

CALIFORNIA BROKER

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PUBLISHER

Ric Madden
email: publisher@calbrokermag.com

EDITOR-IN-CHIEF

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

SENIOR EDITOR

Victoria Alexander
email: editor@calbrokermag.com

ART DIRECTOR/PRODUCTION MANAGER

Steve Zdroik

ADVERTISING

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

CIRCULATION

email: calbrokermag@calbrokermag.com

BUSINESS MANAGER

Lexena Kool
email: lex@calbrokermag.com

LEGAL EDITOR

Paul Glad

EDITORIAL AND PRODUCTION:

McGee Publishers, Inc.
3727 W. Magnolia Blvd., #828
Burbank, CA 91505
Phone No.: 818-848-2957
email: calbrokermag@calbrokermag.com.

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TABLE OF CONTENTS

GUEST EDITORIAL

- 6 CVS-Aetna Deal Has Everyone Talking**
By Zachary Tracer and Robert Langreth
Wonder what people in insurance-related fields think about the potential CVS-Aetna merger?

VISION

- 10 New Year, New Benefits – 5 Strategies for Effectively Communicating the Value of Premium Vision Plans to Employees**
By Lily Lam
Employees recognize the value of vision benefits—and they want access to the best possible plans that cover both routine eye exams and the latest in eyewear fashion and technologies.



HEALTHCARE

- 16 Health-O-Rama**



A Trip Down the Aisles of Today's Healthcare Market—A 2018 Healthcare Info Shopping Spree For Benefits Brokers! The Broker Is Here To Stay. This is why.

Industry insiders David Reid and Bryan Wood offer their insight.

- 20 Diabetes May Be Driving Up Costs, But There's Something That Can Be Done**

By Tom Milam
This is what we know: employers cannot decrease healthcare costs. However, there is a group of employees who can decrease healthcare costs with the right support.

- 22 Digital Health Meets Financial Necessity: 1 + 1 = 3**

By Stephanie Tilenius and Toney Chimienti
It is not a surprise to any of us in the digital health or insurance sector that the costs associated with healthcare continue to rise at alarming rates. This is where digital health comes in.



- 27 Three Things Employers Want from Brokers**



By Meredith Ryan-Reid
By providing fresh perspectives on emerging workplace trends, brokers will become invaluable to their clients in deploying strategies on how to get an engaged and loyal workforce.

- 29 Small Group View from the Top: Three Questions for Four Insurance Insiders**

By Victoria Alexander
Wonder what's going to happen to small group in 2018? California Broker has you covered. We recently reached out to a few people in the know when it comes to small group health insurance.



- 34 Three Ways Clients Can Support Employees Diagnosed with Cancer**



By Sandy Witt
We all know someone who's been affected by cancer. Whether you've been touched personally or you've had a relative, friend, co-worker or client diagnosed, you understand that there can be many unknowns with this challenging disease.

401(k)s

- 36 Socially Responsible Investing Ratings Can Boost Your 401(k)'s Value**

By Robert C. Lawton
Morningstar Star Ratings for mutual funds recently introduced Sustainability Ratings. See how they can be used to boost interest in 401(k)s.

LIFE INSURANCE

- 38 The Right Kind and Right Timeframe for Life Insurance**

By Richard M. Weber
Let's face it—we all know the reality: term insurance is cheap; by comparison, permanent insurance is expensive. But the right insurance at the right time is invaluable.



LEGAL INSURANCE

- 40 The Versatile Benefit Employers Might Not Know They Need**

By Dennis Healy



Voluntary benefits have evolved in the last few decades to provide a wide variety of options that can help employees deal with major catastrophic events. Yet, only 27 percent of employees report high satisfaction with their benefit offerings. Legal insurance can change that.

DISABILITY

- 42 Recent Claims Department Trends**

By Art Fries
A veteran disability claim consultant sounds off about disturbing practices he's seeing in disability claims.



ALSO IN THIS ISSUE:

Guest Editorial.....	6	Classified Advertising	46
Annuity Sampler.....	8	Ad Index.....	46
News Etc.....	44		

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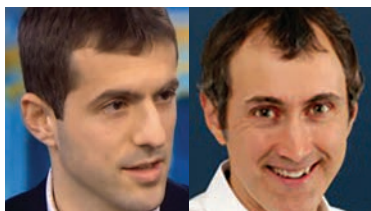
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By ZACHARY TRACER and
ROBERT LANGRETH

CVS to Pay \$67.5B for Aetna to Create Giant Health Firm with ‘10,000 New Front Doors’

CVS Health Corp. will buy Aetna Inc. for about \$67.5 billion, creating a healthcare giant that will have a hand in everything from insurance to the corner drugstore.

CVS will pay \$207 a share for Aetna, with \$145 a share in cash and the rest in stock, the companies said in a recent statement. That’s a 29 percent premium to Aetna’s share price on Oct. 25, the day before the companies were reported to be in talks.

The deal is among the biggest healthcare mergers of the past decade, combining the largest U.S. drugstore chain with the third-biggest health insurer. CVS also manages drug benefits plans for employers and insurers, a business that could help steer some of Aetna’s 22 million customers into CVS drugstores when they fill a prescription. The deal will give Aetna’s insurance plans a closer on-the-ground tie to where customers get care.

Including CVS’s assumption of Aetna’s debt, the deal will be valued at \$78 billion. It’s expected to close in the second half of 2018, the companies said.

In a joint interview, CVS Chief Executive Officer Larry Merlo and Aetna CEO Mark Bertolini said combining the companies would help CVS expand a variety of retail medical services, from vision care to nutrition advice to audiology, making basic care more convenient and less costly for consumers.

Aetna will be operated as a separate business unit, and any new services will be designed to appeal broadly to customers of other insurance companies as well, the executives said.

The immediate financial benefits of the deal are projected to be relatively modest. The companies said they expect \$750 million in synergies, and profit im-

provements in the low-to-mid single digits the second full year after the merger is completed. The companies are betting on longer-term profit from reshaping how their customers get care, by creating what the executives are calling “10,000 new front doors for the healthcare system” at CVS’s stores and clinics.

“Think of these stores as a hub of a new way of accessing healthcare services across America,” Merlo said in the joint interview. “We’re bringing health care to where people live and work.”

The deal will be financed with a mix of cash and debt. Barclays Plc, Goldman Sachs Group Inc. and Bank of America Corp. have committed to provide \$49 billion of financing, the companies said.

AMAZON LURKS

CVS and Aetna are joining hands as the health sector is looking over the horizon at Amazon.com Inc., and how the Internet retailer could shake up the business of buying, distributing and selling drugs and medical products if it gets into health care. The retail industry has been battered by the online giant. Amazon hasn’t revealed its plans.

“One of the problems with the healthcare system is it’s so fragmented and there’s so little coordination,” said Steve Kraus, who invests in health firms at Bessemer Venture Partners. “A better vertically integrated, less-siloed system is a good thing in my mind.”

Merlo, the chief executive of CVS, disputed the idea that the deal was a defensive move against Amazon’s possible entry into the pharmacy business.

“This transaction is really about growth, it is about expansion, it is not about contraction,” Merlo said.

The deal could also set off a new round of takeovers as CVS and Aetna’s

competitors look at the reshaped landscape. On Nov. 30, Express Scripts Holding Co.’s top executive said the company would be open to a deal at the right price, though wasn’t actively looking for one.

“We don’t need to sell to be very successful in the future, but we are always open to others who may all of sudden conclude they want what we have,” Express Scripts’ Tim Wentworth said in an interview. He also mentioned the possibility of partnering with Amazon on an online-pharmacy arrangement.

MORE DEALS?

Express Scripts is just one company in a universe of independent drug plans, insurers and supply-chain middlemen.

WellCare Health Plans Inc., Humana Inc. and Centene Corp. could become merger targets after the CVS-Aetna deal, according to Matthew Borsch, an analyst at BMO Capital Markets. Drug distributors like Cardinal Health Inc. or McKesson Corp., and retailers such as Walgreens Boots Alliance Inc. could also face pressure to find partners.

CVS, which operates about 9,700 retail stores and 1,100 walk-in medical clinics, has been moving beyond its drugstore roots for years. In 2007, it bought pharmacy-benefits manager Caremark Rx — a business that made up almost half of the Woonsocket, Rhode Island-based company’s operating profit in the third quarter. In 2014, CVS stopped selling cigarettes and added “Health” to its name.

