learn how you can avoid the hassles that accompany these frequent blunders.

## **MISTAKE 1: SELECTING A PROVIDER THAT DOES NOT INTEGRATE WITH THIRD-PARTY VENDORS.**

Not all wellness portals are created equal and some may lack the ability to easily integrate with the applications, products and services of third-party vendors. If a wellness portal is unable to collect data from third-party vendors, it leads to more manual up-keep and makes it difficult for administrators and end users to easily sort through the information to find the relevant pieces of data. You can avoid the hassle of having to manually input data by choosing a wellness portal that will seamlessly integrate with your existing partners and organize the data on a user-friendly dashboard.

The best way to ensure that you do

not make this mistake is to create a list of your current and future wellness partners and ask your potential wellness providers about their ability to integrate with them. You can also prioritize which data sets, such as medical claims or biometric screening results, are most important and inquire about how the wellness portal can incorporate them. By planning ahead and asking the right questions, you can avoid any potential integration issues.

## **MISTAKE 2: SELECTING A PROVIDER THAT WILL NOT ALLOW PORTAL CUSTOMIZATION.**

By choosing a wellness provider that does not allow for portal customization, you're limiting the capabilities of your program. Portal customization is

important for several reasons. First, by matching the branding to include your company's logo or color scheme, you're creating a uniform appearance with aesthetic appeal. Second, you want a portal that allows you to choose from a variety of product options to ensure that you're offering technology that is relevant to your population. Finally, you want the flexibility to create custom programs, such as company-specific incentives, or custom challenges that will best engage your population.

### **MISTAKE 3: SELECTING A PORTAL THAT WON'T LET YOU PICK AND CHOOSE THE FUNCTIONALITY THAT YOU NEED.**

A wellness portal with limited functionality makes it impossible for your wellness technology to evolve as your wellness program grows, but it also makes it difficult to keep participant engagement high if the functionality is stagnant. For example, some wellness portals include features that may be useful down the road but too sophisticated for first-time users. While applications, such as health risk assessment and biometric screening results, are handy at the start, other features, including incentives and rewards, social challenges and digital health coaching, may be better used once you have an established wellness program.

To ensure that you're choosing a wellness portal with the right level of functionality, ask "what if" questions, such as "what if my company grows?" or "what if I don't like a particular wellness vendor?" Make sure that the portal can easily adapt to meet your goals with minimal effort on your part.

### **MISTAKE 4: SELECTING A PORTAL THAT DOES NOT GIVE YOU REAL-TIME REPORTING.**

Wellness portals that fail to offer fast and accurate reporting of data have no place in today's fast-paced digital world. From laboratory results to health assessment statistics, getting immediate access to data through web-based reporting should be a top priority for you. If your portal fails to offer real-time, interactive reporting, and instead relies on outdated meth-

ods, you'll quickly discover that user engagement rates will decline.

Be sure to ask potential providers how data is displayed and how often the reports are updated. You also want to make sure that the data is easily accessible via a variety of devices, whether it's a computer, tablet or smartphone, so that administrators and users can view their health care information with any device.

### **MISTAKE 5: SELECTING A PORTAL THAT DOES NOT SUPPORT WEARABLES.**

With all the buzzworthy wearable technology available, it only makes sense to choose a wellness provider that supports wearable fitness devices, such as Fitbit and Jawbone. Not only do wearables make it easy to track results, but they also help to ensure the accuracy of the collected data.

Choosing a wellness portal that doesn't support the use of wearables simply adds another barrier to participation and increases the need for administrative maintenance of the wellness program. Instead of automatically updating the portal with results, employees have to manually record data, which imposes a hurdle that can be overcome through device integration. Furthermore, when incentivizing or providing activity-based challenges – having the ability to pull in data from wearables enables administrators to use pure objective data. Without wearables, questions can arise about the validity of the results for challenges and incentives purposes.

### **MISTAKE 6: SELECTING A PORTAL THAT DOES NOT OFFER A VARIETY OF TARGETED ENGAGEMENT TOOLS.**

Targeted engagement tools, such as interactive social challenges or HIPAA-compliant messaging, are easy and fun ways to encourage active participation in a wellness program. Unfortunately, not all portals offer a variety of options or allow for customization of the engagement tools. Companies that choose a wellness portal that lacks these features may find it more difficult to get employees excited about the health pro-

gram and may see a lack of participation.

Look for a wellness portal that offers the ability to create, customize and launch challenges, coaching and incentive programs that best meet the goals of your company and its employees. Make sure that there are a variety of ways to get the message out about relevant programming. You'll want to check that the portal allows you to send targeted communications to ensure that the participants are hearing the right message. Whether you're looking to improve the overall health of your employees or target specifics, such as a healthy weight challenge, a portal that offers flexibility will help you meet your goals.

### **MISTAKE 7: NOT VERIFYING THE PROVIDER USES CUTTING EDGE SECURITY FOR PERSONAL HEALTH INFORMATION.**

When it comes to your personal health information, or PHI, there's no room for error. However, data breaches can happen, especially if your wellness provider isn't using cutting edge security.

While providers are required by federal law to protect your data, there are questions you should ask to better understand the level of security. Find out what protocols are used to protect your information on the server as well as during transmission. Also, ask who has access to the data and how the data is encrypted to get a better understanding of how well it's being protected.

By following these simple guidelines for choosing a wellness portal that is built for success, you can avoid the pitfalls that commonly plague buyers. Always create a list of what you wish to accomplish with your program and communicate these plans to any potential wellness portal vendor. Most importantly, don't be afraid to ask questions when evaluating wellness portal vendors – you can never ask too many questions, but you can always regret not asking the "right" questions. ★

*Derek Kren is vice president of sales at MediKeeper Inc., a provider of health and wellness software portals. Email: dkren@medikeeper.com.*

# AVOIDING THOSE FAMOUS LAST WORDS: 'I FEEL FINE'

# Here's Why Wellness Programs Can Save Lives

By JOHN DENERY



**S**tudy after study shows that more Americans are becoming obese as they spend less time engaging in physical activity. The American Diabetes Association estimates that about 30 million Americans are aware that they have diabetes and more than 8 million more are undiagnosed. The prevalence of preventable disease is increasing at an alarming rate. One study estimates that 40 percent of Americans born from 2000 to 2011 will develop diabetes. Similarly, metabolic syndrome, which can increase chances of heart disease, stroke, diabetes and many other medical problems, now affects more than one in three U.S. adults. Both diseases are largely preventable and cause expensive consequential illness.

