

# CALIFORNIA BROKER

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SERVING CALIFORNIA'S LIFE/HEALTH PROFESSIONALS & FINANCIAL PLANNERS

JANUARY 2017

## POST ELECTION HEALTHCARE SHOCK WAVES



**WHAT WILL BE THE RIPPLE  
EFFECTS IF THE ACA IS  
REVISED OR REPEALED?**

**ALSO INSIDE: Healthcare • Medicare • Life & LTC • Annuities • HSAs  
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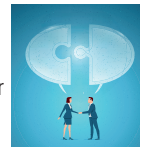
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## A Message to Agents from John Nelson, Warner Pacific Co-CEO

The passage of the ACA was not the final chapter in how people get their healthcare coverage. Rather, it was just another new beginning. And no doubt, we are all likely to see more “new beginnings” in the next few months and coming years.

The one thing the public can always count on is you. With all of the complexities, uncertainty and talk that are associated with the healthcare system, you are THE stabilizing force for the individuals, families and employers you serve.

Your knowledge and heart are what make everything work. Insurance companies know it. Lawmakers know it. And so does the American public. When you succeed, everyone benefits, especially your customers.

We look forward to the journey ahead with you. No doubt we’re all in for some exciting times. As always, you can count on us for relevant information on whatever changes may be coming our way.

As we’ve been for more than 30 years, we’re all about doing everything we can to support you — now and in the future. You entrusting us to help you take care of your customers humbles us, and we take this responsibility very seriously. Your business means the world to all of us and our families.

We hope you had a wonderful holiday and wish you a terrific 2017.



John Nelson



# You Can Rock the Year in 2017

by JOE NAVARRO

**Y**our answer to five important questions will shape your success in 2017.

1. What technology do you offer to make my enrollment process and employee communication easier? Consumers have grown to expect best-in-class user experiences from online and mobile interactions. Their experiences with any product or service—anywhere—now shape demand in the digital and benefit world. You can expect to see more and more of those demands.
2. What concierge-like services are you offering and how will you deliver more targeted, relevant long term experiences to attract and retain clients? Today's consumers are mobile; their attention is fleeting; and their demands for great experiences are high. They are totally different than the previous dominant generation.
3. The competition will ramp up as changes are made in the Affordable Care Act. What are you doing to better know your clients, get their attention, and meet the needs of their employees? Consumers will comparison shop like never before and brand loyalty will decline accordingly. With change comes disruption. Your existing and future clients will be open to an agency that better understands them and offers them refreshing solutions.
4. Are you doing what you have always done and expecting the same results? The sales cycle will continue to change as will your clients. What are you doing differently to market your agency? What can you do to truly understand the data that you are sitting on? It is a good time to start mining the gold in your client data. How do you become a master at measurement and analytics.

More importantly if you don't understand the reason why you should what will you do to get up to speed in our new world of data mining? Data-driven agencies will know more of "what good looks like" and will fine tune customers experiences by measuring data more aggressively and optimizing ways to meet the needs of existing and future clients.



5. Are you aggressively innovating as we enter into a new phase of health care reform? It has only just begun. You will be hearing from all the pundits and industry experts on what is to become of our industry. What is important is to figure out who is providing you the best direction/services/tools and latch onto them for "Mr. Toad's Wild Ride." Here's a given: Our industry will continue to change dramatically. Unpredictability will open the door to possibilities. You will have tremendous opportunities to grow your business. The book on health insurance will continue to be re-written and it will remain a very difficult read for most consumers/businesses (translation: your future clients). My prediction is that health insurance advisors/consultants like you

will become more popular than Elvis in 2017 (Thank you very much). So what do you do now? Embrace it!

Start looking at creative thinking/marketing as a required skill set for you and your agency rather than a characteristic we all associate with the likes of Walt Disney, Steve Jobs, or Steven Spielberg (great group of people by the way). It requires you to invest the time and believe passionately in the need to ride the wave of innovation and implement new strategies for success. The modern agent is a marketing technologist with a goal of creatively differentiating their agency from the competition, knowing that the rules have changed, and understanding that consumers want something that will motivate them beyond what has been the norm in the past.

You have a couple years of fourth quarter insanity under your belt. Take that experience and go crazy with creativity to restructure your agency and how you grow your business. Take the "my tech tools are better than your tech tools" conversation going on today. Remember as recently as a few years ago when this was a blip on the radar. Today it is not only on the radar but dominates the conversation (especially if you sell group products). Is it a game changer and a money maker if you combine it with the right personalized services? Count on it.

So how do you stand out?

1. Communicate (creatively market) often offering as much value as possible in the shortest time possible with the understanding your future clients want "instant on" (That's where the marketing technologist comes in).
  2. Simplify your tech tools discussion and reassure them that you are
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	Bests	Fitch	S&P									
American Equity	A-	A-	ICC13 MYGA (Guarantee 5) (Q/NQ)	S	2.15%*	5 yr.	None	9%, 8, 7, 6, 5, 0	Yes	\$10,000 (Q) & \$10,000 (NQ)	3.00%, age 0-75 & 2.10%, age 76-80**	
			ICC13 MYGA (Guarantee 6) (Q/NQ)	S	2.35%*	6 yr.	None	9%, 8, 7, 6, 5, 4, 0	Yes	\$10,000 (Q) & \$10,000 (NQ)	3.00%, age 0-75 & 2.10% age 76-80**	
			ICC13 MYGA (Guarantee 7) (Q/NQ)	S	2.50%*	7 yr.	None	9%, 8, 7, 6, 5, 4, 3, 0	Yes	\$10,000 (Q) & \$10,000 (NQ)	3.00%, age 0-75 & 2.10%, age 76-80**	
*Effective 12/6/16. 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%* <sup>a</sup> 2.60%* <sup>b</sup>	5 yr.	None	8%, 8, 8, 7, 6, 5, 4, 3, 2, 1, 0	Yes	\$10,000 (Q&N)	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	S	1.60%* <sup>a</sup> 1.80%* <sup>b</sup>	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)												
(*Guarantee Return of Premium) (Q/NQ)												
American General Life Insurance Companies	A	A+	A+	American Pathway Fixed 7 Annuity	S	2.10%* <sup>a</sup> 2.30%* <sup>b</sup>	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)
Effective 11/17/16. Includes .25% first-year bonus and is for purchase payments over \$100,000. Escalating five-year yield is 2.25%. For under \$100,000 first-year rate is 2.10%. Escalating rate five-year yield 2.10%.												
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)
Effective 11/17/16. Includes 1.00% first-year bonus and is for purchase payments over \$100,000. Escalating seven-year yield is 2.44%. For under \$100,000 first-year rate is 2.45%. Escalating rate seven-year yield 2.34%.												
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
*Effective 11/17/16. Eff. yield is 2.67% based on 1.65% first year rate, 1.00% available portion of 10% annuitization bonus (available starting in contract year two) and 0.02% interest on available portion of bonus at the rate of 1.65%. Surrender value interest rate 1.65%. Accepts additional purchase payments in first three contract years. COM12255												
The Lincoln Insurance Company	A+	AA	AA	MYGuarantee Plus 5	S	1.80%* <sup>a</sup> 1.95%* <sup>b</sup>	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%* <sup>a</sup> 2.05%* <sup>b</sup>	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%* <sup>a</sup> 2.15%* <sup>b</sup>	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%* <sup>a</sup> 2.25%* <sup>b</sup>	8 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												
North American Co. for Life and Health	A+	AA-	A+	Gaurantee Choice (Q/NQ)	S	2.20%* <sup>a</sup> 2.45%* <sup>b</sup>	5 yr.	None	10, 10, 9, 9, 8	Yes	\$2,000 (Q) \$10,000 (NQ)	2.00% (0-80) 1.50% (81-85) 1.00% (86-90)
*CA rates effective 12/6/16 - a (less than \$200K) b(200K or more)												
Reliance Standard	A+	A	A	Eleos-MVA	S	3.55%*	1 yr.	None	8%, 7, 6, 5, 4	Yes	\$10,000	3.25%**
*Effective 12/2/16. Includes 1.50% 1st yr. bonus. Min. guarantee is 1.00%. **Reduced 20% ages 76-80, and 40% ages 81-85												
Reliance Standard	A+	A	A	Apollo MVA (Q/NQ)	S	4.45%*	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	2.95%*	7 yrs.	N/A	8%, 8, 7, 7, 6, 5, 4, 0	No	\$10,000	Varies
*Effective 12/15/16. 2.45% base rate with no guaranteed return of purchase payments. Plus 0.50% bonus for \$250,000 and above.												





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# Travel Health Insurance: The Unexpected New Necessity

by BRENDAN SHARKEY

Last year, over 73 million Americans traveled internationally on work assignments, leisure travel, or study abroad programs. The seasoned traveler or veteran global citizen is likely to be familiar with the benefits offered by travel health insurance – namely the relative affordability of the coverage in comparison to a domestic health insurance plan, access to quality medical care internationally, and 24/7 customer support. However, millions of Americans still meticulously prepare and make arrangements for their trips while remaining unaware of the risks they may encounter by not taking equal measures when it comes to their medical care while abroad.

Domestic health insurance plans are designed to work best domestically and may leave critical gaps in international care. Many travelers may be surprised to learn that services covered by their domestic carrier overseas are strictly on a “pay and claim” basis, leaving subscribers to absorb sometimes pro-



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hibitively high medical costs, depending on the treatment they are administered. Travelers sometimes face a serious medical emergency that requires a medical evacuation using an air ambulance or an expensive medical procedure. Most travelers are not in a position to make an upfront payment in the tens of thousands of dollars to secure these services and then file a claim with their domestic health insurance carrier when they return home. Keep in mind, most domestic plans don't cover expensive medical evacuations. For those that say they do, good luck finding the actual terms of coverage spelled out in a certificate of insurance.

If the unexpected isn't enough to put travel health insurance at the forefront of your pre-trip planning list, consider the routine. The majority of our medical cases outside of the U.S. have been for routine sick visits, infections, common digestive problems, management of a chronic illness, orthopedic visits, and primary care.

Traditional travel insurance, which many travelers do rely on, may also leave critical gaps. Travel insurance is mostly designed to protect against the cost of the trip with a focus on trip cancellation, interruption, and baggage loss benefits. These policies typically provide medical care only in the case of medical emergencies and have little to no coverage for non-urgent or routine medical care. Travel health insurance offers seamless payment from insurer to a health-care provider and incorporates routine and primary care, bridging the gap between the traditional secondary or supplemental coverage (coupled with a traveler's existing domestic plan) and a primary, more comprehensive travel health insurance package.

The need for travel insurance went beyond trip cancellation or lost luggage for the tens of thousands of college students in Paris at the epicenter of the November 13, 2015 terror attacks and the millions of travelers heading to Zika-impacted Rio de Janeiro in the summer of 2016. Suddenly, tangible risks threatened their safety and well being. Travel health insurance plans that covered medical services and evacuation were a vital lifeline and source of support. In light of the terrorist events



and epidemics of the last few years, a whole range of integrated disaster response services is now available with travel health insurance, including video consultations, specialist referrals, medical evacuations where local treatment is sub par and political and natural disaster evacuation.

Take the recent story of a college student who embarked on an exciting post-graduation trip around the world. Her adventure brought her to Chiang Mai, Thailand where she began exhibiting symptoms of typhoid fever, which is rare in the United States, but much more prevalent there. When she purchased her individual travel health insurance plan, she admittedly put little (if any) thought into the idea of ever needing to access the benefits. At her sickest and most vulnerable, in a country where she was not familiar with the medical system nor the language, she now looks back on that coverage as her most vital lifeline and clearest path to recovery.

Additionally, the duration of a subscriber's time abroad or on assignment is significant in determining the appropriate insurance for their needs. Expats in particular, (categorized under periods of a relocation of six months or more), need insurance that provides robust benefits that are not simply limited to emergency treatment since the likelihood of accessing healthcare in their host location is significantly increased. Aside from the limitations of their domestic U.S. health insurance

policies in terms of the overseas coverage and network, expats should pay close attention to the fine print. While eligibility requirements may vary, many can find themselves no longer insured under their domestic plan after as early as 60 days living and working outside of their home service area.