The biggest U.S. health insurer, UnitedHealth Group Inc., is also the most diversified. United owns doctor clinics and an outpatient surgery chain, and has a pharmacy-benefits management, called OptumRx, built on the acquisi-



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tion of Catamaran Corp. in 2015.

POTENTIAL OBSTACLE

Consolidation is picking up among healthcare suppliers and administrators, as insurers seek more control over how their consumers get care. But two proposed megamergers among insurers — including a deal between Aetna and Humana Inc. — were blocked this year on antitrust grounds, leading the companies to look beyond rival insurers for potential deals.

The CVS-Aetna deal's antitrust prospects may depend on which U.S. regulator is tasked with reviewing it,

according to Bloomberg Intelligence analyst Jennifer Rie. The Federal Trade Commission has been less critical of tie-ups among companies in adjacent businesses, known as vertical consolidation. The Justice Department, on the other hand, last month sued to block the merger of AT&T Inc. and Time Warner Inc., a vertical deal.

Michael Newshel, an analyst at Evercore ISI, said the DOJ effort to block the AT&T-Time Warner deal does raise concerns, but a CVS-Aetna deal does have a path forward. Aetna would likely need to divest some or all of its Medicare drug plan business, he said.

In the joint interview, the CVS and Aetna executives declined to comment on whether they might have to divest parts of the Medicare drug business. But Bertolini said the companies are prepared to work with regulators to do what it takes to get the deal approved.

"We are obviously going to get some scrutiny. We are prepared to deal with whatever comes along to make this work," said Bertolini. ★

This article was originally posted on the blog PEO Industry Topics. You can access it online at <https://peocompass.com/cvs-acquire-aetna/>.

▶ ANNUITY SAMPLER **DECEMBER 1, 2017**

Company Name	Ratings			Product (Qual./Non-Qual.)	Type SPDA FPDA	Initial Interest	Guar. Period	Bailout Rate	Surrender Charges	Mkt. Val. (y/N)	Min. Contrib.	Comm. Street (May Vary)
	Bests	Fitch	S&P									
American Equity	A-	A-	ICC13 MYGA (Guarantee 5) (Q/NQ)	S	2.30%*	5 yr.	None	9%, 8, 7, 6, 5, 0	Yes	\$10,000 (Q) & \$10,000 (NQ)	3.00%, age 18-75 & 2.10%, age 76-80** 1.50% age 81-85**	
			ICC13 MYGA (Guarantee 6) (Q/NQ)	S	2.45%*	6 yr.	None	9%, 8, 7, 6, 5, 4, 0	Yes	\$10,000 (Q) & \$10,000 (NQ)	3.00%, age 0-75 & 2.10% age 76-80** 1.50% age 81-85**	
			ICC13 MYGA (Guarantee 7) (Q/NQ)	S	2.60%*	7 yr.	None	9%, 8, 7, 6, 5, 4, 3, 0	Yes	\$10,000 (Q) & \$10,000 (NQ)	3.00%, age 0-75 & 2.10%, age 76-80** 1.50% age 81-85**	
*Effective 11/9/17. Current interest rates are subject to change on new issues. **Commission may vary by issue age and state. See Commission Schedule for details												
American General Life Insurance Companies	A	A+	A+	American Pathway Solutions MYG (*Guarantee Return of Premium) (Q/NQ)	S	2.50%** 2.80%**	5 yr.	None	8%, 8, 8, 7, 6, 5, 4, 3, 2, 1, 0	Yes	\$10,000 (Q&NQ)	1.5% age 0-75 .75% age 76-85
*CA Rates Effective 6/2/17. First year rate includes 1.50% interest bonus. a (less than \$100K) ; b (100K or more)												
American General Life Insurance Companies	A	A+	A+	American Pathway Fixed 5 Annuity	S	1.45%** 2.45%**	5 yr.	None	9%, 8%, 7%, 6%, 5%, 0%	No	\$5,000 (NQ) \$2,000 (Q)	2.00% age 0-85 1.00% age 86-90
*CA Rates Effective 8/7/17 Includes 1.15% 1st year bonus, 1.00% base rate subsequent years. a (less than \$100K) b (100K or more) (*Guarantee Return of Premium) (Q/NQ)												
American General Life Insurance Companies	A	A+	A+	American Pathway Fixed 7 Annuity	S	2.45%** 3.45%**	7 yrs.	None	9%, 8%, 7%, 6%, 5%, 4%, 2%, 0%	No	\$5,000 (NQ)	3.00% age 0-85 1.50% age 86-90
*(Guarantee return of premium Q/NQ) *CA Rates Effective 6/2/17. First year rate includes 4.0% bonus 1 st year. a (less than \$100K) b (100K or more)												
Great American Life	A	A+	A+	SecureGain 5 (Q/NQ)	S	2.15%	5 yrs.	N/A	9%, 8, 7, 6, 5	Yes	\$10,000	2.50% 18-80 (Q), 0-80 (NQ) 1.50% 81-89 (Q&NQ)
Effective 11/6/17 Includes .25% first-year bonus and is for purchase payments over \$100,000. Escalating five-year yield is 2.40%. For under \$100,000 first-year rate is 2.00%. Escalating rate five-year yield 2.25%.												
Great American Life	A	A+	A+	SecureGain 7 (Q/NQ)	S	1.70%	7 yrs.	N/A	9%, 8, 7, 6, 5, 4, 3	Yes	\$10,000	3.50% 18-80 (Q), 0-80 (NQ) 1.50% 81-85 (Q&NQ)
Effective 11/6/17. Includes 1.00% first-year bonus and is for purchase payments over \$100,000. Escalating seven-year yield is 2.59%. For under \$100,000 first-year rate is 1.60%. Escalating rate seven-year yield 2.49%.												
Great American Life	A	A+	A+	Secure American (Q/NQ)	S	1.55%*	1 yr.	N/A	9%, 8, 7, 6, 5, 4, 3	No	\$10,000	5.75% 0-70 4.65% 71-80 *Effective
8/7/17. Eff. yield is 2.57% based on 1.55% first year rate, 1.00% available portion of 10% annuitization bonus (available starting in contract year two) and 0.02% interest on available portion of bonus at the rate of 1.55%. Surrender value interest rate 1.55%. Accepts additional purchase payments in first three contract years. COM12255												
North American Co. for Life and Health	A+	A+	A+	Guarantee Choice II (Q/NQ)	S	2.25%** 2.50%**	5 yr.	None	10, 10, 9, 9, 8	Yes	\$2,000 (Q) \$10,000 (NQ)	2.00% (0-80) 1.50% (81-85) 1.00% (86-90)
*CA rates effective 12/12/17- a (less than \$200K) b(200K or more)												
Reliance Standard	A+	A	A	Eleos-MVA	S	3.55%*	1 yr.	None	8%, 7, 6, 5, 4	Yes	\$10,000	3.25%**
*Effective 12/2/16. Includes 1.50% 1st yr. bonus. Min. guarantee is 1.00%. **Reduced 20% ages 76-80, and 40% ages 81-85												
Reliance Standard	A+	A	A	Apollo MVA (Q/NQ)	S	4.40%*	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 12/8/17												
Symetra Life, Inc.	A	A	A	Custom 7 (Q/NQ)	S	3.10%*	7 yrs.	N/A	8%, 8, 7, 7, 6, 5, 4, 0	No	\$10,000	Varies
*Effective 10/10/17. 2.60% base rate with no guaranteed return of purchase payments. Plus 0.50% bonus for \$250,000 and above.												

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NEW YEAR, NEW BENEFITS...



5 STRATEGIES FOR EFFECTIVELY COMMUNICATING THE VALUE OF PREMIUM VISION PLANS TO EMPLOYEES

By LILY LAM

Employees recognize the value of vision benefits—and they want access to the best possible plans that cover both routine eye exams and the latest in eyewear fashion and technologies.

Offering premium vision benefits is a great way for employers to boost satisfaction while standing out as a company that cares about its employees. In fact, the 2017 Transitions Optical Employee Perceptions of Vision Benefits survey (comprising 1,002 U.S. adults, ages 18+, employed full- or part-time, whose employers offer vision benefits) found that almost all employees (98 percent) believe that including vision coverage as part of an overall benefits package

reinforces that a company cares about its employees' well-being.