At the same time, the cost of health-care is increasing – for both payers and providers. PwC Health Research Institute found that costs have risen by more than 6 percent annually over the past five years. In 2016, costs are rising at more than six times the rate of inflation, according to the Bureau of Labor Statistics. Spending on deductibles by employees went up more than 250 percent and contributions toward premiums jumped 83 percent in the decade from 2005 through 2015.

## 'FEELING FINE' DOESN'T EQUAL HEALTHY

Despite the rising prevalence of preventable disease, maintaining health is often a low priority for American employees, taking a back seat to other stressors like money and work. So, as

long as they “feel fine,” most people tend to forget to go for regular check-ups and fail to check on their ongoing health maintenance. About 86 million Americans have pre-diabetes. This means millions of Americans are in a critical stage for medical intervention. How can we stop this escalator of disease and get employees to understand what it truly means to “feel fine?”

Dr. Scott Conard, medical director at Stephens Insurance, remembers three cases from early in his career: patients deliberately ignored his diagnoses of pre-disease and recommended treatments because they told him they “felt fine.” Their unwillingness to take action to improve their health led to the worst outcome possible. All three of those patients died due to treatable illness. This experience was a paradigm shift for him both personally and professionally, and put him on a new path working with stakeholders such as employers and health plans across the country. It was this shift that led him to form a partnership with Stephens Insurance and assist in developing a strategy called Blueprint for Health.

### EMPLOYERS PLAY A KEY ROLE IN MAINTAINING HEALTH

Our data shows on a consistent basis that a small set of an employer’s population, about 5 percent, consumes the majority of the healthcare dollars, up to 70 percent. What’s equally intriguing is that up to half of this group had no previous claims history at all. In other words, prior to their health event they all “felt fine.”

Based on this data, it’s clear that the key to preventing these diseases and to lowering costs is to focus on maintaining optimal health throughout one’s lifetime, rather than only treating illness when it occurs. It’s through this idea of truly “being fine” rather than just “feeling fine,” that Stephens’ Blueprint for Health was developed. At its core, Blueprint recognizes that employers are often the first line of defense for encouraging employees to focus on their own health. Armed with data to identify and work with at-risk employees, and partnered with motivated, caring primary care physicians and other healthcare providers, employers are able to lead their employ-

ees from merely treating symptoms to halting disease progression or preventing illness before it even starts.

The potential benefits of this approach mean that employees are healthier and more productive at work, and employers benefit by keeping costs down. This is more than a perk meant to attract and retain talent, it is also a business decision that has the potential to positively impact costs.



***'This paradigm shift to actively engaging employees in their own healthcare empowers them with a clear path to use responsive, competent providers.'***

Preventive medicine plays a key role in this effort and among our clients has been shown to eliminate a significant amount of the highest-cost claims. Further, U.S. adults who have a primary care physician have a 33 percent lower healthcare spend than those who only see a specialist, according to one report. This indicates that prevention can work – if employees are able and empowered to seek support and manage their health by seeing a physician on a regular basis.

### ACHIEVING BETTER HEALTH AND LOWERING COSTS

Implementing the Blueprint for Health focuses clients’ health insurance programs on preventive care and employ-

ee education so staff sees their individual health as a priority. Simply put, the Blueprint reorients the employer-sponsored healthcare system toward preventative medicine and has helped address the challenges of the highest-cost claims, according to results from clients who have implemented the Blueprint.

ArcBest Corp. is one example of an early adopter of the Blueprint for Health program. Since first engaging with Stephens Insurance in 2012, it has built the Arkansas transportation company’s culture around wellness and proactive health management.

The company began the process by offering monetary incentives to employees who completed basic biometric screenings, established a primary care physician relationship and completed age- and gender-appropriate tests. When the program launched in 2012, only 30 percent of employees participated, but by 2015 that number reached 51 percent and is expected to grow.

The key to seeing success such as ArcBest’s is an organization-wide commitment to changing behaviors in order to achieve better health. ArcBest has seen strong support and commitment for this movement from all levels of the company.

“Not only are employees seeing better health outcomes but our company has seen a reduction in health care spending and a more highly engaged and productive workforce,” said Rich Krutsch, senior director of People Services at ArcBest.

This paradigm shift to actively engaging employees in their own healthcare empowers them with a clear path to use responsive, competent providers. It may seem daunting. Yet the rising cost of healthcare in the last decade demonstrates that the current system is likely to yield annually increasing costs and no real solution for largely preventable health problems. There’s a better way. And the first step on that better way is widening the focus from providing coverage for treatment of illness to maintaining health through benefits programs. ★

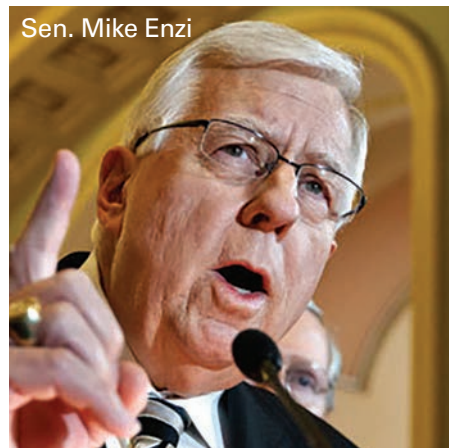
*John Denery is an executive vice president and director of life and health with Stephens Insurance in Little Rock, Ark.*

- **Repeal of ACA on Fast Track**
- **Study Shows Covered California Saves Money for Consumers**
- **Employer Groups Expect to Add Workers**
- **New Products**
- **People**

## HEALTH CARE REFORM

### CONGRESS MAKES HASTE TO UNDO OBAMACARE

Lawmakers returned to Washington in January and wasted no time getting to work on the repeal of Obamacare. Sen. Mike Enzi, R-Wyo., introduced a resolution just hours after the new Congress convened that will serve as the vehicle for repealing much of the president's signature health care law.