When it comes to travel health insurance, the writing has been on the wall for decades. In the past 20 years, the number of Americans holding passports has increased by 300% to almost 19 million; statistics suggest that the uptick of applications continues monthly. The availability of travel health insurance and the variety of coverage options will only continue to correlate directly with this trend. Brokers will continue to be a resource for their clients in need of these valuable solutions.

We must bring that same vigilance we hold in insuring our luggage and itineraries to our physical health and security. ★

*Brendan Sharkey is the director of Individual Products for GeoBlue. From the nuts and bolts of international health insurance to the crucial themes of global health and safety, Brendan is frequently called upon to discuss the global insurance landscape. His contributions include CNBC "Squawk Box," WGN AM Talk Radio, Forbes, The Wall Street Journal, NY Times, USA Today, LA Times, among others. A citizen of the world, Brendan has lived in Scotland, Canada, Australia, and the United States. To contact Brendan Sharkey email [bsharkey@geoblue.com](mailto:bsharkey@geoblue.com).*

## **CIGNA LAUNCHES PERSONALIZED SERVICE TO HELP CHOOSE HEALTH PLAN**

While many service providers are automating, offshoring and dumbing down their capabilities, Cigna is investing in an integrated hi-tech/hi-touch approach to customer decision support and service. Starting January 1, 2017, 1.2 million Cigna commercial health plan customers will get One Guide access to guided consultations via phone, mobile app and "Click-to-Chat" for choosing their benefits, building a personal health team of doctors, clinicians, and coaches and reducing their health expenses through reward programs. A survey of One Guide early adopters reveals the following:

- They have 10% higher engagement rates in chronic, wellness and lifestyle health advocacy programs.
- They have 3.2% higher transactional net promoter scores.
- There is a 48% increase in mean incentive balance, as compared to non-users.

## **STREAMLINED ENROLLMENT**

Benefitfocus has expanded its client base in the education sector. The Benefitfocus platform integrates personalized recommendations, decision support tools and contextual videos to lighten the education burden of benefit administrators. The mobile optimized platform helps them reach a dispersed workforce. For more information, visit [Benefitfocus.com](http://Benefitfocus.com).

## **LIFE INSURANCE WITH WELLNESS BENEFITS**

John Hancock launched a wellness program for its Vitality life insurance policyholders. They can earn a new Apple Watch Series 2 for just \$25 by being more active. Policyholders choose their Apple Watch Series 2, pay the \$25 initial fee (plus tax), and get an Apple Watch Series 2 to get started. Participants track their activities and earn Vitality Points that go toward monthly payments for their watch over two years. John Hancock Vitality members will be able to fully fund their Apple Watch by meeting monthly Vitality Active Rewards targets that are achievable over 24 months. John Han-

cock's Vitality program allows policyholders to save significantly on their premiums and earn valuable rewards by taking small steps to live healthy, like walking, exercising or getting regular check-ups. The program expanded earlier this year with the addition of the Vitality HealthyFood benefit. Customers can earn points and save up to \$600 a year on their grocery bills for choosing healthy foods at participating grocery stores. For more information, visit [manulife.com](http://manulife.com).

## **PRACTICE MANAGEMENT TOOL FOR ADVISORS**

Voya Financial launched its Business Builder tool for financial advisors as the latest addition to the firm's expanding suite of practice management resources. The new tool will allow advisors to set and monitor the progress of business growth goals. The Business Builder tool is for advisors who serve retail clients and participants in school, government, and nonprofit employer-sponsored retirement plans. The tool provides a comprehensive view of gross dealer concession (GDC) sales, and net new assets across multiple product categories, which enables a more efficient estimate of growth projections. For more information, visit [voya.com](http://voya.com).

## **WELLNESS MOBILE APP**

Humana launched Goal Guru, an iOS and Android-compatible mobile app and web experience. It gathers data from a multitude of trackers and mobile apps. It allows users to participate in competitions and engage each other through wellness tracking. It also offers 24/7 interaction with a digital coach. The app is designed to improve the activity level of employees by monitoring of steps, weight, and sleep. Users get personalized news feeds throughout the day and can increase engagement by messaging a team or individuals to initiate a challenge.

## **DOCUMENT SERVICE**

LifeSite introduced LifeSite Pro, a secure digital vault for information exchange and document management, especially for financial service and insurance companies. LifeSite's interactive portal helps them securely or-

ganize, store, and share their clients' information in one place. For more information, visit [lifesite.co](http://lifesite.co).

## **SCAN HEARING AID BENEFIT**

The majority of SCAN Health Plan members with hearing loss can now get significant savings on new hearing aids thanks to a 2017 benefit being introduced by the not-for-profit Medicare Advantage health plan. The new benefit includes a routine hearing exam, hearing aid fitting and evaluation, and two hearing aids per calendar year with a simple copayment of \$699 or \$999 per hearing aid, depending on the hearing aid selected. This is a significant out-of-pocket savings when compared with the average retail price of two hearing aids, which is approximately \$4,700 per pair according to the National Academies of Sciences report on hearing aid affordability.

## **MED SUPP FITNESS BENEFITS**

Members in Anthem's currently marketed Medicare Supplement Plans A, F and N in California will have full access to SilverSneakers at no extra cost. SilverSneakers offers access to more than 13,000 fitness and wellness facilities nationwide, as well as the SilverSneakers FLEX network, which includes classes and activities at community-based locations. Members can take advantage of a host of comprehensive program features including facility amenities and a variety of specialized group exercise classes taught by instructors trained in senior fitness.

## **SHORT-TERM LIMITED MEDICAL INSURANCE**

The new 90-day duration limit imposed on Short-Term Medical insurance for compliance with the Affordable Care Act, positions the Short-Term Limited Medical product from Standard Life and Accident Insurance Co. to fill a unique niche since it is categorized as Limited Medical and therefore not subject to the ruling. Benefits of short-term limited medical coverage include a fast approval, no restrictions on health care providers, and affordability. For more information, visit [American-National.com](http://American-National.com).

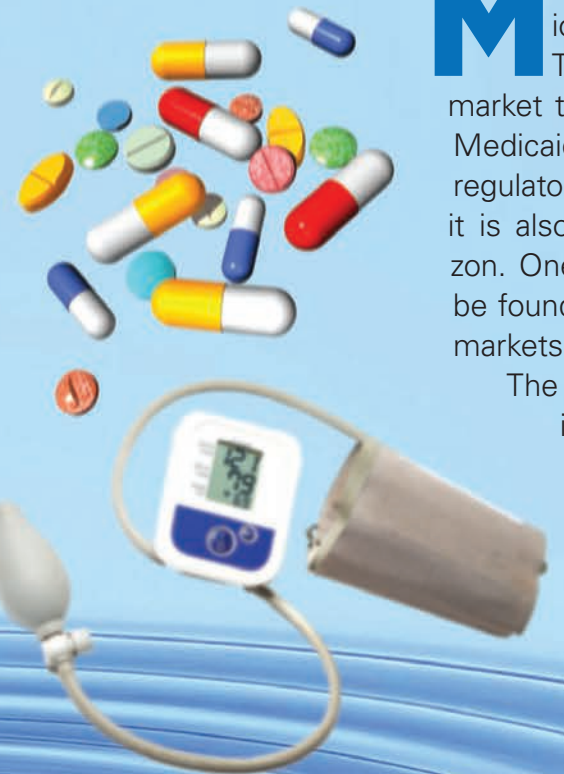
# POST ELECTION HEALTHCARE SHOCK WAVES...



**WHAT WILL  
BE THE RIPPLE  
EFFECTS IF THE  
ACA IS REVISED  
OR REPEALED?**

# HOW THE TRUMP PRESIDENCY WILL AFFECT ACA

by ERIC HELMAN



**M**any analysts are commenting on the more likely scenarios of the repeal and replace theory, in which President Trump and the Republican majorities tweak the individual market to enable carriers to sell across state lines, provide for Medicaid expansion in the form of block grants, and reduce the regulatory burden on employer-provided insurance. However, it is also possible that revolutionary changes are on the horizon. One possible source of such a revolutionary change may be found in the convergence of tax policy, the health insurance markets, and the desire to reduce the burden on businesses.

The appointments of Steven Mnuchin and Rep. Tom Price increase the likelihood that the next healthcare reform will come in the form of tax reform.

President-elect Donald Trump has promised that reform of the tax code will be one of his key priorities.

The recent appointment of former investment banker and hedge fund investor Steve Mnuchin and the content of

his post-appointment interviews reconfirm this priority. While all the specifics have not been published, some of the key themes are reduction in the corporate tax rate, provision for the repatriation of foreign earnings without taxation, and reduction in individual tax rates. Mr. Mnuchin's comments have offered some clarity on the last point when he said on CNBC, "Any reductions we have in upper-income taxes will be offset by fewer deductions so that there will be no absolute tax cut for the upper class." The implication is that there will be an elimination of individual deductions (also known as tax expenditures) for upper-income filers. The exclusion of employer-provided benefits is the largest area of tax deductions. While Mr. Mnuchin did not specifically mention employer benefits, his comments did put mortgage interest on the table and it is difficult to see how they deliver a meaningful marginal rate reduction without including one of the other big hitters.

Another interesting aspect of the employer benefit exclusion (as well as the mortgage interest deduction) is that it is regressive in nature. In other words, it provides more value to higher income individuals than lower income individuals. In fact, 49% of the value of this exclusion goes to individuals making over \$100,000 per year. (78% of the value of the mortgage interest deduction goes to households making more than \$100,000 per year.) The elimination of this type of tax exclusion would benefit the lower and middle classes at the expense of the wealthiest Americans. Of course, if the purpose of the elimination was to fund an overall reduction in marginal rates from 39% to 30%, much of this lost value would be restored back to the households who pay the most taxes and formally benefitted the most from the health insurance exclusion. Another attractive feature of this type of move would be that it "simplifies" the tax code – also a promise of Republicans.

But how does this relate to the promise to "repeal and replace" the ACA? Enter Representative Tom Price. Price's Empowering Patients First Act proposes a new refundable tax credit and includes only one idea to pay for said credit—a cap on the tax deduct-

ibility of employer-sponsored health coverage. It is clear that the two proposed cabinet secretaries have something in common here and they both target the tax deductibility of employer-provided benefits.

But what would happen if many of the employer provisions of the ACA were repealed and the special tax treatment for employer-provided benefits were also eliminated? Would this not lead to the massive reductions in

***"Whether 'repeal and replace' amounts to a revolution or a gradual series of rollbacks without a clear direction, the continued pressure of healthcare inflation, regulatory compliance, and tightening labor pools will force both employers and benefit consultants to apply innovative and creative strategies for employee benefits."***

the number of insured Americans? Perhaps not. One of the things we learned over the past several years is that the number one indicator of whether an individual would seek out health insurance in the future was their previous experience with health insurance.

The migration of millions of Americans from employer-sponsored insurance to the individual market may also have some other positive effects. First and foremost, it would serve to stabilize this market for the private insurance companies that have exited many locales. This would be appealing to both the insurance companies and to Trump, who is loath to remove the elimination of medical underwriting – a very popular provision of the ACA. (Of course, another promise of the Trump administration is to let individuals buy insurance across state lines, reducing the impact of local market exits.) Second, if the tax subsidies in the individual market under the ACA were re-

tained, their progressive nature would tend to benefit lower and middle-class families more than the employer-based tax exclusion. Finally, employers might be inclined to move some of the cost of employer-provided health insurance into compensation increases. This would increase take home pay in the short run, improving the perception of employees on how the Trump administration impacted their household economics.

So, where does this leave the employer-driven benefits market we know today? As health insurance moves from an employer-chosen plan that is enrolled in, to an individually-selected plan that is purchased, leading employers will be forced to reevaluate their role in helping their employees with their overall financial wellness – of which health insurance will still be a foundation.

Additionally, the early experiments with private exchanges have shown us that when employees have more choices they tend to choose lower value plans with lower premiums. This trend will increase the value of supplemental and ancillary insurance plans, which still work much better in a group environment. As the economy grows and labor markets tighten, employer fringe benefit programs will increase in importance regardless of the role of health insurance in employer benefit programs.