But while employees want access to premium vision benefits, research has also shown that many who do have access may not be taking full advantage of all they have to offer—putting them, and their employers, at risk for increased medical costs and decreased employee productivity. According to Transitions Optical research, while the vast majority (83 percent) of employees used their vision benefits to pay for all or part of an eye exam within the past year, this also means that nearly one in five did not—meaning they are not getting the routine eye care that they need.

TAPPING INTO THE POWER OF VISION CARE

Why aren't some employees using their vision benefits? It could be because while virtually everyone wants access to premium vision care, many mistakenly believe that routine eye exams are only necessary for those who need corrective eyewear, such as eyeglasses or contact lenses. Quite the opposite is true.

Comprehensive eye exams go far beyond identifying vision problems and correction needs—allowing eye doctors to look for early signs of eye diseases that can become an incredible cost burden and lead to vision loss if not detected early. For example, glau-

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coma—often referred to as the “silent thief of sight”—is one example of eye disease that damages the eye’s optic nerve and causes people to lose their peripheral vision. Most people don’t notice any symptoms until they have lost significant vision—and this vision loss cannot be reversed. With access to routine, comprehensive eye exams, glaucoma can be detected and treated early by an eye doctor before it is too late.

Additionally, routine eye exams can also help to detect serious overall health issues, such as diabetes and hypertension—two of the costliest health issues for employers. According to the American Diabetes Association, diabetes alone is estimated to cost \$245 billion annually in direct costs and lost productivity, and people with diabetes have health care costs that are 2.3 times higher than someone without diabetes.

Beyond detection and treatment of eye and overall health issues, eye exams provide employees with access to the latest lens technologies. Consider these stats from the Transitions Optical survey: six in 10 employees say they would be more likely to enroll in a vision plan if they knew they could experience better vision, and more than half said they would be more likely to enroll if they knew that an eye exam could provide insights into their overall health. The more employees that take advantage of their premium vision benefits, the better the ROI for the employer. But there is obviously a need for ongoing education about the importance of getting comprehensive eye exams and taking advantage of premium eyewear/lens options offered by plans.

By following these five steps, benefits brokers can play an integral role in helping their clients effectively communicate the value of vision benefits—and provide access to resources about what their specific plans brings to the table.

1 SHOW THEM THE BENEFITS: EXPLAIN WHAT’S COVERED

Many employees are unaware of the lens options covered by their vision plans. In fact, according to the 2016 Transitions Optical Employee Perceptions of Vision Benefits survey, less than one in three employees feels very informed about the lens materials covered by their vision plans.

Access to certain lens enhancements can make a world of difference to employees—even if their correction needs are slight. For example, certain lens options—including antireflective coatings and photochromic lenses—can alleviate problems such as eyestrain, fatigue and headaches caused by glare reflecting off of a computer screen, digital device or surface. Alleviating glare can also help to improve posture in the workplace, as people tend to move forward or backward throughout the day in order to eliminate glare from their computer screens.

Premium eyewear options can also help filter harmful blue light, the high energy visible light between 415 to 455 nanometers on the light spectrum and considered most toxic to retinal cells. It

"Informed employers can help ensure their employees are informed about their vision benefits and are using them to their fullest potential."

comes mainly from the sun and digital devices. Emerging research points to a possible link of exposure to blue-violet light and developing long-term issues such as age-related macular degeneration. Photochromic lenses help to reduce exposure to harmful blue light while blocking 100 percent of harmful UVA and UVB rays.

As an added bonus for employers, offering premium lens options not only helps to maintain an employee’s eye and overall health, but this access may even help to keep employees content at their current jobs! In fact, the Transitions Optical survey found that 87 percent of employees said they would be more likely to stay at a company offering coverage of premium eyewear options.

2 MAKE THE GRADE: PROVIDE EDUCATION ABOUT PREMIUM EYEWEAR

Giving employees access to premium lens options through their plans is one thing—but educating them on how these lens technologies can improve

their eye and overall health is even more critical.

Harmful blue light, for example, is something that is of concern to all employees—with all generations agreeing that reducing exposure to it is important when it comes to choosing their eyewear. Millennials—who are making up an increasingly large portion of today’s workforce—are the most likely to say that reducing blue light exposure is important, with 83 percent feeling this way, according to the Transitions Optical survey.

But while 78 percent of employees agree that reducing harmful blue light is important, only 26 percent of employees say they actually have eyewear that reduces blue light exposure and, even more alarming, 28 percent don’t know whether their lenses reduce blue light exposure. The survey also found that nine in 10 employees agree that having coverage of premium lens materials—like impact-resistant polycarbonate lenses, photochromic lenses and anti-reflective treatments—is important when selecting a vision plan.

Considering their strong desire for access to premium lens options, employees may be more likely to purchase lenses that reduce harmful blue light exposure if they were provided with information about which lenses actually do so. Offering education is key—and employees expect it. In fact, 88 percent say they want their vision plan to provide educational materials on how lens technologies work.

3 USE AVAILABLE ONLINE RESOURCES TO REACH EMPLOYEES

There’s no doubt that education is important—but how should it be delivered to employees?

It’s always nice to have handouts and presentations—especially during the enrollment period—but many employees are also going online when it comes to looking up eye health information. According to the 2016 Transitions Optical survey, more than half of employees rely on their vision care plan for information about their vision benefits—and one-third prefer to access this information through their vision plan provider’s website. Employees are looking to their vision care benefits providers for infor-

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mation about coverage options and out-of-pocket costs—as well as information on technologies that are covered by their individual plans.

Many vision benefits companies offer online resources that can be easily accessed by brokers or employers to share with employees. EyeMed, for example, offers a user-friendly site called Eye Site on Wellness (eyesightonwellness.com) that's continually updated with articles, videos, quizzes and interactive content on how to take care of your vision, how to use your vision benefits and what to know about eye care and eyewear technology. Among the many useful pieces of content, one feature helps employees learn the basic differences in lens technologies, while another demonstrates what different kids' vision issues may be signaled by their behaviors.

Other optical companies, like Transitions Optical, also offer online resources that can be shared with employers and employees—including sight and cost savings calculators detailed in the next section.

4 SHOW THEM THE SAVINGS: EXPLAIN WHAT'S POSSIBLE WITH PREMIUM VISION BENEFITS

Employees often look at initial costs when deciding if they would like to enroll in their employer-sponsored vision benefits plans. While vision care costs are relatively low—and yield a very high ROI—many may choose to pass if they don't understand their need for routine vision care beyond vision correction.

To increase vision benefit use, it's important for employees to understand the potential long-term cost savings possible through their vision plan options. In other words—the savings they may not be seeing.

One tool that can do this is the Sight on Savings calculator from Transitions Optical. The calculator—found online at SightOnSavings.org—sums up the potential savings for an individual who enrolls in a premium vision benefits plan. The online tool allows users to input their age, gender and ethnicity for tailored results, and then provides information on which eye diseases, vision problems and overall health issues they are more likely to experience. The

calculator also provides an estimated cost-per-year to treat these vision problems and health issues—and explains how many of these can be diagnosed and treated early and effectively by getting annual comprehensive eye exams. (Putting off these exams = higher long-term costs and potential, irreversible vision loss.)

Knowing what they could be saving is instrumental in helping to ensure that employees are signing up for and taking full advantage of their vision plans. Consider that six out of 10 employees who are not enrolled in a vision plan said they would be more likely to enroll if they knew they could save money on overall medical costs, according to the Transitions Optical study.

"...offering premium lens options not only helps to maintain an employee's eye and overall health, but this access may even help to keep employees content at their current jobs!"

The study also found that employees are willing to pay more for access to premium vision benefits—with eight in 10 saying they would be willing to pay more for a plan that fully covers premium lens technologies. Brokers can play a role in helping to encourage utilization of premium vision plans by sharing the Sight on Savings calculator with employers so that they can, in turn, share it with their employees.

Beyond the employee version of the calculator, there is also a version that brokers can share directly with employers. The Vision Plan Savings Calculator—found at HealthySightWorkingForYou.org/Calculator—lets employers input their workforce demographics by age, gender and ethnicity. The online tool uses pre-populated national averages to determine how many of a specific workforce's employees are likely to have vision or health-related issues. The data provided can help employers estimate the possible cost savings for

their workforce simply by offering a premium vision benefits plan.