Sen. Mike Enzi

"Today, we take the first steps to repair the nation's broken health care system, removing Washington from the equation and putting control back where it belongs: with patients, their families, and their doctors," Enzi, chairman of the Senate Budget Committee, said in a press release on his website.

It's a clear signal that "repeal" will come soon, and "replace" will come maybe not so soon. The move was the first step in Republican lawmakers' plan to fulfill their most ardent campaign promise – to repeal the Affordable Care Act and replace it with a Republican alternative.

Republicans have to use a special

legislative maneuver, called a budget resolution, to undo the ACA because they don't have enough votes to overcome a Democratic filibuster in the Senate, according to NPR. Budget bills aren't subject to filibuster, so lawmakers will be able to repeal the parts of the law that have budget and tax implications.

That means they can essentially gut the law, removing all the subsidies that help low- and middle-income people buy health insurance and getting rid of the smorgasbord of taxes – on medical devices, insurance companies and wealthy individuals — that pay for those subsidies

Enzi's resolution calls on the Senate to get a bill to the Budget Committee by Jan. 27.

Republican lawmakers say they don't want the 20 million people who have newly gained insurance because of the ACA to lose their coverage. So they plan to phase out Obamacare over time while they devise a replacement plan that they say will make affordable health insurance available to everyone, without the much-hated mandate to buy insurance if you don't want it.

Many analysts are skeptical that this "repeal and delay" strategy will work.

"The most likely end result of 'repeal and delay' would be less secure insurance for many Americans, procrastination by political leaders who will delay taking any proactive steps as long as possible, and ultimately no discernible movement toward a real marketplace for either insurance or medical services," said Joe Antos and James Capretta of the conservative American Enterprise Institute.

\* \* \*

### OBAMACARE IS 'CANCER,' ACCORDING TO DOCTORS AND SURGEONS – CUT IT OUT QUICKLY

While Republicans in Congress argue over repealing or replacing or delaying on the Affordable Care Act, the Association of American Physicians and Surgeons presented an immediate action plan in a recently released White Paper.

"ObamaCare is not like a weak but still beating heart," said AAPS executive director Jane Orient, M.D. "It's more like a cancer. You don't want to replace a cancer. You just want to support the patient as he recovers from its removal."



Jane Orient

President Obama said that people could keep the health care plan they liked, Orient said, but she then asked: "If you don't like your government plan, do you have to keep it?"

Orient said the entire health care delivery system and benefits are like the Leaning Tower of Pisa, propped up only by counterweights to offset unsustainable debt.

"True reform means we must reject unsound economic premises and remove barriers to competition," she said. "We don't want to replace one damaged tower with another one having the same disastrous flaws."

\* \* \*

### ACTUARIES TAKE STAND AGAINST REPEALING WITHOUT REPLACEMENT

In a letter to the leadership of the U.S. Congress, the HealthPractice Council of the American Academy of Actuaries warned of severe consequences for the individual health insurance market if the Affordable Care Act is repealed without a viable replacement being enacted at the same time. Eliminating reimbursements to insurers for cost-sharing reduction subsidies would raise similar concerns. The consequences could include spiraling premiums, insurer withdrawals from the individual market, and loss of coverage for millions of Americans.

The Academy urges Congress to consider what would be needed if a repeal proposal does not include significant measures to prevent substantial disruption and instability in the individual market. Avoiding these consequences means having incentives

for enrollment and prevention of adverse selection. Delaying the effective date of repeal while a replacement is worked out likely won't be enough to ensure the stability and sustainability of the individual market.

## CALIFORNIA NEWS

### INFUSION EXPRESS ADDS TREATMENT CENTER

Infusion Express, an alternative to hospital infusion centers, announced its second San Francisco Bay Area treatment center as part of a national expansion of its consumer-driven model.



Infusion Express Treatment Center

Infusion Express offers individuals with chronic conditions the option of care in a private setting with extended hours, including evenings and Saturdays.

The Fremont treatment center is one of several new Infusion Express locations opening in major metro areas this year. Infusion Express contracts with self-insured employers and many health plans for in-network coverage.

Patients who need regular infusion treatments traditionally went to a hospital or a physician's office. As infusion treatments can take three to four hours, that can lead to scheduling challenges and parking expenses.

Don Peterson, chief executive of Infusion Express in Overland Park,

Kansas, said the company's goal is to furnish a choice to patients.

"We've created a comfortable alternative that offers the same high-quality healthcare they receive at a hospital or doctor's office in a setting where they're treated like a guest," he said. "Not just a patient."

### SANTA CLARA FAMILY HEALTH PLAN ADOPTS TRIZETTO SOFTWARE

Cognizant, a New Jersey company, announced that Santa Clara Family Health Plan, a California-based health plan, selected its TriZetto software solutions to support the administration

are protecting themselves from rate changes and paying much less than the average price of plans by shopping for the best value. The study looked at the policies Covered California consumers purchased between 2014 and 2016 and found the average price paid in each year has been between 11 percent and 15 percent less than the average price of the plans offered.

"This study shows how Covered California consumers are being smart and saving money by shopping," said Peter V. Lee, executive director of Covered California. "Consumers are getting the best value, which means most are paying far less than 'the average' premium."

\* \* \*

### EPIC HONORED AS ONE OF BEST PLACES TO WORK

Epic Insurance Brokers & Consultants, a retail property, casualty insurance brokerage and employee benefits consultant, has been recognized by their team members as one of the Best Places to Work in Insurance in a survey conducted annually by Business Insurance Magazine and co-sponsor Best Companies Group. This is the seventh time that EPIC has received this award.

The award is based on employee engagement and satisfaction with company culture, benefit programs, management practices, career opportunities, and work-life balance. Based on employee feedback, EPIC was ranked No. 10 in the medium employer category (250 – 999 U.S. employees).