Whether "repeal and replace" amounts to a revolution or a gradual series of rollbacks without a clear direction, the continued pressure of healthcare inflation, regulatory compliance, and tightening labor pools will force both employers and benefit consultants to apply innovative and creative strategies for employee benefits. In any event, the landscape will not change overnight. The passage of Obamacare took two years. In the meantime, strategic delivery of these benefit programs will remain critical to their overall effectiveness. □

*Eric Helman is Chief Strategy Officer for Hodges-Mace, where he is responsible for creating, communicating, executing, and sustaining strategic initiatives. Eric brings a vast background in innovative employee benefits administration and enrollment processes to the thriving Atlanta-based employee benefits firm. To reach him, email [erichelman@hodgesmace.com](mailto:erichelman@hodgesmace.com).*



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**POST ELECTION  
HEALTHCARE  
SHOCK WAVES**

# IS THE ACA REPEAL TAKING SHAPE?

by ALAN KATZ

There'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).

Come January, Republicans will need to prove they can handle the prose part. As discussed in my previous post, 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

***"What should not be overlooked...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."***

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

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 revoking President Barack Obama's executive orders or issuing new ones. The legislation and executive orders become effective at the end of either 2017 or 2018 to allow for a "smooth transition."

and Albert Hunt on Bloomberg.com do a great job in reporting on this evolving strategy. Meanwhile, opposition to TBDCare is already building as evidenced by an editorial in the *Denver Post*.

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, insur-



***"For GOP leaders trying to avoid the wrath of voters...living under a frightening dark cloud for a couple of years might look better than ushering in the health care reform apocalypse."***

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."

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 they don'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

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.

Jennifer Haberkorn on Politico.com

ance 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 principal of a start-up, Insurgency Benefits, bringing The Protect Plans to market – non-traditional benefit programs to reduce employers' costs, improve employees' health, and provide producers with a market advantage. He is also CEO and co-founder of Take44, the company behind NextAgency—enterprise software to help benefit brokers to level the playing field with high-tech competitors. A past president of the California and the National Associations of Health Underwriters, Alan led the legislative efforts of both organizations and testified before several Congressional and state legislative committees. In 2003 he received NAHU's highest honor, the Harold R. Gordon Memorial Award, as Health Insurance Person of the Year. CAHU named Alan as its Member of the Year in 2000 and 2007 and he received a Presidential Citation in 2015. He is currently president of the Los Angeles Association of Health Underwriters. For more information, visit <http://alankatzblog.com>.*

## POST ELECTION HEALTHCARE SHOCK WAVES

# GET READY FOR TRUMPCARE

by MICHAEL LUJAN

**D**onald Trump is our President Elect and will immediately begin building a cabinet and the work to fulfill his campaign promise to "immediately repeal and replace Obamacare." Trump said he would "ask Congress to convene a special session so we can repeal and replace." although Congress will be in session right after the inauguration, so it wouldn't be necessary to call a special session. In any event, the very challenging work will start soon as Trump's campaign left little room for anything less than full repeal... and he has the House and Senate majority to actually do something but hasn't really offered specific details for what a replacement plan would look like. The Committee for a Responsible Federal Budget did a review of Trump's healthcare plan and estimates a cost of \$279 to \$490 billion over 10 years. Another report from the Congressional Budget Office showed a \$137 billion net increase to the deficit over the next decade if the ACA is repealed. Tuesday's transfer of power may now achieve what 60 previous GOP attempts to repeal could not. But replace with what?

Trump often refers to removing state lines or barriers to encourage health insurance carriers to compete across state lines. He also supports health savings accounts and state block grants to fund Medicaid. If he makes good on his campaign promise, this could also mean a phased rollback the advanced premium tax credit (APTC), the government subsidies established under the ACA but continuing to some elements of the ACA, like keeping the pre-existing conditions ban and dependents to age

26. Still, a repeal could mean 24 million Americans lose the coverage they obtained through state and federal public exchanges by 2024 – so this will not be easy.

***"...Don't be too surprised if TrumpCare ultimately looks a lot like ObamaCare. Remember, ObamaCare was originally modeled after RomneyCare in Massachusetts so there's a pattern here."***



Was healthcare a factor in the election outcome? To the extent that health care or "Obamacare" factored into the election, I think the timing of large rate increases was very untimely for the Clinton campaign. Many employers and individual consumers have been receiving significant rate increases during the final weeks of the campaign. Massive rate increase in states like Pennsylvania (53%), Arizona (63%)

and Tennessee (115%) made news headlines and likely swayed some undecided voters to support Trump and his vague promise for "something much better."

House Speaker Paul Ryan also has a proposal to replace Obamacare but was also pretty vague. Without clear consensus or details, an immediate replacement plan seems unlikely and could be a major disappointment to supporters who took him at his word... to replace it immediately. It would not be surprising to see some of Clinton's ideas worked into a new GOP plan or proposal including extending a Medicare buy-in option for Americans over 50 years old. Possibly prescription drug reforms which allow importing lower cost drugs from abroad and other unconventional solutions.

Health care affordability is on an unsustainable trajectory for too many Americans. Whether it's solved by tweaking the ACA or a complete overhaul, it will be a tough couple of years as no fix will have an immediate impact. The new administration must address the underlying cost of healthcare which makes health insurance unaffordable.

Vice-President Elect Pence could have great influence in crafting a workable ACA fix or replacement. During the campaign, Pence said "We don't want the socialized healthcare they have in Canada. We want American solutions...". But under Pence, Indiana opted to expand its Medicaid program under the ACA, unlike 19 other mostly red states, including Texas and Florida. It's possible Pence's own favorable ACA experience could help inform a national policy which preserves

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some of the ACA and allows states to apply waivers or modifications like he did in Indiana. For example, most state Medicaid plans do not require co-pays for office visits or emergency room visits... a modification made by Pence through a state waiver where Indiana Medicaid patients pay from \$1 to \$25 per visit. Indiana might serve as a better-than-average example of states making the ACA work... their rate increases are below the national average, but the recently had four of their eight carriers exit their state exchange. Rather than a public option, it's possible the new administration could work toward a solution that truly encourages private carriers to compete and stay in the individual market. Simply "removing state lines" and allowing competition across state lines is not enough if the market conditions and risk mix is not sustainable or attractive to carriers.

Trump once supported and praised single-payer... "like in Canada and Scotland...".

In summary, don't be too surprised if TrumpCare ultimately looks a lot like ObamaCare. Remember, ObamaCare was originally modeled after RomneyCare in Massachusetts so there's a pattern here. Likewise, don't be surprised to find gridlock and lack of consensus for a TrumpCare proposal within the GOP-controlled Congress. There are very strong opinions about the ACA and if any of it should stand. A compromise solution might feel like a betrayal to Trump supporters who really expected him to repeal on day one, but Republicans could have difficulty getting the 60 votes needed to repeal through a 100-seat Senate. On the campaign trail, Trump made a very ambitious to-do list for his first days on the job. We will soon find out where healthcare stands among these many competing priorities. ★

*Michael Lujan is a co-founder at Limelight Health, the benefits quoting platform that powers some of the largest carriers, general agents and national broker firms... and thousands of independent agents from California to New York. He is also an advocate for the uninsured, small business and the more than half million licensed insurance agents who serve this important market segment. Learn more: [www.cahu.org](http://www.cahu.org)*

**POST ELECTION  
HEALTHCARE  
SHOCK WAVES**

**SIX ACA  
REPEAL**

# CHALLENGES FOR REPUBLICANS

by DR. MERRILL MATTHEWS

**P**resident-elect Donald Trump made repealing and replacing Obamacare, which passed with only Democratic support, one of his major campaign themes. But he and Republicans in Congress will face a

***Politico reports, "Smart, politically attuned congressional Republicans are already scared of the implications." But they need to get started immediately to fulfill that oft-made campaign promise.***

number of challenges trying to fulfill that pledge.

Republicans retained their Senate majority, but they do not have the 60 votes necessary to end a filibuster. So unless they can persuade some Senate Democrats to join them or unless Republicans eliminate the filibuster—Democrats could block the measure, making full repeal is almost impossible.

Senate Republicans can repeal important parts of Obamacare through the reconciliation process—those relating to tax and budget issues—because that only needs 51 votes. (The new Senate will have 52 Republicans.)

But some parts, such as regulations, would remain.

Many Republicans, including the president-elect, now embrace some of Obamacare's provisions, such as prohibiting insurers from denying coverage and allowing children to stay on their parents' policy up to age 26. But those mandates are what's making Obamacare so expensive and unworkable.

Many Republicans are worried about the political fall-out from ending 20 million people's health coverage—even though Democrats weren't concerned about the millions. The left and the media will complain that repealing Obamacare will increase the number of uninsured and health care spending. And perhaps the biggest challenge is that Republicans are divided, and have been for the past six years, over what to replace Obamacare with and how to implement that change.

Repeal and replace could be a minefield. As Politico reports, "Smart, politically attuned congressional Republicans are already scared of the implications." But they need to get started immediately to fulfill that oft-made campaign promise. □

*Merrill Matthews, Ph.D., is a resident scholar with the Institute for Policy Innovation, a research-based, public policy "think tank." He is a health policy expert and weekly contributor at Forbes.com. He also serves as Vice Chairman of the Texas Advisory Committee of the U.S. Commission on Civil Rights. For more information, visit [www.IPI.org](http://www.IPI.org).*



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# The Untapped Power of Health Savings Accounts

by BOB HEYDET



**F**ifty-two percent of large companies offer at least one high-deductible health plan (HDHP) in their benefit package. A quarter of employees nationwide were enrolled in employer-sponsored high-deductible plans in 2015, up from just 4% in 2006, according to the Kaiser Family Foundation. Studies also show that when given the option, nearly half of Millennials chose low-cost plans with higher deductibles. This has become increasingly important now that Millennials make up the largest sector

of the U.S. labor force. Health Savings Accounts (HSAs) are the perfect complement to HDHPs to give employees the medical spending power they need today as well as a savings vehicle for the future.

Companies would be wise to heed the growing trend, as HSA eligible plan offerings provide a true bright when employer costs for employee health care continue to skyrocket. The best news is that it's a bright spot of green that translates into real savings for employers. Last year, a survey by Mercer revealed that the medical costs averaged \$9,228 for each



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employee enrolled in an HDHP with an HSA. That compares to \$11,212 for PPOs and \$11,248 for HMOs. Any employer would be happy to have those savings. Further, employers score big with reduced payroll taxes, decreases in FICA (Social Security and Medicare) matching, and lower federal and state unemployment taxes when their employees open and fund health savings accounts through payroll direct deposit.

On the employee side, the benefits of choosing an HSA eligible plan are often overlooked or under-appreciated. An HSA eligible HDHP is usually the lowest-cost option in terms of paycheck deduction. But, an even greater advantage of participating in an HSA qualified HDHP is one that may not be fully articulated by brokers/employers or understood by clients/employees, which is having the opportunity to open, fund and use a health savings account. For example, HSA money can be used to pay for current medical expenses or saved for future qualified health expenses. HSAs also offer a triple tax advantage: contributions through payroll to an HSA aren't taxed which means contributing lowers an employee's taxable income. The balance in an HSA grows tax-free and the funds are available tax-free to pay health costs. Unlike flexible spending accounts (FSAs) or even the ubiquitous 401(k), health savings accounts are portable, meaning that consumers can continue to use their HSA dollars even after leaving a job or the job market altogether. On top of that, the individual owns the HSA so as long as one is covered by an HSA eligible HDHP, that individual may continue making contributions up to the IRS annual limits.

In 2015 an estimated 16.7 million HSAs were open. By 2019, it is projected that the number of HSA account holders will increase to 30 million. So how can brokers ensure that their clients are among the growing number of employers encouraging employees to join the ranks of HSA holders? First and foremost, educate employees about the multitude of benefits available by participating in an HSA eligible HDHP. These plans and accounts are still relatively new offerings, so em-

ployers and employees may be unfamiliar with them and what this type of health plan entails. Don't underestimate the value of laying out a basic description of how it works and how it benefits them. For employers, this can mean lots of activity leading up to the open enrollment period. For example, employers should offer information in multiple formats: FAQs, in-person presentations, Q&A sessions, as well as online videos and tools such as an HSA goal calculator.

It's crucial to promote the long-term benefits of HSAs, including introducing the notion of using the HSA as a supplemental retirement savings ve-

***"Helping clients take full advantage of all the benefits offered by funding HSAs will go a long way in ensuring that more consumers become better-informed healthcare spenders and savers and are better prepared to meet their medical needs."***

hicle. In fact, engaging employees on how to use an HSA for retirement savings may be the tipping point that inspires them to make the change. Again, education is vital. Help employees understand how HSAs are similar to other retirement savings vehicles by providing them with relevant articles, videos, and statistics.