5 BE PROACTIVE YEAR-ROUND: PROVIDE ONGOING EDUCATION AND RESOURCES

Providing education at peak times—like during open enrollment—is important, but extending that education year-round helps to remind employees of the value that their vision benefits offer them and encourages them to schedule appointments if they haven't already.

The good news? Employees don't mind a reminder! Nearly all employees (95 percent) in the Transitions Optical survey say they want their vision care provider to reach out to them proactively with information about lens technologies, innovation and general eye health—and nearly six out of 10 want to be contacted multiple times throughout the year with this information. Many vision plans are already paving the way for easier communications. EyeMed, for example, gives its clients the option to have an eye exam reminder email sent directly to their employees. The plan also does a special mailer to members who have been identified as being at risk for diabetes, hypertension and/or high cholesterol—overall health issues that can negatively impact an employee's eye health and the employer's bottom line.

By helping employers take these simple steps, benefits brokers can help to ensure client satisfaction. And, of course, informed employers can help ensure their employees are informed about their vision benefits and are using them to their fullest potential. ★



Lily Lam, principal and vice president of operations, One-Digital Health and Benefits, sets the strategic vision for the company, managing both the growth, sales, operations and COBRA teams. She uses her business development, management and consulting background to align OneDigital's services to the needs and goals of the client to deliver the best possible solution for their specific situation. Lily has been nominated two times for her leadership by the Orange County Business Journal as a Woman in Business. She is also an active member of SHRM, PIHRA and the International Foundation of Employee Benefit Plans & Orange County Employee Benefits Council as an executive board member.

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Health-O-Rama

A Trip Down the Aisles of Today's Healthcare Market



Welcome to "Health-O-Rama." Below we feature a Q&A in which two long-time benefits experts share their perspectives as to why the broker is here to stay. On page 20 we look at the effect of diabetes on group health costs and on page 22 there's a feature that shows how the emerging field of digital medicine can improve outcomes and help cap costs. On page 27 we offer three tips for providing a fresh perspective on emerging workplace trends and there's a Q&A with in-the-know players in the small group field on page 29. On page 34 you can learn about key ways to help your clients work with employees who are dealing with cancer. We hope this "Health-O-Rama" will get you on the right start for providing cost-effective health coverage in 2018.

THE BROKER IS HERE TO STAY. THIS IS WHY.

An interview with DAVID REID and BRYAN WOOD

According to the U.S. Small Business Administration, more than 98 percent of businesses are categorized as small businesses. That's 6 million small businesses with more than 60 million employees, despite the fact that 75 percent of small businesses employ fewer than 10 people. Small businesses are the backbone of the U.S. economy with their owners maintaining a strong focus on their core business objectives.

Small business owners are dedicated to keeping their business running and generally can't spend enormous amounts of time analyzing their insurance and benefits needs. Even if they go online, there are no Expedia-like services available to simplify the process. However, they also can't afford to hire advisors like an attorney or an accountant, who charge steep hourly fees.

Many people fear technology will replace brokers. However, given the dynamic of the small business market, combined with the cost and complexity of benefits, brokers are not going anywhere. They are the gatekeepers to this industry in the small business space.

California Broker asked David Reid, CEO of EaseCentral with over 30 years of experience in the employee benefits and group insurance industry, and Bryan Wood, agency principal at B. Wood Insurance, which specializes in employee benefits, to discuss the importance of the broker, why they are here to stay, as well as technology's future role in the insurance process.

Q: TECHNOLOGY AND BROKERS: DOES IT HELP OR HARM?

David Reid: Technology allows brokers to do more for their customers with fewer resources. National digital brokers partner with traditional brokers and sometimes buy their books of business. They are also able to provide more services to these customers on 50 to 60 percent of commissions. In addition to efficiency, it allows a broker to offer capabilities demanded by today's buyers that cannot be delivered in a legacy, paper-based strategy.

Harm? Harm only comes from not adopting. There is a pending tsunami rate adoption across the entire market place. The question is not whether employers are going to take advantage of these offerings, the question is which brokers will be left behind.





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Bryan Wood: Technology allows the broker to spend more time assessing the best solution for the employer, and the employees to spend less time on the transactional and administrative tasks of enrolling.



At the same time, if the broker doesn't combine technology, expertise and excellent service on all fronts, then they will lose touch with their clients, and eventually lose business to another broker who does do this.

Brokers offer personal service and product expertise. Helping an employee navigate healthcare is personal and not something that you want to turn over to a website and make self-service. This causes headaches for both the employee and employer.

Q: HOW DO BROKERS PROVIDE A PERSONALIZED TOUCH?

DR: Most employers care about their employees' wellbeing, but do not want to get involved with their personal details. Nothing hits closer to home than benefits. Brokers insure employees are well represented and put employers at ease that someone is representing them.

Benefits also bring challenges to the employer/employee relationship. In tough times, changes can be difficult. The broker provides an unbiased, neutral relationship between employers and employees that facilitates new products and ideas.

BW: Employee benefits are a personal matter that clearly impact the employee's productivity and job satisfaction. By providing a personalized experience, it allows the employer to focus on what they do best, and save time on employee-sensitive issues.

Q: WHAT GUIDANCE DO BROKERS PROVIDE THAT TECHNOLOGY CANNOT?

DR: Easy. Expertise. There is no replacement for this and it is essential. Brokers have the ability to know their customer and the market place that is available to them. Combined with expertise, brokers are able to pair the best possible solutions. Technology is a tool for them to do this efficiently but it is just that, a tool not a solution.

BW: Employees can get upset and an experienced, and service-oriented, broker does this homework upfront for you, before it becomes a problem. The more your broker knows, the less time your staff spends on dealing with the insurance companies. Say you wanted boat insurance. Do you think you would get the same type of coverage if you buy it online, or if you spoke to a specialist that has been dealing with claims for 10 to 15 years and understands how different coverages work? Not to mention the boat expert also owns his or her own boat. Employees are without a doubt the most valuable asset to a business, and when they need to use their insurance, how do you want it handled? Turning to a live person is always going to beat technology when things get complicated.

Q: HOW DOES A UNIFIED RELATIONSHIP BETWEEN BROKER AND TECHNOLOGY CREATE A SIMPLIFIED WORKFLOW?

DR: Brokers work with many clients and carriers. Their regular demands give them ample opportunity to become system experts. This enables them to deploy the technology in a highly efficient manner. Rather than technology being an expense, it provides positive ROI. Technology friendly brokers bring, by far, the most efficient methods for both employers and employees to access, understand and manage their benefit plans.

BW: It makes the benefit, HR and payroll flow process much better. Most HRIS systems will incorporate all three into one place, eliminating paperwork and costly errors on all fronts. Employees are more productive when their benefits are at their fingertips 24/7. If you can integrate this all with payroll or communicate it to payroll with ease, then you save time on the process and money on the costly errors.

Q: HOW CAN BROKERS WORK WITH EMPLOYERS TO DETERMINE THE BEST BENEFITS FOR NEXT CALENDAR YEAR?

DR: Ask employers to set clear parameters around budgets and costs. If employers can define the amount they are going to spend in aggregate or per employee, it provides a clear road map

for their broker.

Also set expectations around benefit offerings that are core to the employer. With limited budgets, some employers prefer to contribute to fewer core benefits and make other benefits voluntary. More employers are creating a 'shopping cart' to which they contribute, allowing employees to purchase what meets their particular needs. Additionally, consider more innovative approaches, including level or self-funded health plans and tax-leveraged wellness initiatives.

BW: Discuss the needs of the group from all angles. Begin with the costs, and then research the doctors and networks that the employees are using. Additionally, understanding the benefit plan combinations that can accommodate an employer moving forward year in and year out is key.

Q: CAN YOU SHARE SOME FINAL THOUGHTS?

DR: Mobile is the gateway to millennials and is a key part of an effective strategy for engagement. Mobile also changes the touch points from just 'open enrollment' or 'on-boarding' to becoming dynamic touch points based on events. For example, presenting the option to add to life insurance coverage based on enrolling a newborn child. With a digital platform, all needed information is available to reduce this to a simple 'yes' response via mobile while sitting in the hospital.