"At Epic, we believe that a strong, positive culture is built on opportunity, personal responsibility, mutual trust and respect, commitment to the community, a healthy work/life balance, and having fun," said Mary Smith, executive vice president of human resources said.

## NATIONAL NEWS

### EY PREDICTS BUMPY RIDE FOR INSURANCE INDUSTRY

The coming year promises to hold continued disruption on several fronts for the insurance industry: changing consumer demands, digital technology advances, cybersecurity, and the shifting political landscape are just a few, according to the 2017 EY U.S. life-annuity and property-casualty insurance outlooks.

### STUDY SHOWS COVERED CALIFORNIA SAVES CONSUMERS MONEY

A study by the Commonwealth Fund found Covered California consumers

The slow growth of the U.S. economy, coupled with adapting market shifts, are predicted to be prominent factors in 2017. However, converging demographics and regulatory and technological changes are also opening new opportunities for insurers to reach consumers and to strengthen their workforces.

Technology will be a driving force in 2017. According to Douglas French, Principal, Ernst & Young, insurers are looking at different technologies. They are looking at machine learning to make underwriting decisions. They are looking at all kinds of data, from medical to behavioral. They know they cannot take months to underwrite a policy. They need to do it in days – and soon, even quicker.

Insurers must go beyond the customer experience and consider internal stakeholders as well.

Dave Hollander, EY Americas insurance leader, sees this as an ideal time to make plans that take into account the future of the nature of work. Insurers now have the opportunity to introduce new technology, such as robotics, and more effective workforce management activities, says Hollander. By taking out repetitive tasks, they can produce an even more industrious and stimulating work environment for people.

When it comes to life insurance and annuities, watch for regulatory change. From rules on consumer protection and transparency to financial solvency and cybersecurity – and now a potential shift in policy direction – the regulatory landscape for life insurers has never been more complex.

With the industry in transition, and a new administration taking office, this is an ideal time for management teams to carefully assess their market position and plan for where they would like to be long term. In addition to reassessing strategic positioning for the years ahead, insurers should also consider using M&A to improve competitive positioning and should also look to find the right InsureTech strategy for the firm.

Insurers should be prepared to enter the next phase of digital innovation by getting control of data across the enterprise and using technology to improve business approaches. Given the vast amount of personal and health data that resides in insurance firms, and their com-

plex vendor relationships, building a robust data security system is crucial and challenging. To do this, insurers should look to make cybersecurity a continuous business activity by drawing on technology and people to secure data.

Insurers can build new talent management strategies by assessing whether the firm has the needed talent for the future and by creating clear pathways to transfer knowledge.

To adapt to a fast-moving marketplace and differentiate themselves from competitors, insurers must stay focused on the customer and adapt their go-to-market strategies. A culture of innovation will help accelerate the development of new products and business models. In the face of shrinking returns, insurers will need to apply advanced analytics and save money by automating insurance processes and building smart technology.

\* \* \*

**EMPLOYER GROUPS SEE GROWTH, EXPECT TO ADD ON-SITE WORKERS**

A survey by the National Association of Professional Employer Organizations shows that industry executives are optimistic about the prospects for strong growth in 2017, with 99 percent indicating they expect an increase in worksite employees this year, and 38 percent predicting a significant increase.

The quarterly survey, conducted after the presidential election in November 2016, also showed that employer revenues, net income, operating income, and average number of worksite employees increased in the third quarter of 2016, compared to the third quarter of 2015.

“The results of this survey reinforce what we have thought all along: It’s a good time to be in the employer organization industry,” said Napeo Chief Executive Pat Cleary. “More and more small business owners are realizing the value of the HR solutions PEOs provide, and we expect that to strengthen with the ongoing improvement of the economy.”

\* \* \*

**REFERRAL MANAGEMENT COMPANY EXPECTS CONTINUING GROWTH**

Par8o, a referral management company in Boston, has announced it will coordinate care for well over 1 million patients in 2017. Clients now include national

provider organizations such as Dignity Health, Mount Sinai Health System, Iora Health, and Lightbeam Health Solutions.

Rapid growth in 2016 also included large employers and players such as MGM Resorts and WellHealth Quality Care, now part of Healthcare Partners. Of particular note, Par8o saw significant growth in its urgent care and retail care business, including adoption by CityMD, the largest urgent care chain in New York City.

**NEW PRODUCTS**

**DENTAL BENEFITS CARRIER LAUNCHES NEW PLAN OPTIONS**

TruAssure Insurance Co., a dental benefits carrier in Naperville, Ill., announced the launch of a set of new dental plan options for small and large companies, as well as for families and individuals. These new options offer employers flexible, standalone dental plan coverage with a focus on prevention and access to a large, national network of dentists.

Family and individual options offer coverage focusing on prevention and flexibility, in many cases providing benefits such as teeth whitening and orthodontia. The introduction of these plans is in direct response to the growing demand for dental insurance and preference for flexible, affordable benefits. According to the National Association of Dental Plans, three-quarters of employees expect their employers to provide dental insurance, with orthodontia and cosmetic procedures such as teeth whitening among the most requested benefits.

\* \* \*

**VARIABLE ANNUITIES FROM TRANSAMERICA**

A new living benefit is now available with most Transamerica variable annuities to enable Baby Boomers and Generation X to better plan their retirement income. The new optional living benefit allows lifetime income payments after age 59 and offers investors the opportunity for up to a 6 percent annual income payment rate for life if they begin drawing income anytime between ages 65 and 79. For investors who are concerned about planning for longer lives and rising costs as they age, the living benefit offers the opportunity for an annual payment rate of up to 7 percent for life if they defer drawing income until

age 80 or later. These annual income payment rates are based on a single life withdrawal after five complete rider years.

\* \* \*

### **\$1 MILLION TERM LIFE OFFERED WITH NO EXAM**

SoFi and Protective are offering a term life insurance product that provides up to \$1 million in coverage through an online application with competitive pricing and no medical exam for a majority of people under 40. Andrea Blankmeyer, SoFi's vice president of finance, said the coverage gives consumers an easy and affordable option.