There is a crisis on the horizon for consumers who aren't saving enough to fund their retirement. Two-thirds of respondents in a survey cited by Money.com fear they will not be able to save sufficiently for their senior years. This may be the key to unlocking the most powerful benefit of an HSA in a way that hasn't been widely considered—use your HSA as a supplemental source of retirement savings!

HSAs can help ensure that healthcare expenses can be covered with tax-free dollars throughout one's entire life, thereby reducing the burden on any other funds set aside for retire-

ment. Even better, account holders 65 and older may use HSA dollars for anything without having to incur a 20% penalty for taking a distribution for a non-qualified medical expense; as is the case for account holders younger than 65.

HSAs should be treated as retirement savings vehicles (for example, creating identical HSA investment line-ups as the plan sponsors' 401(k) and providing an easy-to-access online portal that has the checking account component of an HSA and the investment account within one ecosystem).

Employers should present options that encourage employees to reformulate their retirement strategy to include HSAs. Employees should be informed that, although the HSA allows the same tax benefits that a 401K does, the 401K does not allow disbursements until retirement or tax-free disbursements for medical expenses in retirement. HSA account holders don't have to wait for retirement and can use funds for current medical expenses tax-free or save those dollars for future medical expenses; providing more flexibility when saving for retirement.

The long and short of it is to save those 401k dollars for trips to see the grandkids and save your HSA dollars, tax-free now for those inevitable medical expenses we'll all incur during retirement. And when you have to pay for those medical expenses in retirement, use tax-free HSA dollars as opposed to 401k dollars that are included and taxed as income.

Helping clients take full advantage of all the benefits offered by funding HSAs will go a long way in ensuring that more consumers become better-informed healthcare spenders and savers and are better prepared to meet their medical needs. ★

*Bob Heydet has more than 19 years of experience in healthcare and benefits sales and has been with WEX Health since 2006. Prior to joining WEX Health, Bob spent nine years with ADP in various sales roles selling cloud and software-based applications for Human Resources, Payroll and Benefits Administration. Bob holds a degree in Marketing from Xavier University and lives with his wife and two boys in San Diego, CA. For more information, visit [www.wexhealthinc.com](http://www.wexhealthinc.com).*

# INIEWS

## MORE CONSUMERS ARE RELYING ON BROKERS FOR MEDICARE PART D

A study by Connecture finds that Medicare enrollment through multi-carrier brokers is up 8.4%, from 29% to 38%. More Medicare beneficiaries are seeking help from brokers who

consumers vulnerable to higher out-of-pocket costs and lower satisfaction with their selected plan. For consumers and plan sponsors, comparing and enrolling in plans based on total annual costs ensures better transparency, lower costs, and more product satisfaction.



can provide shopping and enrollment services. Connecture found that shopping activity by brokers is up 27% and enrollment by brokers is up 17%. Brokers can use health plan and drug comparison technologies to offer Medicare beneficiaries more comprehensive and cost effective plan comparison and enrollment options.

The study also finds that costs for mandated prescription drug plans (PDP) have increased 9% to 12% over last year. A sample population of 50,000 Medicare beneficiaries spent \$172 million. If those same consumers enrolled in plans based only on the lowest possible premium, their out-of-pocket costs would have been \$2,229 or 16% higher than the sample. Regardless of prescription drug needs, beneficiaries are more likely to enroll in a cheaper plan. However, picking a plan based solely on premiums leaves

## WASHINGTON STATE SAYS ZENEFITS' FREE SOFTWARE VIOLATES STATE LAW

Washington state Insurance Commissioner Mike Kreidler ordered Zenefits to stop the free distribution of its employee benefits software, noting that the tactic violates Washington state insurance law against inducements. Washington is the first state to take action against the company for violating inducement laws. Under an agreement with Kreidler, Zenefits can challenge the order within 90 days. California-based Zenefits began operations in Washington in 2014, selling online human resources services to businesses. As part of its free software offer, Zenefits provided certain features with a paid commission. To access these premium features, the company required the client to designate Zenefits as its broker of record, then collected

the commissions associated with the insurance product sold. Kreidler said, "The inducement law in Washington is clear. Everyone has to play by the same rules." The law permits a licensed producer to offer no more than \$100 per person during a consecutive period of 12 months. Zenefits markets the software's value at \$29,100 to \$45,000 per year. The company will determine what fee to charge its Washington customers starting Jan. 1, 2017, in accordance with the order. Kreidler also fined Zenefits \$100,000 in October 2016 for employing unlicensed producers to sell insurance in Washington. The company allowed unlicensed employees to complete 179 insurance transactions between Jan. 1, 2014 and Nov. 30, 2015. Washington is among a handful of states, including most recently California, to fine Zenefits for allowing unlicensed producers to sell insurance. Kreidler's investigation also found that Zenefits offered individual clients up to \$2,000 in cash for referring companies through a program called "Friends with Zenefits." Zenefits paid at least one individual \$250 for two referrals.

## ZENEFITS HIT WITH \$7 MILLION FINE

The California Department of Insurance fined Zenefits \$7 million. It's the largest penalty assessed by any commissioner against Zenefits and one of the largest penalties for licensing violations ever assessed in the department's history. Zenefits was charged with allowing unlicensed employees to transact insurance and circumventing insurance agent education requirements. A 2013 start-up, Zenefits is a San Francisco-based company that provides online HR services to businesses and encourage the same businesses to use Zenefits as an insurance broker. The California Department of Insurance launched an investigation in 2015, after getting complaints that Zenefits employees were transacting insurance without a license. Shortly after the investigation began, the company announced publicly that it was not complying with insurance laws and regulations. Zenefits' CEO, Parker Conrad resigned. Insurance Commissioner Dave Jones said, "Zenefits is an example of an Internet-based start-up whose former leaders created a



culture where important consumer protection laws were broken – a bad strategy that placed the company at risk and that other start-ups should not follow given our strong consumer protection laws and the Department of Insurance’s rigorous enforcement of those laws.”

The settlement agreement includes a \$3 million penalty for licensing violations, including allowing unlicensed employees to transact insurance, a \$4 million penalty for subverting the pre-licensing education and study-hour requirements for agent and broker licensing, and a \$160,000 payment to reimburse the Department of Insurance for investigation and examination expenses. The settlement provides that half of the total \$7 million in monetary penalties are suspended in recognition of the self-reporting and remedial actions the company has already implemented including replacing the CEO, retraining of all licensed producers, and implementing automated process to verify that only licensed individuals solicit and sell insurance products. The suspended portion of the monetary penalty will be reinstated if Zenefits fails to confirm continued compliance with licensing and regulatory mandates based on an examination of the company’s business practices to be conducted in 2018. The difficulties drove Zenefits to cut a deal with some of its investors in June to

reduce its valuation to \$2 billion from \$4.5 billion, according to the Wall Street Journal. A well-funded competitor, Gusto, is focusing on selling insurance to small companies and has been taking some customers from Zenefits, according to Bloomberg Technology.

**ONLY 29% OF AMERICANS WANT AN ACA REPEAL**

The Kaiser Health Tracking Poll finds that 26% of Americans want to see President-elect Donald Trump and the next Congress repeal the Affordable Care Act, and an additional 17% want them to scale it back. Thirty percent want to see the law expanded and 19% want to see lawmakers implement the law as it is. Fifty-two percent of Republicans want to see the Affordable Care Act repealed, down from 69% in October. At the same time, 24% of Republicans want to see the law scaled back, up from 11% in October. Thirty-one percent of those who want to see the Affordable Care Act repealed, want it just repealed and not replaced. About two-thirds wants lawmakers to repeal the health care law and replace it with a Republican-sponsored alternative, with 42% wanting lawmakers to wait to repeal it until the details of a replacement plan have been figured out and 21% wanting lawmakers to repeal it immediately and figure out a replacement plan later.

Thirty-eight percent of those who

said they wanted the law repealed, changed their opinion after hearing that it would mean that insurance companies could deny coverage to people with pre-existing conditions. A slightly smaller share change their opinion after hearing that more than 20 million Americans could lose their coverage. While President-elect Donald Trump and Republican leaders in Congress work on a replacement to the Affordable Care Act, the new poll finds many of the law’s specific provisions remain popular even among President-elect Trump’s supporters, potentially complicating the path ahead.

For example, majorities of Republicans, Democrats and independents favor the following:

- Allowing young adults to stay on their parents’ insurance plans until age 26 (85% of the public, including 82% of Republicans)
- Eliminating out-of-pocket costs for many preventive services (83% of the public, including 77% of Republicans)
- Providing financial help to low- and moderate-income Americans who don’t get insurance through their jobs to help them purchase coverage (80% of the public, including 67% of Republicans)
- Giving states the option of expanding their existing Medicaid programs to cover more uninsured low-income adults (80% of the public, including 67% of Republicans) and
- Prohibiting insurance companies from denying coverage because of a person’s medical history (69% of the public, including 63% of Republicans).
- In contrast, 35% of the public agree with provisions that nearly all Americans have health coverage or pay a fine (63% have an unfavorable view). Fifty-seven percent of Democrats favor this provision as do 30% of independents and 21% of Republicans.
- Sixty percent of the public supports the law’s requirement that employers with at least 50 workers offer health insurance or pay a fine is more mixed. In contrast, just 45% of Republicans favor this provision.

Americans are divided on how repeal would affect health care costs for them and their family, with nearly

equal shares saying repealing the law would make costs worse (30%) as saying it would make costs better (27%). Another four in 10 say their health care costs would be about the same. Most also say that, under repeal, they would expect their quality of care and access to health insurance to remain about the same.

### INSURANCE JOB MARKET SOARS

The number of jobs in the insurance industry doubled in October, jumping to 7,700 last month from 2,300 in September, according to the U.S. Bureau of Labor Statistics' Economic Situation Report (<http://www.bls.gov/news.release/empstat.htm>). The overall unemployment dropped by 0.3 percentage points, to 4.6%, last month — the lowest rate since 2007. As NPR's Marilyn Geewax notes, 4.6% unemployment

insurance industry's unemployed rate has averaged 2.6% over the past year. Similarly, our job boards saw a steady increase in the number of available job postings all month, with a particular focus on claims jobs." According to the BLS report, the insurance carriers and related activities sub sector now employ 2,621,400 people, with an unemployment rate of 1.5%. Since the beginning of the year, the insurance industry has gained 44,000 jobs while the unemployment rate has dropped 0.6% from 2.1% in January.

### INDEXED ANNUITIES SOAR WHILE FIXED ANNUITIES TANK

Indexed annuity sales are on record pace for 2016. Sales are expected to hit \$60 billion for the year according to a report by Wink. Third quarter non-variable deferred annuity sales were

\$14.3 billion, which is down nearly 8% compared to the previous quarter and up more than 3% compared with the same period last year. Allianz Life was the number one carrier in indexed annuities, with a market share of 17%. Athene USA moved into the second-ranked position, and rounding out the top five carriers in the market were American Equity Companies, AIG, and Great American Insurance Group, respectively. Allianz Life's Allianz 222 Annuity was the number one selling indexed annuity for the ninth consecutive quarter.

Total third quarter traditional fixed annuity sales were down nearly 24% compared to the previous quarter, and down nearly 59% compared with the same period last year. Athene USA was the number one carrier in fixed annuities, with a market share of 31%. Jackson National took the second-ranked position. Rounding out the top five carriers in the market were Reliance Standard, Great American Insurance Group, and MetLife, respectively. Forethought Life's ForeCare Fixed Annuity was the number one selling fixed annuity.