BW: Utilizing mobile platforms helps to enhance access to benefit options for employees, which increases overall engagement. These platforms make the enrollment and benefit election process way easier and more accurate and allows employees to look at costs instantly, for all options. In the old days (not that long ago) this process could take a day or more to get that information to an employee, causing loss in productivity. In addition, handwritten forms can cause claim issues when a member's application is illegible. This can cause members to not receive ID cards or have a claim denied. If the broker is not embracing technology and providing great service, it is only a matter of time before the employer is presented with a better solution. ★



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GROUP HEALTH: DIABETES MAY BE DRIVING UP COSTS, BUT THERE'S SOMETHING THAT CAN BE DONE

This is what we know: employers cannot decrease healthcare costs. However, there is a group of employees who can decrease healthcare costs, both for themselves and for their employer, if they are provided with the tools, resources and personal support required to self-manage their disease.

The group includes employees and their dependents living with diabetes. This chronic condition can be silent yet causes harm to the body 24/7/365 -- unless the individual with it properly self-manages their condition.

Typically, when a person with diabetes receives a diabetes diagnosis, they have been unknowingly living with diabetes for anywhere from two to seven years. And during those years, the diabetes has marched steadily on, prematurely "aging" blood vessels and organs of their body.

Depending on a company's employee demographics (blue collar or white collar, ethnic composition, age groupings, education and income levels) anywhere from 5 percent to more than 15 percent of the employee population could be diagnosed with diabetes. This group in turn accounts for 15 percent to more than 35 percent of the total health plan spending.

Consider:

1. The Health Care Cost Institute documented the average person with diabetes in an employer health plan incurred \$16,021 of annual per capita healthcare spending, compared

DIAB

to just \$4,396 for those with no diabetes.

2. This report showed almost \$2,000 of the total \$16,021 spend for those with diabetes was "out of pocket" and borne by the employee, a significant burden.
3. The HCCI analysis exposed an average 17 percent of those with diabetes were in the hospital during a year. This compares to about 4 percent of those with no diabetes having an inpatient event.
4. With diabetes, the per capita pharmacy spend was \$3,970 for the year of the HCCI analysis. The average annual spend now approaches \$5,000 with the near double-digit price increases of "antidiabetic" pharmaceuticals.

In America, we often tend to think a pill or a shot can most often solve a health problem. The advertisements on television today certainly encourage us to think this way. Those medications for diabetes cost from \$5,000 to more than \$9,000 per year.

Here's another way to think about medications for diabetes: When you have a fever (the "marker" that your body has a problem), appropriately taking acetaminophen or ibuprofen can help bring the fever down. Temporarily. The cause of the fever must be addressed, too. An antibiotic for an infection, for instance.

When a person's body has high blood glucose (another "marker" of a problem), there are medicines that will bring down the glucose levels. Temporarily. As noted above, most of these medications are VERY expensive. The "cause" of the high glucose is not being addressed, and medications alone will not reduce the complications and expensive health events that come with diabetes.

I clearly remember a man of about 50, slender in build, standing before me at a benefits fair two years ago, saying



"They just told me three weeks ago I have diabetes...but I feel fine." In the early years with diabetes that is sadly true. You do not "feel" the high glucose, and that is an insidious challenge of living with diabetes.

To successfully manage diabetes, the individual should certainly follow the evidence-based guidelines as instructed by a physician. This very often includes regular self-testing of their glucose, sometimes once a day, or three, or even up to 10 times, depending on the type of diabetes they have and how well they are managing their condition.

Our reviews of employer health plans reveal that fewer than half of the employees diagnosed with diabetes --sometimes not even one in 10-- are actually testing their glucose. Those not testing are driving down the road at night with no headlights, and this means a crash will be inevitable at some point. When a person with diabetes does not test, they are simply leaving their health to chance.

The Division of Research at Kaiser Permanente undertook a study to calculate the incidence of diabetes remission (meaning full control) in their adult population with type 2 diabetes, excluding those treated with bariatric surgery. There were 122,781 individuals that met the study criteria and they were tracked over a seven year period. The results: 1) Fewer than 15 in every 1,000 persons achieved partial (i.e. temporary) remission, but most relapsed and went back to their old ways, and 2) Not quite one in 1,000 achieved full and prolonged/sustained remission.

Fifteen years ago, 80 percent of the new diabetes diagnoses were in the over-age-65 population. This decade the Centers for Disease Control reports 80 percent of the new diagnoses (now 1.5 million each year) are in the under-age-65 population. They are working for you or married to the person work-

ing for you. This condition can no longer be ignored and left to the historical "usual and customary care" health system.

The good news is that when a person with diabetes is provided productive tools, resources and personalized support, they will increasingly take responsibility and begin changing and improving behavior choices. Their health does improve. This means they miss fewer days of work, feel better at work, are more productive and have lower healthcare costs. This does not happen from taking more medications. Steady and sustained improvement can only come from better personal behavior choices.

We are human and are irrational beings. We live in groups and villages, work in teams and organizations. We rely on each other, learn from and help each other. That is what it takes with diabetes, too. And this is what is all too often missing.

Disease management is a personal responsibility with diabetes. No one can do it for you, but a support system to help is essential for success. Qualified people and some "tools" (digital or otherwise) can help the person with diabetes begin taking action for behavior change and health improvement, and to sustain that improvement.

Employers should seek programs and tools appropriate for your population and company culture. Do not look for a quick fix, nor a temporary fix. Diabetes does not go away, but it can be managed by the person with it when provided a robust "village" of support. ★



Tom Milam is CEO of Nashville-based TrueLifeCare, which makes meaningful, positive differences in the lives of people with diabetes and reduces associated health care costs for both the employee and employer. Please contact Kay.Pfeiffer@TrueLifeCare.com for information about TrueLifeCare's Diabetes Management program.

DIGITAL HEALTH MEETS FINANCIAL NECESSITY:

1 + 1 = 3

By STEPHANIE TILENIUS and TONEY CHIMENTI

It is not a surprise to any of us in the digital health or insurance sector that the costs associated with healthcare continue to rise at alarming rates. Employers want to do what is best for their employees.

However, after years of nearly double-digit increases and no sign of leveling off, costs are increasingly being passed along to employees. At the same time, rates of chronic disease such as diabetes and hypertension continue to rise across the country. The combination of these factors, combined with near stagnant wage growth, is placing individuals and families under enormous financial stress and anxiety as a result of trying to manage their health and the ever increasing associated costs.

Given our role as consultants and leaders in the market, we have an obligation to put pressure on the status quo and figure out how we can better serve our clients, employees and families. It

is time for us to start thinking about innovative new models that will improve the health of our communities, while helping individuals afford the medical services they need.

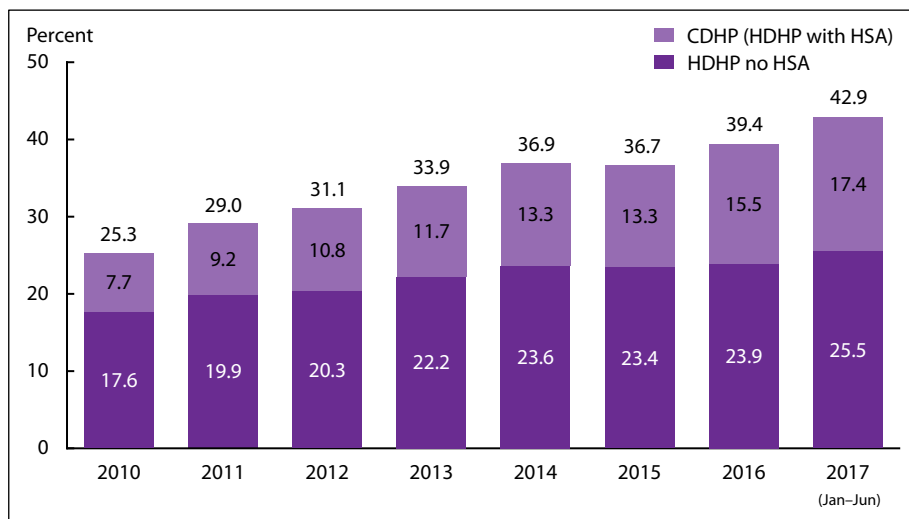
UNDERSTANDING THE SCOPE OF THE CHALLENGE

The trend toward higher and higher deductible health plans appears to be here to stay. Tens of millions of American families have major medical plans that leave them exposed to thousands of dollars of out-of-pocket medical expenses each year. According to the National Center for Health Statistics, greater than 40 percent of individuals under the age of 65 with private insur-

ance coverage are enrolled in a high-deductible health plan (HDHP).