\* \* \*

### **NATIONWIDE ROLLS OUT NEXTSHARES FUNDS**

Nationwide introduced NextShares exchange-traded managed funds, offering an innovative way to invest in actively managed strategies. The funds offer the potential for benchmark-beating returns by applying their manager's proprietary investment research. As exchange-traded products, NextShares may offer cost and tax efficiencies that can enhance shareholder returns. The funds are traded on the Nasdaq.

\* \* \*

### **INTEGRATED PLATFORM AVAILABLE TO ADVISERS**

Envestnet Retirement Solutions is offering retirement advisers an integrated platform that combines practice management technology, research and due diligence, data aggregation, compliance tools, and intelligently managed account solutions.

## **PEOPLE**

### **HEALTH CARE ATTORNEY EISCHEN JOINS MCGLINCHEY IN IRVINE**

McGlinchey Stafford has added James J. Eischen Jr. to the firm's Irvine, Calif., office as a member. Eischen, a seasoned health care attorney, will work within the firm's Health Care and Business Transactions practice groups.

Eischen has nearly 30 years of experience in business, health care and real estate, and is a national authority and speaker within the medical law and communications fields. He is recognized nationally for his federal compliance experience, structuring consumer/patient financial contribution and reim-

James J. Eischen Jr.



bursment models for private/concierge medical groups and health care IT product developers.

"We are excited to welcome Jim to our Irvine office," said J-P Perrault, who heads McGlinchey Stafford's Business Transactions practice group. "His extensive knowledge of health care practice formation and structuring adds depth to our team. Additionally, his insight assisting companies with their health care options and incentives is key to our clients, as this is a challenge nearly every employer faces thanks to evolving federal regulations and guidelines."

Eischen's broad health care practice also includes life science company/start-up enterprise support, integrating physician and wellness models, navigating the corporate practice of medicine, and related compliance issues. He advises physicians, health plans, and business enterprises in matters connected to reimbursement, contracts, interdisciplinary health professional employment and labor issues, and Health Insurance Portability and Accountability Act compliance. Additionally, Eischen is well-versed in the fast-growing membership-based connected care, direct primary care and concierge medical practice enterprise models, and newer connected-care models that are innovating U.S. primary care delivery.

Eischen also handles a wide range of health care business, including physician independent practice associations as well as physician practice purchase and employment transactions. He also works with companies that deliver well-

ness products and programs to ensure their compliance with reimbursement and privacy laws and regulations.

"My practice is focused on helping companies find ways to make health care work for them, and helping physicians structure their practices optimally for doing business in today's marketplace," Eischen said. "McGlinchey Stafford's client-first focus and commitment to innovative service are a natural fit for me and I look forward to leveraging the firm's national footprint as I continue to expand my practice."

Eischen received his J.D. from the University of California at Davis in 1987, and his B.A. from Creighton University in 1984.

McGlinchey Stafford's Irvine office, founded in 2013, has grown to 10 attorneys serving the firm's clients across the state in commercial litigation, consumer financial services litigation, health care, and labor and employment matters.

\* \* \*

### **LLOYD NAMED TO AFLAC BOARD**

Aflac Inc. announced the appointment of Karole F. Lloyd to its board. Lloyd's term will expire at the company's Annual Meeting of Shareholders in 2017, at which time she will stand for election along with the other director nominees. The Columbus, Ga., company has also appointed her to serve on the Audit and Risk Committee.

Lloyd brings more than 37 years of accounting leadership and experience to Aflac Incorporated's Board, consulting with many of Ernst & Young's highest-profile banking, insurance, consumer products, transportation, manufacturing, and retail clients through mergers, IPOs, acquisitions and divestitures.

"Karole's inspirational leadership and strategic thinking combined with her extensive accounting and advisory experience across many industries provides valuable perspective, making her an outstanding addition to Aflac Inc.," said Daniel P. Amos, chairman and chief executive officer of Aflac Inc. ★

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# ANALYTICS, NEW PRODUCTS, PREVENTIVE CARE:

# How to Innovate in Dental Benefits

By BRIAN WATTS

**M**any of the significant changes in the health care space that are on the horizon will have implications for oral health and dental coverage. While the Affordable Care Act has increased access to dental care for both children and adults through Medicaid expansion, essential health benefits, and the health insurance exchange, it also has standardized health

plans – making it more important than ever for brokers to be creative in delivering added value to clients. However the landscape changes, at least one thing is clear: commercial dental plans must be innovative and should help push the envelope for better outcomes and greater cost savings.

Ancillary benefits are a practical way for brokers to provide added value to

their clients. And dental benefits remain one of the most popular ancillary benefits for both employers and their employees. However, there has been no real innovation in dental benefits for years, and what has been described as “innovative” has mostly been cosmetic (pun intended).

The act was built on the principles of the Triple Aim, which is to provide bet-

ter care to more people at lower cost. Debate about the effectiveness of the act and its ability to achieve the Triple Aim has always been fierce. But few dispute the need to reduce spending and achieve better outcomes. Quality-driven, value-based health care is here to stay and people will continue to need coverage and payment systems to support it.

### ALIGNMENT REQUIRED

To that end, the dental industry must align with the medical industry to focus on value-based care. In fact, new patient-centered models of care must incorporate all facets of a patient's health – including oral health – in order to realize the potential of better outcomes at lower costs. That would be real innovation.

Using this as a guide, brokers can engage their clients with new ideas that finally have the potential to deliver what every client asks for.

For years, government dental plan administrators have been successfully employing strategies – driven by government regulations – to achieve the dual-goal of better health outcomes for less money. While commercial customers' expectations vary far more widely than those in the government space, they still share that same goal. And, while it won't be easy, it's a discussion worth having.

We already know right-sized networks can help make medical care more affordable. But did you know the same has been effectively done on the dental side? To drive tangible change, brokers and dental benefit companies need to think differently about how to apply analytics to create meaningful differentiators in this space.