MYGA sales for the third quarter were \$7.2 billion; down more than 18% compared to the previous quarter, and up over 18% compared to the same period last year. New York Life was the number one carrier in MYG annuities, with a market share of 17.5%. Security Benefit Life took the second-ranked position. Rounding out the top five carriers in the market were Midland National Life, AIG, and Athene USA, respectively. Security Benefit's Life RateTrack 5-Year was the number one selling multi-year guaranteed annuity. While fixed annuity sales have been sluggish, MYGA sales are doing fairly well. Banks are driving sales of these products because rates on competing products, such as certificates of deposit (CDs), are still hovering at less than 1%. This is driving sales of these CD-like annuities. For more information, go to [www.LookToWink.com](http://www.LookToWink.com)

### 401(K) POLICIES GET IN THE WAY OF SAVINGS

Many 401(K) plans have policies that hinder worker's ability to save, get employer contributions, and keep employ-



is what most economists consider "full employment," which she says is "when the number of people seeking jobs is roughly in balance with the number of openings." The drop in unemployment was a surprise — economists had thought it would hold steady at 4.9%. Jay Rollins, owner of InsuranceJobs.com said that it is the largest increase in 12 months. "Last month's unemployment was the lowest rate of the past 12 months. The last time the insurance sector reached 1.5% was May 2015. Instead, the in-

\$22.8 billion; down over 12% from the prior quarter, and up nearly 0.5% from the same period a year prior. Allianz Life was the number one carrier for non-variable deferred annuity sales, with a market share of 11%. Athene USA was second with American Equity Companies, AIG, and Security Benefit Life rounding-out the top five carriers in the market. Allianz Life's Allianz 222 Annuity indexed annuity was the number one selling non-variable deferred annuity for sales. Total third quarter indexed annuity sales were

er contributions (vesting) if they leave their job, according to a report by the General Accountability Office (GAO). GAO looked at 80 401(k) plans ranging from fewer than 100 participants to more than 5,000. Thirty-three did not allow workers younger than 21 to participate in the plan; 19 required participants to be employed on the last day of the year to get any employer contribution for that year; and 57 required employees to work for a certain period before employer contributions to their accounts are vested. Plan sponsors and plan professionals said they employed these policies to lower costs and reduce employee turnover.

Assuming a minimum age policy of 21, GAO projects that a medium-level earner who does not save in a plan or get a 3% employer matching contribution from age 18 to 20 could have \$134,456 less savings by their retirement at age 67 (\$36,422 in 2016 dollars). Saving early for retirement is consistent with Department of Labor guidance as well as previous legislation and allows workers to benefit from compound interest, which can grow their savings over decades. In addition, the law permits plans to require participants to be employed on the last day of the year to get employer contributions each year, which could reduce savings for 's mobile workforce. For example, GAO projects that, if a medium-level earner did not meet a last day policy when leaving a job at age 30, the employer's 3% matching contribution that was not received for that year could have been worth \$29,297 by the worker's retirement at age 67 (\$8,150 in 2016 dollars). GAO also projects that vesting policies may reduce retirement savings. For example, suppose a worker leaves two jobs after two years, at ages 20 and 40, and the plan requires three years for full vesting, the employer contributions forfeited could be worth \$81,743 at retirement (\$22,143 in 2016 dollars). The Department of Treasury is responsible for evaluating and developing proposals for legislative changes to 401(k) plan policies but has not recently done so for vesting policies. Vesting caps for employer matching contributions in 401(k) plans are 15 years old. A re-evaluation of these caps would help to

assess whether they unduly reduce the retirement savings of 's mobile workers.

GAO also interviewed federal officials and 21 retirement professionals and academic researchers. GAO suggests that Congress consider a number of changes to ERISA including changes to the minimum age for plan eligibility and plans' use of a last-day policy. GAO is recommending that Treasury assess whether vesting policies are appropriate for today's mobile workforce.



### HOW EMPLOYERS ARE MANAGING PRESCRIPTION DRUG COSTS

Employers are stepping up efforts to manage prescription drug costs, according to a survey by Willis Towers Watson. Employers are paying particular attention to high-cost specialty medications used to treat complex conditions, such as cancer and hepatitis C. The following are common strategies among employers:

- 63% are evaluating and renegotiating pharmacy contracts; another 31% are planning or considering doing so by 2018.
- 61% added programs to ensure appropriate use of prescription drugs, up from 53% in 2015; 85% are considering doing so by 2018.
- 52% exclude compound drugs; another 13% are considering doing so by 2018.

Employers are using these increasingly popular strategies for specialty drugs:

- 39% are evaluating specialty drug spending through the medical benefit instead of the pharmacy benefit, up from 26% in 2015; 82% will con-

sider it by 2018.

- 19% changed coverage to influence where and how specialty drugs are administered; another 43% are considering doing so for 2018.
- 18% established different copays for specialty drugs to promote lower-cost alternatives, such as biosimilars. That percentage could triple over the next two years.

Nadina Rosier of Willis Towers Watson said, "Companies tend to adopt simple solutions that result in a financial benefit first and move on to more complicated strategies later. Our survey shows that employers are rapidly becoming more aggressive, for example, by evaluating specialty pharmacy spend[ing] through the medical benefit to get more visibility into where these drugs are being administered. This is an essential component of managing specialty pharmacy spend[ing], but it is just the beginning. Employers still need to take action based on what they learn."

### 2017'S BEST LIFE INSURANCE COMPANIES

Voya took the top spot in Insure.com's annual Best Life Insurance Company survey. The 15 top insurers are rated on affordability, customer service, and likelihood to recommend. In the survey of more than 1,690 policyholders, Voya, formerly known as ING, got an impressive five out of five stars for customer service and 4.75 stars for value for the price. Eighty-nine percent of policyholders would recommend the life insurance company. Here is a summary of the results:

#### First place: Voya

Overall score: 97.1  
Value for price: 4.75  
Customer service: 5  
Would recommend: 89%

#### Second place:

##### State Farm Life Insurance

Overall score: 92.5  
Value for price: 4.75  
Customer service: 4.75  
Would recommend: 87%

#### Third place:

##### John Hancock Life Insurance

Overall score: 90.4  
Value for price: 4.5  
Customer service: 4.5  
Would recommend: 89% ★

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# How to Increase Voluntary Benefit Sales in the New Year

by KEVIN MCNAMARA

**T**he voluntary benefits industry has seen expansive growth in recent years, with sales having increased each year since 2010. Many brokers and employers have already added voluntary products to their benefit offerings. But 2017 may be the year to implement new sales strategies to ensure continued growth. Here are five trends to help brokers and advisors grow their book of business in 2017.

## 1. REFINED BENEFIT OFFERINGS

Clients have a different rationale for providing voluntary benefits to employees. A recent LIMRA study found that 70% of employers offer voluntary benefits to improve morale among their employees and to attract and retain new talent. Regardless of the rationale for adding benefits, brokers may see the trend in 2017 to be refining a client's offering to help ensure the right benefits and coverage amounts are being offered.

Selling voluntary products isn't just about adding countless benefits. In fact, adding too many benefits at one time may defeat what a client is trying to accomplish. Brokers should be counseling clients to add benefits strategically while implementing a communications strategy to engage employees and educate them on the importance of the benefits.

## 2. MULTI-METHOD COMMUNICATION STRATEGIES

Brokers may find that a one-size-fits-all communications strategy no longer works for all employees within a client's organization. In 2017, brokers should consider deploying a multi-pronged approach that meets the communications methods available to employees, such as email, text messages, direct mail and face-to-face meetings. Multi-method enrollment

strategies are a trend we're seeing occur primarily in the large-group market. I recently worked with a broker who conducted a multi-method enrollment strategy with a client that was transitioning from a different carrier.

All employees received at-home communication informing them of the changes and had access to enroll online. The broker also partnered with an enrollment firm to meet one on one with employees needing help with the transition. This approach is growing with small- to midsize employers, too, with more and more vendors available to support both clients and brokers.

## 3. DECISION SUPPORT TECHNOLOGY

Communicating with employees on their benefits choices should take multiple forms, but 70% of employees are interested in using online options to learn more about their benefits. Decision support tools, which can be accessed through mobile or desktop channels, can help employees understand the need for certain coverages in everyday terms and in the way that they want to consume information.

As an industry, there's a fundamental need to help employees receive better education around insurance products. Many employees aren't aware of what the benefits provide and what's in it for them. Decision support tools drive informed benefits decisions and deliver better outcomes for employees and employers alike.

## 4. FACE-TO-FACE SUPPORT

Although digital enrollment tools are a focus for clients, the presence of technology doesn't solve the whole enrollment equation. Benefits counselors and effective on-site presentations can be incredibly helpful for clients

with employees who may want more personalized assistance. Employees always have questions about their benefits, and having on-site support can help brokers and employers when employee question-and-answer sessions get tough. Even though many people like online shopping, many don't trust a computer for something as important as determining their benefits portfolio.

## 5. INTEGRATING WITH-CUSTOMERS' CURRENT TECHNOLOGY PLATFORMS

Many employers have already purchased and implemented technology platforms to help automate benefit administration, from payroll to enrollment to carrier billing. When approaching clients about voluntary products, brokers should ask their clients about their current technology and look for ways to maximize their existing capabilities for communications and member maintenance. We're seeing brokers who have strategic technology partners, but many of their clients feel they will save money and time if they can leverage what they're using today. Brokers and carriers will need to be more nimble and commit the right kinds of resources to get voluntary products built and working on legacy systems in order to help secure a sale. □

*Kevin McNamara is a senior enrollment strategist at Standard Insurance Company, and has worked in the voluntary benefits industry for more than 15 years. In his current role, Kevin is responsible for developing and implementing enrollment policies and practices, and ensuring a consistent enrollment experience. In addition, he designs and develops strategies that target the needs of unique employer groups, the demographics of a company's employee population, broker expectations and local marketplace protocols to improve participation levels for new and existing employer groups.*

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# The Evolution of Insuring Small- to Mid-Size Employers

By MONICA MAJORS

**W**e know the health care landscape has changed over the past decade. Employers face new challenges. Health plans have responded by overhauling product offerings. Benefit brokers and agents have brought expertise on the changes to employers. Managing these changes will help small-to-midsize employers better understand cost-effective coverage options for their employees.

Over the past decade, business owners have faced a myriad of changes. The workforce has been shifting. Last year, Millennials surpassed Baby Boomers as the nation's largest living generation. Technology has been evolving quickly. Today's consumers are less likely to leave home without their mobile device than without their wallet. Employers are facing heightened consumer expectations; a more tech-savvy population is demanding anytime, anywhere engagement. While technology allows for increased service or faster response rates, it also brings added challenges, ranging from the need for better data management to increased competition and more.

The healthcare-related challenges employers face have also changed. More than a decade ago, health plan premiums were growing by leaps and bounds. Back-to-back, year-over-year increases of 30% or more were not uncommon. Small group employers, in particular, were struggling with how to compete by offering comprehensive benefits. To cope, some stopped providing dental and vision coverage. And many shifted more costs to employees.

All of this created an environment conducive to change. And in response, presidential candidates used their plat-

form leading up to the 2008 elections to promote healthcare system overhaul. The passage of the Patient Protection and Affordable Care Act (ACA) two years later brought about sweeping changes in short order—changes that forever altered the health care landscape in the U.S. Employers today are still struggling to understand and interpret what the law means for their businesses.

The entire underwriting process changed too. Today more people than ever are able to find coverage through public exchanges and Medicaid. However, little, if any, cost relief has been realized. As the market landscape changed, carriers exited markets, and mergers and acquisitions reduced the number of players, leading to fewer choices for buyers. Products have evolved to meet changing regulatory requirements. Through it all, employers continue to struggle with offering the right benefit packages to attract and retain talent.

Insurance brokers have responded to market changes and continue to find ways to attract and serve small-to mid-size commercial customers. They've built expertise and assumed a more consultative role in the marketplace. They've become familiar with various elements of the ACA and the effects. They understand tax implications and other requirements, and share that information with business owners and benefit managers to help them navigate the ever-changing environment.

Larger brokers have developed or leveraged in-house research and compliance capabilities. Smaller ones have made use of expertise found in the carriers they represent and through independent resources. And they've



used this knowledge to make sure clients have the information and health plan products they need to remain competitive—and compliant.

The reality is that the healthcare marketplace continues to evolve. Today we see more preferred or narrow network options available, and many midsized employers are exploring self-funded options instead of fully-insured products. Many providers find themselves with full patient panels or very limited access—largely because of an increase in the number of insured people under the ACA. And increased regulatory and compliance requirements are demanding providers and payers to do more for less.