High-deductible health plans often put individuals and families in a position where they are unable to afford the cost of their healthcare. A recent Kaiser Family Foundation report highlighted the challenges that families and individuals are facing when it comes to paying for out-of-pocket expenses associated with healthcare. Their study focused on the amount of liquid assets that individuals and multi-person households have access to in order to deal with health emergencies, and the results are a real eye-opener when seen in the context of HDHPs.

Consider a mid-tier HDHP with an



Percentage of persons under age 65 enrolled in a high-deductible health plan without a health savings account or in a consumer-directed health plan, among those with private health insurance coverage: United States, 2010–June 2017

individual deductible of \$2,000 and a family deductible of \$4,000.

- For a single person household, 53 percent of those with income between 150 percent and 400 percent of the federal poverty level have less than \$2,000 in liquid assets.
- Multi-person households are struggling even more, with 59 percent of those with income between 150 percent and 400 percent of the federal poverty level having less than \$4,000 in liquid assets.

(As a reference point for 2017, 150 percent to 400 percent of the federal poverty level for an individual is an annual income of \$18,090 to \$48,240, and for a household of four, the income range would be \$36,000 to \$98,400.)

The cost of seeking care can lead to real impact in the health and well-being of employees. Individuals who are covered by an HDHP provided by their employer are more than twice as likely to delay seeking care for cost reasons than those covered by a traditional insurance plan (8.5 percent vs 4.1 percent). In other words, employees could be choosing to forgo tests or procedures that can help detect the onset of serious issues. The impact of this could be much greater costs down the road, with negative impact on their overall personal health, and depleted financial security of their family.

Additionally, the financial benefits of overcoming and/or preventing chronic disease are clear. Focusing on diabetes, the medical cost for a person with

diabetes is 2.3 times higher than the cost for someone without diabetes. The Centers for Disease Control and Prevention estimates the total direct and indirect estimated cost of diagnosed diabetes in the United States in 2012 was \$245 billion. At an individual level, this would be an average medical expense of \$13,700 per year for someone diagnosed with diabetes. Going deeper, about \$7,900 of the total annual cost can be associated with diabetes.

MOVING TO A FOCUS ON PREVENTION

With chronic illnesses on the rise in our country, we must rethink our fundamental approach to improve the health of individuals and the greater population. Additionally, being healthy encompasses much more than just physical health if a person is going to stay well. How will we ever get control over the health expenditures in this nation if chronic conditions keep increasing at substantial rates? The financial strain on families today is also much higher with high deductible health plans, and large out-of-pocket responsibilities. Where do we start?

The key will be getting employees with health conditions the help they need to get better and healthy again! Employers should look to partners with innovative and cost-effective solutions that offer personalized one-on-one coaching, include mobile tools with interactive, evidence-based content, and have a user-centric design that will lead

to long term user engagement. Additionally, implementing solutions that will help avoid sudden and substantial financial burden in obtaining care for new and existing conditions will encourage employees to seek the medical attention they need.

OVERCOMING CHRONIC DISEASE

Digital health companies are quickly changing the wellness landscape, with new solutions delivering impressive results. According to a recent article in the Wall Street Journal, “the emerging field of digital medicine—a combination of remote monitoring, behavior modification and personalized intervention overseen by the patients’ own doctors—can improve outcomes in some of the most costly and tough-to-manage categories such as diabetes, heart disease and lung disease.”

A study published by JMIR mHealth showed that among a broad population of individuals with a BMI of 25 or greater, a tailored, multiple-month, health program delivered via a mobile platform with personalized coaching could drive down overall body weight and help users drop a hypertensive stage. Seventy-five percent of the users lost weight. Furthermore, nearly a third of participants lost an average of 9.5 percent. For participants with hypertension, 75 percent were able to drop a hypertensive stage.

Healthcare providers have also begun to leverage digital health solutions to help their patients achieve better results across a variety of metrics such as patient activation, medication adherence and reduced hospitalizations. Doctors at Duke used a mobile app to connect cardiac rehab patients with a human health coach to help with their recovery. For the patients working with a health coach through the mobile app, they saw a significant increase in the percent that agreed with statements: “I have been able to maintain (keep up with) lifestyle changes, like eating right or exercising.” and “I know what treatments are available for my heart attack.”

New papers are constantly validating what physicians have long known but have struggled to put into practice: environment and behavior changes are the building blocks to addressing chronic disease and helping

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- 75% with hypertension improved an entire hypertensive stage

To learn more, go to [vida.com/vidagap](https://www.vida.com/vidagap)

¹ Based on published results: JMIR: A Mobile Phone-Based Health Coaching Intervention for Weight Loss and Blood Pressure Reduction in a National Payer Population: A Retrospective Study, June 2017

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For California, this material contains an example of insurance offered to qualified employers. The exact provisions governing the insurance are contained in the master policy issued to each group on policy form numbers M-9111CA and M-6015CA, policy numbers MG-162 and HP-53. These products are exclusive to California.

Outside of California, this material contains an example of insurance offered to qualified employers. The exact provisions governing the insurance are contained in the master policy issued to each group on policy form number M-9134, policy number MG-163. This product is not available in all states.



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OFFERING MORE ACCESSIBLE INSURANCE BENEFITS

Supplemental insurance products have helped provide employees financial protection when unplanned events occur. Critical illness, hospital indemnity plans, and accident plans can be of great assistance to families struggling to cover medical costs. However, the traditional indemnity structure only covers select events, and unfortunately can also include pre-existing condition clauses. For employees with a HDHP struggling with the cost of care for diabetes or other chronic illness, which will incur costs year over year, these insurance products most often won't help cover these expenses.

Many supplemental gap products take an employee-centric approach to providing financial protection. Rather than an indemnity schedule, most gap coverage is based on the out-of-pocket expenses associated with care under a major medical plan. Employees are reimbursed for their deductibles, co-pays and coinsurance that are incurred for

themselves and their family for covered expenses. Most plans are designed with an annual inpatient and outpatient coverage level, which can cover the first dollar of employee out-of-pocket expense, or can be structured to be compatible with an HSA health plan offering. The growth in these plans has been steadily increasing over the past few years, as employers recognize the need to help employees address one of their major concerns -- how they will be able to afford to keep themselves and their families healthy?

BUILDING AN INNOVATIVE NEW SOLUTION

Is it time to think about pairing insurance with a digital therapeutic and personalized health coaching? Providing financial protection for out of pocket medical expenses helps ease the stressful burden of high-deductible health plans. Meanwhile, helping employees improve their health through access to a personal health coach, evidence-based clinical programs, and a mobile platform for tracking their progress could help reduce the future cost of their medical care. Logic dictates that the answer is "yes", but engaging employees needs to be innovative and creatively implemented.

Beyond the simple combination of each unique value proposition, there should also be the opportunity to offer something more. How can a combined solution be designed such that "1 + 1 = 3"? Creativity will be the key. Potentially insurance carriers will even offer incentives to employees who either take steps to improve their health or achieve positive health outcomes.

Products that increasingly integrate incentives for improving health to the cost and benefits of health insurance are likely to be a growing trend. The shift is already taking place in other markets, such as life insurance, and it will be exciting to see emerging models of creative health insurance combinations. ★



Stephanie Tilenius is the CEO/founder of Bay Area-based Vida Health.



Based in Visalia, California, Toney Chimienti is CEO and president of Chimienti & Associates.

EMPLOYEE BENEFITS 3 THINGS EMPLOYERS WANT FROM BROKERS

By MEREDITH RYAN-REID

The workplace today is changing faster than ever before. There are four generations working side by side, Generation Z is entering the workforce and the gig economy, virtual working and flexible working conditions are changing the nature of work. On top of this, new digital and automation technologies are disrupting the workplace, contributing to angst among both employees and employers.

What these changes mean is that employers today are relying on brokers more than ever before to help them navigate the evolving workplace. Not only are employers looking to brokers to be strategic, trusted partners and thought leaders, but they're also turning to them for their holistic workplace expertise.

For brokers, the opportunities are vast. By being on the pulse of new workplace trends – from data security to automation to financial wellness – brokers can build even stronger partnerships with employers and, most of all, help them to put in place new strategies to recruit and retain top talent during a time of significant transformation.