Commercial plans can and should get more aggressive in their use of available data to identify the most effective providers based on quality and cost. The power of analytics can be used to support providers and educate purchasers and their employees to create meaningful and positive behavioral changes. If plans use the formidable amount of data at their fingertips, we could see more efficient dental networks, more effective claims edits, and more targeted dental benefits.

### NEW PRODUCTS, OUTREACH EFFORTS

For example, claims data can help us understand the disease continuum by age group and thus inform new products or outreach efforts that aim to address the highest cost areas. Couple this with survey data, such as last year's big news story that more than half of older Americans skip dental checkups, and we can create targeted efficiencies. Cost and



**'...dental benefits haven't had innovation for decades. Now may be the perfect time to initiate that change...'**

quality metrics can also measure provider performance and help shape provider education and outreach to directly impact areas of high cost and low quality.

We also can shift perspectives and tie dental to overall wellness. We know that oral health impacts overall health but the concept is gaining ground in the media, scientific research and the greater health care community. And it should be part of your discussion with your clients. High-cost medical needs for everything from pregnancy to diabetes can actually become better controlled with regular dental visits. In fact, some experts note that including oral health care in the broader solution to address population health may help achieve optimal value-based care.

### TACKLE GUM DISEASE

Recent research has shown gum disease treatment can actually lead to better health management for populations with chronic conditions. The Dental Trade Alliance calculated a possible \$495 million savings if 20 percent more oral cancer cases were detected early and a savings of \$39 billion if 60 percent of people with diabetes better managed their oral health.

Ultimately, dental coverage is a critical link to improving both oral and overall health outcomes, reducing persistent health disparities, and containing systemic costs. It is time we all adopt the new normal – you cannot be healthy without a healthy mouth. This understanding can lead to innovation in medical-dental integration, outreach efforts, and ultimately happier clients – who are more loyal clients.

There are definitely some important catalysts that will continue to shape our industry no matter which way the political winds blow. Remember, commercial dental benefits haven't had real innovation for decades. Now may be the perfect time to initiate that change – and you could hold the key. ★

*Brian Watts now leads California Dental Network for DentaQuest. The network, which has about 60,000 members, provides dental plans to individuals and groups across the state.*

# How to Protect Retirement Plans From Unexpected Healthcare Costs

By CHAD PARKS

**A**s a rule, Americans don't save enough. With pensions nearly extinct and income from Social Security falling far short of requirements, Americans are on their own when it comes to preparing for retirement. Social Security benefits are

up from \$220,000 last year. That's more than the total of most Americans' entire retirement savings. It doesn't even include

**'...unplanned healthcare costs can push retirees into serious financial distress... brokers should take steps now to help clients optimize savings through smart, low-cost financial management that can minimize the impact of unexpected risks.'**

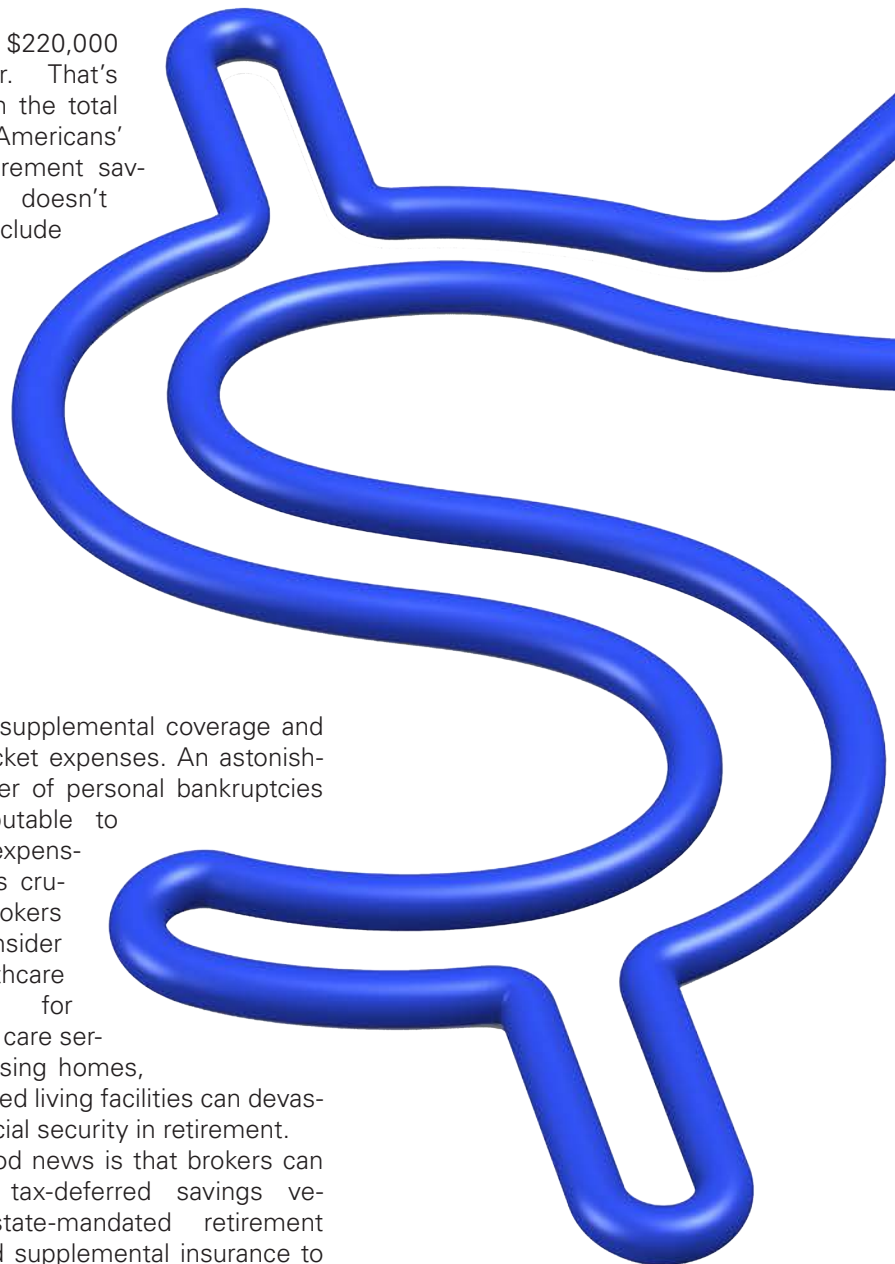
much more modest than many people realize; the average benefit in June 2015 was \$1,335 a month, or a bit over \$16,000 a year, according to the Social Security Administration.