As a result of these changes, employers seem as if they are caught in the middle. Not only must they manage the day-to-day operations of their businesses and the competitive landscape in their industries, employers also need to continually re-evaluate their coverage options and look for cost-effective ways to retain their employees. □

*Monica Majors, is vice president, strategic sales and marketing, Sutter Health Plus.*

Medicare business out for a small one-time referral fee and many others who have just simply leave money on the table and don't refer the business out at all. Getting certified to sell MA plans can be taxing, yet with lifetime residual income and commission increases for 2017, the benefits far outweigh the time investment.

So what does it take to get certified to sell MA plans? Well for brokers who already hold their California life and health license, you're halfway there. For everyone else, getting licensed is the first step, followed by completing the AHIP exam – a 50-question test on marketing MA plans and fraud, waste and abuse. Next brokers would need to get appointed with an FMO agency that holds multiple carrier contracts and can provide broker support to agents. Lastly, your FMO agency will direct you on how to get contracted with the various carriers in your area.

Selecting the right FMO agency is critical to your success and as a broker you will want to find an agency that offers timely commissions, sales opportunities in your area, and ongoing training, but most importantly find a partner that keeps compliance as a priority. Selling MA plans is different than other insurance products, as it is regulated by the Centers for Medicare and Medicaid Services, otherwise known as CMS, and who enforces compliant marketing and sales practices.

Once you get through the hoops of getting certified to sell, you can start earning lifetime residual income. In 2017, in California commission payouts for those new to Medicare, is \$553 and the annual renewal and plan switch rate is \$277 which is over a 3% increase from commission payouts in 2016.

If you're considering getting certified to sell Medicare Advantage products, now is the best time to get started! You will have from January-September to learn the industry, build your relationships and get ready for the 2018 Annual Enrollment Period, AEP, where most agents write 70-80% of their business. ★

*Vanessa Vizard is Marketing & Compliance Director for HRBC Insurance.*

# Medicare Is One of the Biggest Opportunities in the Insurance Industry

by VANESSA VIZARD

**W**hile brokers have a slew of product offerings to sell in the marketplace many are missing out on one of the biggest opportunities in the insurance industry today – Medicare Advantage (MA) plans. We've all heard the statistics that 10,000 seniors turn 65 every day, but did you know that California has 10% of the market share? So why aren't more brokers offering MA plans in their product portfolio?

I've spoken to many insurance brokers who refer their

# Prescription Drug Plans: A Remedy For the Referral Headache

by HENRY FIGUEROA



I've heard it said that the confirmation of a job well done is that a referral follows from your work. Imagine with me the two-fold gratification you might feel if you solve an intimate and meaningful problem for a client, and then gain a referral from that work, which quite possibly only you can do. It's a wonderful feeling. I'm talking about the gratification that follows helping a client with their prescription drug plans in the Medicare space. Oh can I hear the boos and hisses from the industry now. But, have you ever heard it said that working with a client on their prescription drug plan can increase your referrals by as much as 40%? Our agents know this to be true, and in this article I'm going to develop why that's the case. Let's look at the "problems" with the PDP market first.

## TIME TO REVENUE RATIO

There are several objections to offering prescription-drug plans (PDPs) as a business builder. The biggest ob-

jection I've heard over the years, as a former wholesaler and a carrier sales manager, is the time-to-revenue problem. An agent may earn a \$50 com-

penensation for one to three hours of work. Factor in drive time, diminished mental capacity of the client, the rigors of certifying each year, and the anti-

thetical sales regulations within which we work and that \$50 looks anemic after those flashy million dollar promises arrive in your in-box. This a short sided perspective, and yet so many wholesalers fall into this trap year after year. Maybe even your up-line tells you to stay far away from PDPs. If that's the case, you are losing referrals. Let's chat briefly about the rigors of the regulatory items involved in PDP sales.

When it comes to regulations, an agent must certify with each carrier they intend to offer each year, as well as the owner of the up-line under which you write business. Sometimes carriers are in some states and not in others so that could mean more certifications for your up-line. Next question: How do we know which carriers to offer each year? Most have those slick and easy-to-use quote engines that tell us who has the lowest prices. However, the lowest price does not always equal the best coverage for the client. In fact the lowest priced leader mentality in this space may carry the highest risk to the sales professional. One way to keep up with relevant data is Medicare.gov. Most wholesalers will tell you to steer your clients there, but have you ever tried navigating that on your own? Imagine how an 87 year old immigrant, widow, who has Medicare because she was dependent on her late husband's income feels about navigating that website? Now imagine you helped her instead. Do you think she would refer you to others?

**SCOPE OF APPOINTMENT AND THE 48 HOUR RULE**

Here come more of those boos and hisses. We have to follow the 48 hour rule when representing the prescription-drug plans. This should be perceived as an opportunity to do some homework and master your content so that the 1.5 hours of work does not become three. The scope-of-appointment form is really simple.

Penalty: I cannot speak to how saddened my agents become when they arrive at an appointment and find out that someone sold them a Medicare supplement plan and did not tell them about the penalty that would ensue if they did not also choose a drug plan to go along with the supplement. Last

week I fielded a call from an agent in Tucson, Ariz. He was at a person's home and tells me, "Henry, this person I'm with has a Medicare supplement, and has not had a drug plan



***"Take heed fellow producers, the remedy for the referral headache lies in that product you are told to stay away from. Consider the value of the prescription-drug plan from a very different angle and it will pay for you dividends on many levels."***

since getting on Medicare, what will this mean?" In this situation it means that the person has to pay an additional \$28.80 per month as a penalty for her coverage for the rest of her life. So now, instead of a PDP that could have cost \$18 a month this person will pay for Part B of Medicare, plus her Supplement, plus her PDP, plus the penalty, which will amount to roughly

\$350 a month for health insurance. Even with a \$0 premium advantage plan, that \$28.80 penalty will stay with her forever. Who is booing and hissing now, right?

Now consider the intimacy of the prescription drug plan sale. Understanding this part sets up the platform for the increase in referrals. It is also, perhaps, the most compelling reason that not everyone can sell prescription drug plans. Imagine the vulnerability someone feels when they tell you that they are taking a medication for say hepatitis, or rheumatoid arthritis, Cardiovascular Disease, Chemo for Cancer, Antibiotics for uncommon infections or others. And how vulnerable they are to rely on you to ensure they get their medications. We might be a perfect stranger to this prospect and are about to encounter the exact conditions they face that remind them of their own mortality. This is heavy. My team of agents dignifies this person in this vulnerable state. "It's okay Sandra, I understand it may be awkward to speak with me about these medications. I'm not here to judge you; I am here to make sure that you are covered, you are saving money, and you are taking care of your health. I would do the same for your friends, and loved ones. Let's start by..." Soon after we have transcended the "sales" process and have compassionately journeyed through vital decision making with this person. That \$50 compensation becomes a relationship built on trust. Now that I have demonstrated compassion and trust, I have shown that others can trust me. If they can trust me with their medications, it's a no brainer to trust me with a life insurance conversation and others.

Take heed fellow producers, the remedy for the referral headache lies in that product you are told to stay away from. Consider the value of the prescription-drug plan from a very different angle and it will pay for you dividends on many levels. ◻

*Henry Figueroa is regional vice president of Copeland Insurance Group. A sales professional for more than 14 years. Prior to Copeland, he worked in Medicare sales at United Healthcare, and life & annuity sales at Forward Strategies Insurance Brokerage.*

# Win-Win: HOW BROKERS AND PAYERS BENEFIT FROM URGENT CARE

by LAUREL STOIMENOFF, PT, CHC



**H**ealthcare costs have skyrocketed, and as the bills pile up payers, patients and employers are looking for cost-effective solutions. This need for value-based care has increased the role of urgent care centers, which deliver high-quality care for common illnesses and non-life-threatening injuries.

Brokers provide knowledge about benefits to patients on an ongoing basis and also provide a fountain of information to payers about the ways payers' networks can further assist both parties. When included in payers' networks, urgent care centers help payers meet the Centers for Medicare & Medicaid Services' Triple Aim goals, which define the pillars of the value-based model.

Here are just some of the ways urgent care helps accomplish these goals:

## **IMPROVE THE PATIENT EXPERIENCE OF CARE**

For many, getting sick on the weekend or evening means sitting in the emergency room because their primary care physician is unavailable. If an urgent care center is near, they are open to

patients on a walk-in basis and during extended evening and weekend hours, when primary care physicians are unavailable. Roughly 97% of urgent care centers are open seven days a week. This is a crucial statistic considering that 63% of Americans report diffi-

culty getting access to care on nights, weekends, or holidays without going to the emergency room, according to the Commonwealth Fund International Health Policy Survey. This convenient care option is crucial in a day and age when individuals have access to so

many other services on-demand.

The national average wait time in an emergency room is four hours, as many departments experience overcrowding. Compare this to a wait time of 30 minutes or less at 90% of urgent care centers, according to a survey by the Urgent Care Association of America (UCAOA). Offering patients a high-quality, convenient solution allows the emergency department to make room for more life-threatening cases. And patients get more efficient care.

### IMPROVE THE HEALTH OF POPULATIONS

Patient-centered medical homes have a small percentage of patients who comprise most of the cost of care. Medical homes can focus on chronic care and disease management by partnering with urgent care centers to help provide coordinated care for episodic illnesses and injuries. Just as urgent care centers can relieve emergency room departments, this continuum of care can free up the primary care physician to focus on what's most important. There are still millions of Americans who do not have health insurance, and many who do have health insurance are not affiliated with a medical home. According to the Robert Graham Foundation, urgent care centers are often the destination for the 20% of patients who are unaffiliated with a medical home. Urgent care centers provide an essential link for those patients who are suffering from chronic illnesses and are in dire need of a medical home, such as those previously undiagnosed with pre-diabetes or diabetes. An even greater percentage of patients rarely frequent their medical home due to access issues, and urgent care can provide a vital role in lowering the healthcare cost through models that support screening and care coordination.

### REDUCE THE PER CAPITA COSTS OF HEALTHCARE

Healthcare costs can be reduced dramatically by diverting patients with non-life-threatening illnesses and injuries from the emergency room. An average visit to an urgent care center costs less than \$150, compared to \$1,354 for an emergency room visit,

according to Medical Expenditure. When patients visit an urgent care center with a less acute condition, they can also prevent the likelihood of the condition worsening and leading to more costly emergency room visits – and even hospital admissions or re-admissions. This is beneficial not only to the patient's health and pocket but also to the healthcare provider as well.

The savings are substantial. Excellus BlueCross BlueShield studied emergency department utilization in upstate New York and determined that if just 10 common, low-acuity

options is strongly associated with lower emergency department use.

### NATIONWIDE URGENT CARE GROWTH IMPROVES PATIENT EXPERIENCE AND HEALTH.

A need in the marketplace has led to urgent care use growing nationally. With nearly 7,100 urgent care centers nationwide, The UCAOA estimates that the industry has added 1,000 urgent care centers per year since 2013. To further accentuate this dramatic growth, 91% of urgent care centers anticipated growth in 2015; 87% had

***"The full potential (of urgent care) will only be realized when urgent care centers are not only included in payer networks but also better leveraged to optimally contribute to population health, including wellness care."***



conditions had been treated somewhere other than the emergency room, New York State could have saved \$1.3 billion in healthcare costs. On a national scale, up to 27% of all emergency room visits could take place at an urgent care center or retail clinic, generating potential costs savings of approximately \$4.4 billion annually, according to a 2010 article published in Health Affairs.

Patients continue to demonstrate their desire for cost-effective, high-quality healthcare when it is available. A 2015 study by the Massachusetts Health Policy Commission found that when retail clinics and urgent care centers are nearby, patients visit the emergency room less often – leading to approximately 30% fewer emergency department visits. One of the report's key takeaways makes the connection clear. Greater access to after-hour care

acquired or built a new location in the prior year; and 89% said the total number of patient visits increased in the past year, according to the survey.

The true value of urgent care centers is yet to come. Urgent care is still growing throughout the country and as an industry. Payers and brokers can help drive those benefits. The full potential will only be realized when urgent care centers are not only included in payer networks but are also better leveraged to optimally contribute to population health, including wellness care. Brokers can play a key role in this discussion, by advocating for value-based care and including urgent care centers in discussions with insurance providers. ◻

*Laurel Stoimenoff, PT, CHC, is principal of Continuum Health Solutions LLC and chair of the Health & Public Policy Committee of the Urgent Care Association of America.*

# How Do You Help a Family in Crisis? (THAT FAILED TO PLAN FOR LONG-TERM CARE?)

by CHRIS ORESTIS, CSA

**P**eople are warned to plan for the future almost constantly over the course of their adult lives. But too few actually heed the warnings. They don't secure insurance or financial products to mitigate their risks. The vast majority of people will be unprepared to shoulder the costs of long-term care when their time comes. But there are solutions to help many of those people who failed to plan. One of the fastest growing areas of funding long-term care is in the area of crisis management.