Below are the top three things employers are looking for from brokers today:

1. INSIGHTS THAT EXPAND BEYOND BENEFITS

Employers are looking to brokers for more than product information – they're looking for full-service support, the broker findings from MetLife's 15th Annual Employee Benefits Trends Study (EBTS) showed. This ranges from employers looking for recommendations on cost savings alternatives to advice on employee financial



well-being strategies to insights into health care reform and how to comply with legislative requirements. And when it comes to benefits specifically, they're looking for a wider array of advice. Nearly two-thirds of employers say they look to brokers for insights regarding benefits trends and employee benefits needs as well as for recommendations on new and innovative benefits solutions, according to recently released findings.

But that's not all. Data security is also top of mind in the workplace today, with the majority (83 percent) of brokers saying that ensuring data security around employee information keeps them up at night. Employers are worried about this too: nearly all (95 percent) of managers and IT workers say they are concerned about the security of documents in their organization, according to a recent Business Performance Innovation Net-

work survey. Data security is of particular concern to small business owners. According to the Small Business Index, fielded by MetLife and the U.S. Chamber of Commerce, nearly two-thirds of small business owners are concerned about a cyber-attack.

For brokers, this means their insights on the workplace are more valuable than ever before. By staying up to date on new legislation, data security requirements and benefits trends, brokers will continue to be employers' go-to partners for all things related to the workplace.

2. STRATEGIES TO RETAIN EMPLOYEES

In a time of rapid change, driving employee engagement and loyalty is top of mind to employers. In fact, retention was named the top priority among employers, according to EBTS.



For brokers, this provides an opportunity to further increase their value by helping employers understand the value of offering employees the ability to customize their benefits. And, this is more important than ever before, according to EBTS.

In fact, employees say having the ability to customize their benefits is a more important driver of their loyalty than even the ability to work from home. Nearly three-fourths (72 percent) say benefits customization is important for increasing their loyalty to their employers, compared to two-thirds (66 percent) of employees who say having the ability to work from home or remote locations increases their loyalty, according to EBTS. This is most important to millennials – the largest generation in the workforce today – over three-fourths (76 percent) say benefits customization is important for increasing their loyalty to their employers, compared to two-thirds (67 percent) of boomers.

When it comes to choice specifically, over half say they are interested in having their employer provide a wider array of non-medical benefits that they can choose to purchase and pay for on their own and the same amount say they are willing to bear more of the cost of their benefits in order to have choices that meet their needs.

However, employers aren't offering all of the voluntary benefits that employees want. When it comes to accident insurance, for example, just over a third (38 percent) of employees say it's

a must-have benefit but under a quarter (23 percent) of employers are offering it. Similarly, more than a quarter (27 percent) of employees say critical illness is a must-have benefit but less than a fifth (17 percent) of employers offer it. This coverage gap is the same with non-traditional benefits too: half (49 percent) of employees say they want wellbeing programs that reward their healthy behavior, but less than one in 10 (8 percent) of employers offer this. Similarly, over half (53 percent) of employees say they want financial planning programs, but less than a fifth (20 percent) of employers currently offer them.

Employers who get ahead of this trend and provide the financial wellness resources employees are seeking have an opportunity to stand out as an employer of choice and win when it comes to attraction and retention. And an increased focus in this area may also contribute to employers' bottom lines by reducing absenteeism and increasing productivity.

Brokers who are armed with these insights will not only show their increasing value to employers, but will continue to be best positioned to help them with their top objective: retaining top talent.

3. PARTNERSHIPS TO MAKE THE BENEFITS EXPERIENCE EASIER

With the heavy workloads on employers' plates in a 'do more with less' world, employers today are also looking to brokers for help with the burden of benefits administration and new and ef-

fective resources to make the benefits experience as seamless as possible.

In fact, nearly two-thirds (60 percent) of employers say they are increasingly concerned about managing benefits administration, an increase from over half (55 percent) just a year ago. And these concerns may continue to rise as customization and variety in benefits become increasingly popular among employees.

To address these concerns, brokers can maximize their value by partnering with benefits carriers, benefit communication firms or third party administrators to deliver an engaging and optimal benefits experience for employers. That said, EBTS found that only a third of brokers work with these organizations, with nearly half of brokers saying that they can do the work themselves — without partners — and that they are not comfortable putting an enrollment firm in front of a client in case something goes wrong. A fifth (22 percent) said they didn't want to share their current book of business with a third party.

However, as the benefits ecosystem continues to expand, seamless integration between carriers, brokers, third parties and employers will be necessary. Brokers who come to the table with strong partnerships will not only ease administration and make things simpler for their clients, but their collaborative nature will be recognized and applauded.

Ultimately, all of these trends point to the shifting role of the broker in today's evolving workplace. With the workplace transforming in a blink of an eye, employers are turning to brokers more than ever before to help them with their workplace needs. For brokers, this provides a great opportunity to differentiate themselves through thought leadership. By providing fresh perspectives on emerging workplace trends and mastering the evolving benefits landscape, they will become invaluable to their clients in deploying strategies that address one of the

things they care about most: an engaged and loyal workforce. ★



Meredith Ryan-Reid is senior vice president, group benefits, at MetLife.

SMALL GROUP VIEW FROM THE TOP

THREE QUESTIONS FOR FOUR INSURANCE INSIDERS

Wonder what's going to happen to small group in 2018? *California Broker* has you covered. We recently reached out to a few people in the know when it comes to small group health insurance. Special thanks to Scott Boore, Michael Lujan, Michael Payton and Tim Rhatigan for offering insightful answers to our questions. (Continued on page 30)

Scott Boore is senior vice president, head of sales for MORE Health. Boore has more than 25 years' experience in the insurance industry, primarily working with regional and national accounts. He has particular expertise assisting public sector entities and unions, with a deep understanding of their particular needs and concerns. Prior to joining MORE Health, Mr. Boore has worked for national insurance carriers building and developing successful sales organizations. He has also spent time working in the brokerage community in order to develop a better understanding of the issues of risk faced by business today.

Mr. Boore received a Bachelor of Business Administration from Stetson University.

Michael Lujan is communications and technology chair for the Silicon Valley Association of Health Underwriters, and co-founder at Limelight Health. He is the former director of sales for Covered California, past president of the California Association of Health Underwriters, and an outspoken advocate for the uninsured and role of the licensed agent. Michael is a regular speaker and contributing writer on healthcare reform, insurtech and the evolving employee benefits ecosystem for SVAHU.org, California Broker magazine and USC Center for Health Journalism. Opinions expressed are his own.

Michael Payton is the vice President of sales at CHOICE Administrators. He's a graduate of Arizona State University.

Tim Rhatigan is senior vice president small business, United Healthcare. He's a graduate of the College of Financial Planning and University of Illinois at Chicago.

QUESTION 1: WHAT ARE THE TOP TRENDS IN THE SMALL GROUP MARKET?

Scott E. Boore: Attempting, as with most groups, to provide strong benefits in the face of continued rising costs. Trying to stretch the budget and yet maintain quality in healthcare during a time of upheaval is a never ending struggle. Technol-



ogy is certainly offering some relief for groups large and small. A greater use of telemedicine is one example. Another is medical second opinion services that can not only secure better outcomes for the patient but can also help to control employer plan costs and help lower absenteeism and presenteeism costs as well.

Michael Lujan: California's small employers are pressured to provide comprehensive benefits competitive with larger employer groups. California brokers are expanding their portfolio of products and services to include more non-traditional benefits and services previously limited to larger employer offerings. Also, as deductibles and out of pocket limits increase to buy-down renewal increases, brokers need to

"2018 will be a significant year for getting more connected and paperless, helping deliver a better customer experience..."

back-fill with hospital indemnity and gap products. While there are plenty of broker-friendly enrollment platforms, many small group brokers have only passively promoted adoption of these technology platforms for benefits administration with HR and payroll integration.

2018 will be a significant year for getting more connected and paperless, helping deliver a better customer experience with decision tools to help employees spend their premium dollars more effectively (and grow agency revenues). 2018 will be a breakthrough year for telemedicine and tailored benefits for both financial and physical well-being. More mobile tools will emerge to better serve a changing workforce. Influenced by a growing gig economy and a workforce dominated by millennial and gen-x workers, portable benefits are more popular. Brokers are needed more than ever, but need to adapt to these trends.

Michael Payton: There are two that immediately come to mind:

1) Narrow/limited network plans are

growing in popularity. As time has passed under the ACA, we have seen more of a willingness from employers to base their contributions on plans with limited networks, or regional carrier networks. Often times, the majority of members in a group are able to find their preferred physician within these networks. Likewise, many of these plans provide richer benefits, which make them attractive to employees.