To plan for retirement, it's relatively easy to project some fixed and variable expenses, such as mortgage payments, utilities, taxes and travel, but it's nearly impossible to predict healthcare expenses. For most Americans, healthcare will be one of the biggest expenses in retirement – if not the biggest expense.

Fidelity's Retirement Health Care Cost Estimate reveals that a couple, both 65 and retiring this year, can expect to spend an estimated \$245,000 on health care throughout retirement,

costs for supplemental coverage and out-of-pocket expenses. An astonishing number of personal bankruptcies are attributable to medical expenses. So it's crucial for brokers to consider how healthcare expenses for long-term care services, nursing homes, and assisted living facilities can devastate financial security in retirement.

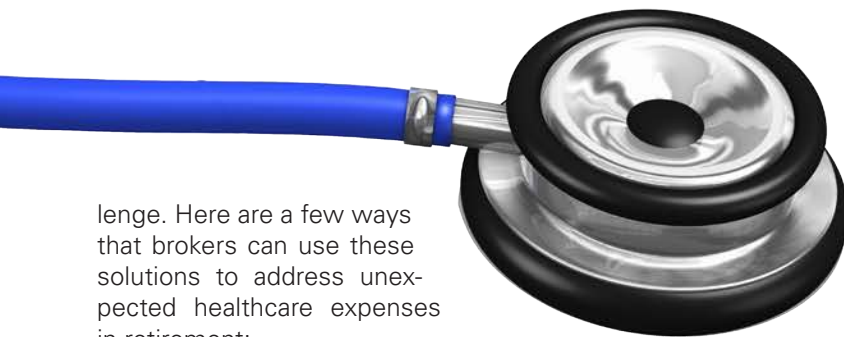
The good news is that brokers can embrace tax-deferred savings vehicles, state-mandated retirement plans, and supplemental insurance to tackle this formidable retirement chal-





ing mandatory employee retirement savings for all small companies. The Los Angeles Times reports that California has taken a step closer to becoming the first state to make retirement savings accounts a near-universal benefit for workers in a plan that lawmakers hope will help ease an expected massive shortfall in retirement savings.

A California state board sent recom-



lence. Here are a few ways that brokers can use these solutions to address unexpected healthcare expenses in retirement:

**Tax-deferred savings accounts:** Too many people avoid or defer health care due to the costs. Many insured people have high deductibles and premiums that represent a sizable portion of their savings. Offering tax-deferred retirement plans and health savings accounts is a smart way to help clients meet these expenses. People can use their accounts to set aside pre-tax income in vehicles that allow for market-related or interest growth. It makes it easier for your clients to get the care they need when they need it, and avoid much more costly care down the road.

**State-mandated employer-sponsored retirement plans:** Many states are recognizing that millions of their citizens don't have access to affordable retirement savings. Nearly half of the states are at stages of implement-



mentations to the Legislature calling for the creation of the California Secure Choice Retirement Plan – essentially a 401(k) plan operated by the state and open to private-sector workers whose employers don't offer a retirement savings plan. Employees of any company with at least five workers would be eligible to participate. That would cover an estimated 6.8 million workers, about a third of California's labor force.

The plan calls for eligible workers to be signed up automatically by their employers and have 2 percent to 5 percent of their wages invested in the plan, unless workers opt out. Your clients will not pay taxes on the money until they take distributions, so it's a great way to grow a nest egg fast. Brokers can seize enormous opportunity by being aware of how this trend will affect their business-owner clients, and offering guidance for the best solution.

**Insurance products:** Longer lifespans present more opportunities for unexpected or extended healthcare costs. Brokers are in a position to offer varying degrees of protection in the form of long-term care insurance, supplemental insurance coverage, or other strategies to ensure stable income. When discussing these options with clients, it's important to explain the pros and cons of each, and carefully consider how these strategies and the dollars contributed to them can fit into an overall retirement plan.

It's a fact – unplanned healthcare costs can push retirees into serious financial distress. Planning for more income and income protection can help shield retirees from that eventuality. Knowing that, brokers should take steps now to help clients optimize savings through smart, low-cost financial management that can minimize the impact of unexpected risks. ★

*Chad Parks is founder, president and CEO of Ubiquity Retirement + Savings, which specializes in fee-for-service planning. The company is headquartered in San Francisco with satellite offices nationwide. Ubiquity serves more than 7,000 small business customers in 50 states, directly and through partners such as Zenefits, Charles Schwab & Co. and Morningstar, as well as payroll companies, financial planners and CPAs.*

# The Future of Technology in Small Group Health Insurance

By KIRK WHELAN

The individual health insurance marketplace has long benefited from efficient online sales and enrollment tools. And the majority of consumers and agents in the individual market have readily adopted these tools. Web-based, anonymous quoting and agent-affiliated web portals have become commonplace, making the online purchasing experience the norm for both agents and consumers alike.

The individual health insurance market has not been the only business segment to take advantage of developing online technologies. During the past decade we have seen many industries, such as banking, retail and even education, harness the power of Internet-based software and mobile technologies, moving away from brick and mortar and paper-based systems.

However, in small group health insurance, the process of enrolling, managing, and renewing clients appears to be stuck in the early 2000s. The lack of adoption of an automated, online purchasing and enrollment experience is due to many factors, but the major hurdles lie in the unsuccessful attempts to establish uniform data interchange formats and the comfortability at which agents and employers are able to utilize ancient business practices as a work around.