There are tools available to financial and legal advisors who work with families in the arena of long term care planning that can help pay for the costs of care at the time that it is needed. One tool that is becoming more prevalent is settling life insurance policy death benefits into structured vehicles that will pay for the costs of senior retirement living and long-term care.

## THE REALITY

To put this concept in perspective, understand that there are fewer than 10 million long-term care insurance policies in-force and more than 100 million life insurance policies in-force. Seniors allow about \$100 billion worth of policies to lapse or be surrendered annually. In fact, 88% of life insurance policies sold will never actually pay out a death benefit because the owner will abandon it at some point before they pass away.

They do this without realizing it is their legal right to settle the policy while they are still alive for the present day value and receive a significant percentage of the death benefit as a cash-out payment. After years of making premium payments, the owner of the policy can use it to help cover their retirement and long-term care

costs. Would you abandon your home without selling it after years of making mortgage payments? Of course not, and no one should abandon a life insurance policy after years of making premium payments if they are able to settle it instead.

## THE SOLUTION

Any type of life insurance policy can be settled while the owner is still alive for a cash payment that will pay out the present-day value of the policy's death benefit. With this sudden realization of funds from a "dead asset," a couple of options designed to protect and efficiently administer the money for long term care expenses becomes possible:

- 1) The person can enroll the funds into a tax-free long term care benefit plan designed to make monthly payments to any form of care they choose.
- 2) A medically underwritten immediate need annuity will provide a guaranteed income stream to help cover retirement and long-term care expenses for life.

It is important to emphasize that these options are designed to address the immediate need to fund retirement living and senior care expenses. In fact, the older and more impaired their health condition, the more they will get when settling their policy and enrolling in either the benefit plan or the annuity. It is a morbid concept, but the older and sicker you are the more money you can get with this approach to help pay for your long-term care costs. A person who would qualify to purchase long-term care insurance would be too young and healthy to enroll in the long-term care benefit plan or the medically underwritten immediate income annuity. In comparison, a person who qualifies to convert a life

insurance policy into a long term care benefit plan or medically underwritten immediate income annuity would be too old or sick to buy long-term care insurance. Over \$100 billion of life insurance is abandoned every year by seniors who could have sold the policy for as much as 60% or more of the death benefit. Policy owners pay premiums to the insurance company for years; they should not abandon a policy by lapsing or surrendering it before determining its present day re-sale value. It is the fiduciary responsibility of advisors to inform clients of their legal right to sell their unneeded policies for a cash settlement that could be used to pay for the costs of long-term care.

Now, insurance companies and agents are being held legally liable for not informing clients about their right to a cash settlement for an unneeded life insurance policy. For example, a Rancho Mirage, Calif., couple filed a class-action lawsuit seeking punitive damages, treble damages, restitution and an injunction against Lincoln in 2012 in U.S. District Court in Riverside, Calif., (Larry Grill et al v. Lincoln National Life Insurance Company—California Central District Court) alleging that they may have been able to sell their policy rather than reducing their coverage if their agent had told them about the life settlement market.

## LONG TERM CARE BENEFIT PLAN

A long term care benefit plan is an irrevocable, FDIC-insured benefit account, which is professionally administered with payments made monthly on behalf of the individual receiving care. The entire proceeds from the policy settlement are placed into the account and then at the direction of the family, the monthly payments are made directly

to their choice of care provider. If care needs change, and the family wants to change care provider and/or the monthly payment amount, all they need to do is provide 30 days' notice to adjust the account instructions. This option extends the time a person would remain private pay and delays their entry onto Medicaid. It is a unique, tax-free financial option to pay for care because all health conditions are accepted, and there are no wait periods, no care limitations, no costs to apply, no requirement to be terminally ill, and there are no premium payments.

In addition to being a Medicaid qualified spend-down inside the look back period, the benefit account is tax-free because the funds are spent on care. Policy owners use their legal right to convert an in-force life insurance policy to enroll in the benefit plan and are able to immediately direct monthly payments to cover any form of senior care they choose: home care, assisted living, nursing home, memory care, or hospice.

#### **ADVANTAGES OF A LONG TERM CARE BENEFIT PLAN**

The client can spend down to Medicaid and can set and adjust the monthly payments at whatever level they need to cover private pay costs they want as long as funds remain in the account.

#### **DISADVANTAGES TO A LONG TERM CARE BENEFIT PLAN**

The policy owner is selling the policy for its present day value and they or the beneficiaries will no longer be able to collect the death benefit.

#### **MEDICALLY UNDERWRITTEN IMMEDIATE NEED ANNUITY**

A medically underwritten single premium immediate annuity is designed to create a guaranteed monthly income stream for the life of the annuitant. The monthly income payments can be used for any purpose such as daily living expenses, medical expenses, or long-term care expenses. With medical underwriting, monthly income payments from a medically underwritten immediate need annuity may be larger for annuitants who are less healthy and in need of care compared to traditional single premium immediate annuities. They can also include an-

nual cost-of-living adjustments to the monthly payouts and purchase death benefit options as a hedge against untimely death.

This financial vehicle helps create certainty for a family by providing a guaranteed lifetime stream of income payments for older, less healthy care recipients who need long-term care now or in the near future. Although the income can be used for any purpose, including medical and living expenses, this annuity is designed to help offset the cost of long-term care for people ages 70 and older with adverse health conditions.



#### **ADVANTAGES TO A MEDICALLY UNDERWRITTEN IMMEDIATE NEED ANNUITY**

A guaranteed monthly stream of income is used to supplement costs of living and care. It offers early death benefit protection, enhanced death benefit and COLA riders, and stop-loss to preserve or delay the need to liquidate other assets/income.

#### **DISADVANTAGES TO A MEDICALLY UNDERWRITTEN IMMEDIATE NEED ANNUITY**

The annuitant can lose a portion of their initial principal if they die earlier than expected.

#### **THE CALL TO ACTION**

To help families avoid this kind of tragedy, you need to switch your mindset from selling products to providing solutions. There's no one-size-fits-all policy to help people plan. And there's certainly no one size fits all approach to dealing with a crisis situation such as this.

There are three critical elements to a responsible retirement plan:

1) Protecting lifestyle by guaranteeing

income.

2) Protecting family legacy by guaranteeing wealth transfer.

3) Protecting health, income, and legacy from the costs of long-term care.

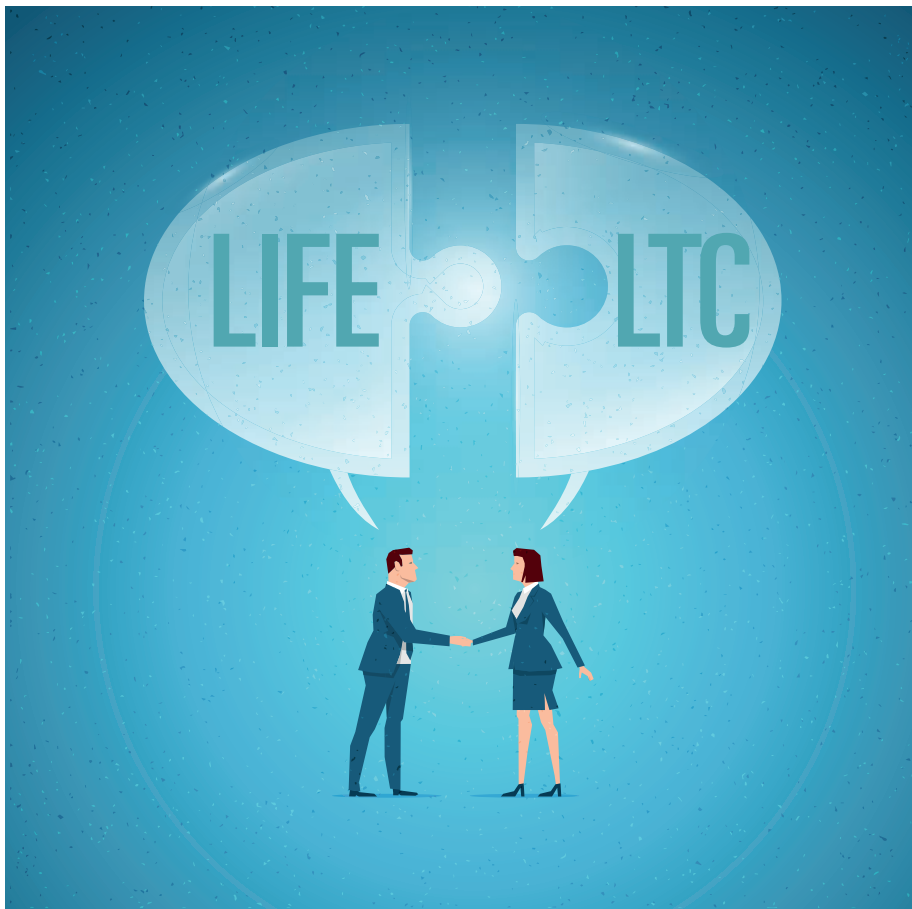
If you have not addressed number three, when the time comes for long-term care you and your family will be forced to sacrifice number one or number two first. The costs of long-term care can be staggering. A person could easily spend \$100,000 (or much more) over a 12- to 24-month period. But what if you could use an existing asset such as a no longer needed life insurance policy to cover the costs so that your income and legacy are protected while ensuring that your health and lifestyle are lived with quality, dignity, and choice? It is being done by people every day.

This is important because seniors have an overwhelming desire to remain independent. They do not want to become a burden on their family or a ward of the state by entering Medicaid. Unfortunately, the current system to fund long-term care has evolved into one that encourages seniors to impoverish themselves and move towards Medicaid as quickly as possible. For the wealthy, long-term care costs can be absorbed. For the poor and disabled, government subsidized care is available. But what about the majority of middle-class Americans who need access to long-term care today? New approaches to funding long-term care must be embraced and using life insurance policies to fund a long term care benefit plan or medically underwritten immediate need annuity is an option that has grown into a mainstream and accepted financial solution for long term care. ★

*Chris Orestis, CSA is the CEO of Life Care Funding and a 20-year veteran of both the insurance and long-term care industries. A former Washington, D.C. lobbyist, he is a nationally known senior care advocate and author of the Amazon best-selling books "Help on the Way" and "A Survival Guide to Aging." He is a legislative expert, featured speaker, columnist and contributor to a number of insurance and long-term care industry publications. Chris is a frequent guest about senior issues on national radio programs; and has also been featured in the Wall Street Journal, New York Times, USA Today, Fox Business News, and PBS.*

# The Increasing Value of Combining Life & LTC

by ROXANNE ANDERSON



Why the declines? Some LTC insurers report originally underpricing their products due to inaccurate projections about mortality, the number of lapsed policies, the number claims, the length of claims, and/or their return-on-investments. Additionally, LTC carriers rely on premiums and money earned from investing premiums to pay claims and profit, but both income sources are being pinched.

In 2008, the Federal Reserve lowered interest rates in an attempt to lift the economy during the recession. The rates have remained low ever since, reducing insurers' returns on their investments. In order to pay claims and remain solvent, LTC insurers have been requesting hefty rate increases and/or scaling back benefits for their traditional products. These changes have deterred people from purchasing stand-alone policies and will likely continue that trend. While a stand-alone policy should not be discredited as an acceptable form of LTC coverage, the LTC market's current situation cannot be ignored and alternative products should be considered.

**N**o matter the focus of your business in the health and life insurance industry, if you want to expand your clientele, increase your earnings, or build your reputation as a reliable advisor, it's imperative that you offer the products that will best serve your clients' medical and financial needs. If life and long-term care (LTC) combination products haven't made their way into your portfolio yet, here's why now is the time to add them.

## TURMOIL IN THE LTC MARKET

Over the past several years, there's been a large decrease in the number of carriers offering stand-alone LTC policies and the number of these policies being purchased by consumers. According to an article published in 2016 by *Forbes*, more than 90% of LTC insurers have left the business. And the American Association for Long-Term Care reports that Americans bought 750,000 new stand-alone LTC policies in 2000, but only 105,000 in 2015.

## UNDIMINISHED NEEDS

A 2016 LIMRA study finds that 42% of people are concerned about burdening others with their funeral expenses; 45% are concerned about burdening dependents if they die prematurely; and 58% are concerned about paying for LTC services. Fifty-one percent of people say they would feel the financial impact of losing their household's primary wage earner within six months, and 52% say they need LTC insurance, but only 16% actually own it. Some of your clients

may be apprehensive about buying life or LTC protection. The fact is that, while dying and receiving LTC are expensive, death is inevitable and the chance that one will need LTC in the future is high. A 2013 study by AARP projects the ratio of family caregivers ages 45 to 65 for each person age 80 or older will decrease to four to one in 2030 and three to one in 2050. The care gap is growing, as this ratio was more than seven to one in 2010. Furthermore, the Dept. of Health and Human Services estimates that 70% of Americans turning 65 can assume they'll use some form of LTC throughout their life. In truth, life and LTC coverage plays an essential role in allowing many people to protect the financial futures of themselves and their loved ones.

### AN INCREASINGLY POPULAR SOLUTION

Medicare doesn't offer death benefits, and only covers stays in certain facilities if they're medically necessary. It won't cover stays for custodial care. Medicaid offers some custodial LTC coverage, but one must qualify for Medicaid to receive these benefits. Considering their limited options, the need for LTC coverage, and the state of the LTC market, it's no surprise that more and more people are turning to life and LTC combination products for protection.

LIMRA's study finds that 24% of people would be extremely likely or very likely to purchase a combination life and LTC product, and another 34% would be somewhat likely to do so. Moreover, all types of life combination products experienced growth in LIMRA's 2015 Individual Life Combination Annual Review. The number of individual life combination policies sold increased 37% and the number of individual whole life combination policies sold increased 61%.

What makes these types of products so attractive? Life and LTC combination products abolish the use-it-or-lose-it nature of LTC insurance. A policyholder who needs LTC draws from the death benefit first. Depending on the policy, the insurer will pay out a certain amount more in LTC benefits. If the policyholder passes away without having used any LTC, his beneficia-

ry receives the death benefit. What's more, unlike stand-alone LTC policies, life and LTC combination policies have a return-of-premium option, and their rates can be locked-in. These features mean policyholders don't have to fear unexpected premium hikes or losing their initial investment if they change their mind.

### FULFILLING YOUR FIDUCIARY RESPONSIBILITY

A 2013 study by The Associated Press-NORC Center for Public Affairs Research found that 37% of Americans age 40 or older believe Medicare pays for ongoing care in a nursing home, and 44% think it pays for ongoing care at home by a licensed home health care aide. What happens if they need either of these forms of LTC and then find out Medicare won't help foot the bill? As your clients' trusted advisor, you should make sure that they're properly informed about the risks related to their future health care and finances and the ways they can mitigate those risks. Having these in-depth conversations with clients is especially important in today's litigious environment.

Life expectancies have increased for those reaching ages 65 and 85, according to the Centers for Disease Control and Prevention. Therefore, remaining silent on the benefits and costs associated with foregoing life and LTC coverage is leaving clients in the dark about two safeguards they could very well need after they retire.

As the LTC market evolves, companies are adapting to provide consumers more dynamic products. Stay on the top of your game by adjusting your portfolio and business plan accordingly. ★

*Roxanne Anderson is a Copywriter at Ritter Insurance Marketing (Ritter). She received her B.A. in English from Elizabethtown College. Ritter is a national field marketing organization that serves as your guiding knight in the insurance market. An industry leader in technology, Ritter offers agents state-of-the-art tools, including its Medicare Quote Engine; a lead-generating CMS-accepted permission-to-contact website, Medicareful.com; and an award-winning educational website and forum, TheAgentSurvivalGuide.com. For more information, please visit RitterIM.com.*

## You Can Rock the Year

(Continued from Page 6)

never too far away when they need you. The strategy can be described as PASS:

- Personalize your message by offering more than one tool.
- Acknowledge the challenges and creatively present solutions. Give them choices.
- Show them how you can simplify the process.

Sell the support you offer. Your biggest differentiator is you. Service what you sell.

3. Mobile has invaded our space and will be a key part of your marketing success including smart phones, tablets, and wearable gadgets.
4. Data-driven marketing is a smarter use of your dollars. There is gold in your data mine of existing and future clients.
5. Video is the messenger of choice among your future clients. It is content rich and can be delivered in an entertaining way even for insurance products.
6. Go beyond health insurance to anticipate the additional needs of your future clients. It will also add to your monthly paycheck.
7. Creatively lighten up your marketing message. Your future clients are done with the doomsday communications of the ACA. Give them something to smile about. Humor lowers defenses when done the right way.

In the land of creativity there are no rules. You are a fighter; you're passionate about the services you offer; and you have definitely made a difference in the lives of your clients. Constantly look out for new ideas and ways to do things better. Creatively motivate your clients to take action and benefit from your many services. You have not come all this great distance and made all this great effort only to miss out on all the opportunities facing you. Be brilliant in 2017. I look forward to seeing you on the marketing trail. ★

*Joe Navarro is marketing director for Warner Pacific Insurance Services*

# How to Use Annuities to Fund Long-Term Care Expenses in Retirement

by JAMIE HOPKINS, Esq. and BOB JOHNSON, Ph.D.

**R**etirement income planning can be like hitting a moving target in the wind. The target keeps moving because you do not know when you will retire, how much money you will need, or how long you will live. The wind is there because there is not an exact straight line path to get to your retirement target as laws will change; interest rates will go up and down; financial markets will rise and fall; and a variety of uncertain risks could affect your plan. One risk that can derail a retirement plan is a need for long-term care. While most retirees will need some long-term care during their lives, it is hard to determine how much care one will need, how expensive the care will be, and how to fund this unknown cost. As such, retirees rely on a variety of funding sources like long-term care insurance, Medicaid, and self-funding. However, the majority of people moving into retirement are unprepared financially to finance their own long-term care expenditures. The financial planning world is beginning to embrace more funding techniques for long-term care expenditures, including the use of annuities.

Long-term care is a topic that most people do not want to discuss. Indeed, it can be challenging to discuss your own declining health and mental capacity. Nonetheless, for most people, this is an inevitable fact of life. Nearly 70% of all people who live to age 65 will require some sort of long-term care in their lives. While the majority



of long-term care services are provided by family members in an informal and unpaid setting, family care giving dynamics are shifting, leading more and more people to develop a funding plan for long-term care expenditures. According to the Genworth 2016 Cost of Care Study, the median cost of long-term care in a semi-private nursing home in California is \$91,250 per

year, which is almost \$10,000 above the national average. However, if you end up receiving care in a private room at a nursing home in California, it will run you well north of \$110,000, which can be devastating financially for both you and your loved ones.

To help cover the costs of long-term care, one should set up a long-term care plan well in advance. Long-term

care planning does not simply involve the decision of whether you should buy long-term care insurance. It necessarily entails a discussion with family and friends about the type of care you want, where you wish to receive care, and how you will pay for it. In effect, long-term care planning is about giving family members permission to seek out help for you in the event of a long-term care event. Long-term care expenses can be paid for out of pocket, through the purchase of a long-term care insurance contract, through government programs (Medicaid), or through other hybrid financial service products that combine the benefits of life insurance or an annuity with long-term care insurance. Additionally, other types of deferred income annuities, including qualified longevity annuity contracts (QLACs), can help retirees meet their long-term care funding needs.

So how can annuities be used to help fund long-term care needs? First, it is important to understand that there are a tremendous variety of annuities on the market. Not all of them will be suitable for every situation, including funding long-term care expenditures. For example, immediate annuities, while very useful in retirement, will not necessarily have any benefits to help fund long-term care costs. However, you can use single premium immediate annuities to create a floor of income in retirement with better payouts than other safe investments, allowing your portfolio to last longer and help cover long-term care expenditures.

Outside of just creating a floor of income, annuities can be used to help fund long-term care expenditures through deferred annuities, QLACs, 1035 exchanges, and hybrid long-term care annuity products. One way to help fund long-term care expenditures is to stagger or layer on deferred annuities. This can enable the retiree to create various levels of income for different periods of retirement. For example, you could purchase a deferred income annuity that starts at age 80 and another that starts at age 90. While these annuity payments will not perfectly match up with the required long-term care expenditures, they will provide increased income near the time when most people need to fund

large long-term care expenditures. In many ways, this is just a form of matching liabilities to assets by setting aside money in a deferred annuity to provide income during a period of high long-term care risk.

The QLAC is one type of deferred annuity that can be an interesting source of funding for long-term care expenditures is. In 2014, the U.S. government adopted new rules allowing for the use of QLACs inside of 401(k)s and IRAs. These specialized, but limited, deferred annuities can help retirees avoid required minimum distributions at age

***"When using an annuity or long-term care hybrid product as part of a long-term care funding plan, it is crucial that the decision works in harmony with the individual's comprehensive retirement income plan."***

70½, increase their retirement income, provide a hedge against longevity risk, and provide a source of long-term care funding. The QLAC is a powerful tool for long-term care funding because it can be purchased inside of an IRA or 401(k), where most retirees house their retirement savings. Additionally, the rules allow the QLAC to stay in the IRA without payments until age 85, at which time payments must begin. However, this can provide a very nice income source for retirees to help fund long-term care expenditures.

Another strategy is to use a so-called hybrid or linked benefit contract, which combines long-term care coverage with an annuity into one product. Some annuities now offer tax-qualified long-term care benefits which enable you to invest the money you have saved for long-term care into a product that provides a fixed income but also will provide higher payouts if

you need long-term care benefits. In some cases, these types of products will double or triple the annuity payment when long-term care is needed. Additionally, these products can be purchased with a single lump sum payment, which might be preferable to long-term care insurance, which generally requires lifetime payment of premiums and the possibility that premiums will rise significantly. Annuity hybrid products also solve the use-it-or-lose-it problem with long-term care insurance. If the long-term care benefit is not needed, some annuity payments are still made and those payments can be used for other retirement needs.

If someone already owns an annuity or life insurance contract, having a 1035 exchange might be a way to purchase a different annuity or a hybrid annuity product to help with long-term care expenditures. The Pension Protection Act of 2006 allowed for 1035 exchanges of traditional life insurance and annuity products into hybrid long-term care policies. For example, a life insurance policy could be 1035 exchanged for a hybrid annuity long-term care policy without having to pay taxes on the buildup of value inside of the life insurance policy. Additionally, an annuity could be exchanged for a hybrid product or another type of annuity to better meet the long-term care funding plan of the individual without any current tax issues. This can be a very efficient way of using existing products to provide some level of long-term care funding.

When using an annuity or long-term care hybrid product as part of a long-term care funding plan, it is crucial that the decision works in harmony with the individual's comprehensive retirement income plan. Also, make sure the product fits the individual's unique needs and goals as every product will not work for every person and situation. Funding long-term care needs as part of a retirement income plan can be challenging, but annuities can be a great ally when utilized correctly and in an integrated manner. ◻

*Jamie Hopkins, Esq. is co-director of the New York Life Center for Retirement Income. Bob Johnson, Ph.D. is president and CEO at The American College.*



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All General Agents offer service, but full service? Well, that's another story.

When it comes to broker assistance RBG has always been the envy of the industry, but as we know, the industry has changed. It's gotten less predictable, more complex, and the bottom line could probably use a tune up, an overhaul, and some major realignment.

In response, Rogers Benefit Group is offering something we call Advanced Full Service. With it, we not only get new group medical cases scrubbed, underwritten, and quickly approved, but we go the extra mile with employers and their employees to show them how to get the most from their plan. We advise them on ways to save money instead of spend money.

All in all, it's great for brokers who want to make sure that everything runs smoothly down the road. Perhaps best of all, there are no charges. Service like this won't cost you a thing.

Will you be having full service today? If you would like to have it tomorrow, visit [www.rogersbenefit.com](http://www.rogersbenefit.com), call or contact any one of our 40 offices conveniently located throughout the country. It's the first step toward finding **the kind of support and service you've always imagined was out there.**

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