Whether or not the industry is ready, change is happening now in the small group market. Benefit plans have become more standardized, and many companies have joined the technology race to establish fully integrated and easy-to-use sales and enrollment platforms. If successfully implemented, all parties are expected to reap the benefits of streamlined administrative processes, including a reduction in the number of required connections,



increased security, and improved margins. And, by the nature of its business, few other organizations are as well-positioned to effectively lead this charge as the exchange marketplace.

## STANDARDIZING THE TRANSFER OF DATA

Much of the small group health insurance industry is burdened by archaic file-sharing practices. Although we saw numerous technology startups emerge in recent years with the goal of tackling these obstacles, operational systems used industrywide remain largely outdated and lacking in efficiency.

How difficult can it be to get on the same page? While we may all desire improved speed and reduced administrative burdens, many in the small group benefits industry continue to play the game with their cards close to their chest. David Reid, chief executive of EaseCentral, a human resources and benefits software company, says: "Although many carriers still have

cumbersome, antiquated solutions for enrollment and change management, the carriers that have adopted a solution often require use of their own proprietary system – requiring an employer to change from completing five different forms to having five different websites." Despite many of our best efforts, steps taken to advance the process tend to create more work, distancing us further from streamlined interactivity.

At the exchange level, technical companion guides are used that outline industry standards to help combat these nuances. However, Covered California for Small Business, for example, must still tailor file formats case-by-case to accommodate subtle differences in requirements among carriers. This not only requires an increase in administrative responsibilities, but sharp managerial oversight and employee training, which all contribute to an increased cost of doing business.

"The opportunity to eliminate manual data entry and paper applications

stands as one of the most obvious and simple solutions for helping drive waste from our health premiums,” says Michael Lujan, co-founder and chief strategy officer of Limelight Health, a cloud-based health insurance quoting platform. “However, the market is still fraught with complexities and new technologies take time to implement.” Although the technological capabilities may exist, implementation is the true battleground. Every affiliated party in the small group insurance market—carriers, agents, general agents, employers, and exchanges—are ultimately responsible for seeing any advancements come to fruition.

#### ADOPTION IN THE AGENT COMMUNITY

The agent, in particular, plays a powerful role in shaping the future of technology in the small group insurance marketplace. “The average age of today’s broker is 55 and many are reluctant to adopt technology tools,” says Reid. “However, these tools are becoming so easy to use and do not require advanced technical skills. Nonetheless, there is a perception that they take time and cost money. In reality, those who have embraced these solutions are finding they can reduce costs and allow any agency to do more with less resources.”

The online tools available to partners of Covered California for Small Business have been fully adopted by the general agent community, but only 4.6 percent of the Covered California agent community are actively using these available resources. General Agent partners have benefited from consolidated administrative processes and the improved return on their time invested. However, with the option to submit manual, paper documentation still intact, brokers have not reaped the same benefits. Having experienced similar issues, public exchanges in regions like Washington D.C., New York, as well as the Federal Small Business Exchange, have encouraged greater adoption rates by their agent partners by eliminating the option for agents to manually submit any paper documentation.

It is no surprise that many companies are targeting the small group

agent for assistance in the movement to online platforms. “We are focused on expansion, getting more insurance brokers to adopt online tools and automation,” Lujan says. “As more insurance channels get familiar with online tools, this will quickly become the norm and each open enrollment can be less burdensome and a more delightful experience.”

Regardless of the shift towards technology, the pressure to adopt online business practices and improve administrative efficiencies will not go away.

***'It is certain that we will see the trend toward the standardization of processes in the small group health insurance segment continue to develop and the integration of online tools become more prevalent.'***

#### PARALLELS ELSEWHERE

Colin Rogers, a prominent health care consultant and current vice president of carrier relations at Zenefits, an online small business HR platform, commented about the parallels of this technology shift to ones we have seen in other segments. “With the advent of private exchanges in Medicare 15 years ago, we experienced a similar shift as carriers were forced to automate a significant portion of their processes as business through these new channels expanded,” he says. “The arc is now continuing with the normalization of small group plans. Although large group had always been predominantly automated, small group had never had a forcing function to drive that technological adoption. We are currently in that painful pre-adolescent stage in the small group market as we make the transition to join the adults.”

However painful the transition may be, standardizing business practices within the small group health insurance industry is a must. Companies are beginning to move toward the use

of Application Programming Interface as an alternative to Electronic Data Interchange.

“As more insurance, payroll, and other benefits-related organizations begin using API integrations, we will begin to see faster and more accurate transmissions of data between various parties,” Lujan said. “As the industry becomes savvier in syncing with users in real-time through API and cloud-based platforms, a leader will emerge that can facilitate the entire process.”

#### THE OPPORTUNITIES AHEAD

Group exchanges have a prime opportunity to tie these pieces together for the agent and the consumer. As technology platforms, exchanges coordinate data transfer among the group, the agent, and the insurer. In a market where many hesitate to lead the charge out of self-preservation, exchanges will be a driver to advance interconnectivity.

As an aggregator, exchanges are also a one-stop data source for agents, employers and carriers. “Conveniently transmitting insurance data between employers and insurance carriers is a growing initiative that stands to help improve the speed and efficiency for insurance enrollment and other administrative processes,” says Lujan. “This automation also promises to help reduce hours of manual data entry and administrative costs for insurance carriers.”

The exchange market truly has the opportunity to increase efficiencies for all involved while simultaneously mitigating security risks by reducing the number of required connections.

It is certain that we will see the trend toward the standardization of processes in the small group health insurance segment continue to develop and the integration of online tools become more prevalent. Often times change is a difficult pill to swallow, but engaging in process improvements will ultimately be a win-win situation for all of us. ★

*Kirk Whelan is the director of Covered California's sales division. He has led efforts in operational, system and agent commission issues that have contributed to the growth of Covered California's individual and small business exchange.*



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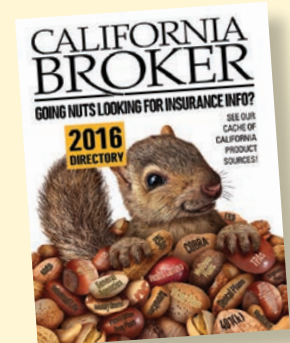
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