2) Technology is gaining traction. Many brokers and their clients are utilizing a growing number of online tools available to them, including online enrollment platforms and eligibility management systems. As the baby boomers age out of the small group market, and a younger generation moves in, we expect the demand for self-service and immediate access to data to continue.

Tim Rhatigan: Consumers are increasingly turning to the internet and mobile technology as a first resource when seeking health care information. According to the 2017 UnitedHealthcare Consumer Sentiment



Survey, 32 percent of Americans now use the internet to shop for health care – up from 14 percent in 2012.

To help people comparison shop for health care based on quality and cost, we created online and mobile resources such as a health cost estimator that uses the actual contracted rates with health care benefits provided. Consumers can find and compare costs and get personalized estimates based on their specific health plans to help anticipate out-of-pocket costs and evaluate health care options.

For minor health concerns, people can register for a virtual visit and pay \$40 or less to talk to a doctor by phone or computer. In addition, telehealth's possibilities are especially compelling for employers. Unplanned employee absences can amount to more than 20 percent of payroll costs each year. Fortunately, more than ever, your employees can get the care they need, anywhere.

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QUESTION 2: DO YOU SEE MORE GROUPS GOING TO COVERED CALIFORNIA FOR SMALL BUSINESS?

Scott E. Boore: I see groups talking about it more. But I haven't seen a wholesale movement in that direction yet.

Michael Lujan: As the first Director of Sales at Covered California, I have an optimistic view for what the CCSB program could be and its potential for growth. The inaugural year of Covered California was frenetic and mostly focused on the mammoth task of successfully launching the individual marketplace, which drove 99 percent of the total exchange enrollment. While SHOP was required by the ACA, the attention and focus was appropriately aimed at serving the individual market and subsidy-eligible population. Today, CCSB is well positioned for growth and manages a robust menu of qualified health plans.

Enrollment in CCSB has increased recently but still has considerably smaller market share than CaliforniaChoice, the states' largest and most successful private exchange for the small group market segment. Covered California could create more unique features and products to help increase CCSB's value proposition and uniqueness in the small group market. CCSB could increase growth by adding new products (like Oscar Health for small business) and unique features and tools for brokers. A successful CCSB is good for the small group market so brokers should encourage Covered California to improve and create a unique value in the small group market.

Michael Payton: Generally speaking, we do not follow the enrollment patterns or movement to any specific entity, including CCSB. However, we can confirm enrollment in an "exchange" model has never been higher. Brokers

and employers continue to recognize as the ACA brought about relative benefit parity, access to care and freedom of choice is of greater value to members than ever before.

QUESTION 3: WHAT ARE SOME THINGS TO KEEP IN MIND WHEN SELLING TO AND SERVICING SMALL GROUP CLIENTS?

Scott E. Boore: Number one is to give them the time and respect that they deserve. The employees in a small group have the same needs and concerns as those in a large group. However because of the smaller group size there is often a need to be more creative and seek ways to get "more bang for the buck". Don't be afraid to suggest something new and different. Smaller groups are often more receptive to new ideas than their larger brethren.

Michael Lujan: The small group market is evolving and changing fast. Employers have many options and new brokers vying for their business with new products, tools and services. Brokers should be paying close attention to their total offering and how it compares to this new competition. Are you just a seller of insurance products or a trusted advisor and partner in your clients' employee benefits strategy? Many "new breed brokers" are finding great success with also solving compliance, HR, payroll and culture strategies.

Our workforce is changing (millennials are now the largest percentage) and has new needs and expectations to meet. If you have not already, 2018 had better be the year you update your technology and website (optimized for mobile), rethink your customer acquisition strategy, and build (or update) your social media presence. Getting more efficient with hunting for new business will help you spend more time servicing and retaining existing customers and fending off aggressive competitors. Disrupt or be disrupted.

Tim Rhatigan: While the UnitedHealthcare Consumer Sentiment Survey found U.S. consumers are increasingly using technology to improve health care

knowledge and access, it also found many still don't understand basic health insurance concepts that are important to using their health plan benefits.

For instance, only 7 percent of respondents could successfully define all four basic health insurance concepts: plan premium, deductible, co-insurance and out-of-pocket maximum. Clearly understanding the health care system remains a challenge for many consumers, with some studies showing low health literacy costing the U.S. economy up to \$238 billion per year.

To help address this issue, small and large employers can play an important role in raising awareness among employees. Small group clients can help promote health literacy and ownership through annual wellness exams, health assessments, newsletters, videos, articles on bulletin boards, and onsite seminars and webinars.

These approaches may help employees get the most from their health plan, and keeping employees happy and healthy throughout the year will benefit businesses in the long run.

Michael Payton: Health care is a very personal thing to most individuals and families. Yet, often times, employers think they know how to best cover their employees' health care needs. The fact is, no one knows better than

the employees themselves. We continue to encourage brokers to have this type of honest dialogue with their small group clients. Work with your groups to identify a budget for health insurance, then help them implement a solution that provides employees the greatest flexibility with respect to access to care, cost, and coverage. As we live, we get to make choices in every aspect of our existence. Where we live. What we eat. Who we marry. What we wear. What car we drive. You get the idea.... So, why don't we traditionally sell health insurance as a sponsored benefit that maximizes individual choice of where and how we consume health care, rather than positioning it as something an employer "gives" or "provides"? ★





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Three Ways Clients Can Support Employees Diagnosed with Cancer

By SANDY WITT

We all know someone who's been affected by cancer. Whether you've been touched personally or you've had a relative, friend, co-worker or client diagnosed, you understand that there can be many unknowns with this challenging disease.

For clients with employees fighting cancer, the support each employee may need can differ greatly based on his or her diagnosis, treatment plan,



physical and mental health and other various factors.

These variables can be overwhelming for your clients to consider when determining what accommodations an employee may need to help him or her remain healthy and comfortable when the time is right for them to return to work.

Now is a great time to check in with your clients to gauge their level of comfort and readiness to support an employee diagnosed with cancer.

COMMUNICATE WITH EMPLOYEES

Many clients think they shouldn't communicate with an employee during a disability leave. While it's important to give an employee the space he or she needs to recuperate and not overstep any legal boundaries, there is no need for a client to distance themselves from their employee during his or her absence. Contacting an employee during treatment can help the employee feel valued knowing his or her employer genuinely cares about their recovery.

Keeping in contact with the employee also can help a client gauge his or her progress. However, it's important to remind clients that their conversations should be focused on the support the employee may need when he or she is ready to return to work and to avoid any questions that directly ask about the employee's medical condition or when the employee is expected to return to work.

OFFER FLEXIBLE RETURN-TO-WORK ACCOMMODATIONS

Once an employee returns to work, a client shouldn't assume it will be business as usual — at least not right away. Every employee's recovery period will be different. Healing and recuperation will take time, but a client's flexibility and understanding of different workplace accommodations could greatly impact an employee's ability to return to work.

Encourage your clients to work with their disability carrier to help ensure the employee has the necessary resources available during his or her recovery period at home and also at work, once the employee is able to return.

A disability carrier can evaluate each

employee's individual situation, gathering both medical and workplace information, to develop a customized return-to-work plan that fits the employee's health needs and job responsibilities. Recommended workplace accommodations could range from re-

"Cancer can be a tough diagnosis, but it makes a big difference when an employee knows he or she is not alone in navigating their return to work."

duced job duties, to a modified workstation or even frequent rest breaks. Small adjustments can make a big difference in helping improve an employee's comfort and ability to return comfortably to work.

Take this success story as an example of how simple workplace accommodations recommended by a disability

"Addressing an employee's entire situation can help expedite their return-to-work timeline and enhance their productivity in the workplace."

carrier helped one employee return to work. A customer service representative was diagnosed with bone cancer in her leg and learned she would need invasive surgery. The employee was told the surgery could cause muscle and nerve damage, impacting her ability to walk or climb stairs. She also was warned after the surgery that she may experience stiffness and pain if she stayed in one position for too long.

To help overcome these potential workplace challenges, the employee was connected with her company's disability carrier and assigned a consultant to develop a return-to-work plan that addressed these concerns. For the first two weeks, the employee worked

a part-time schedule, allowing her to ease back into work and take breaks as needed to walk around and reduce pain and stiffness. The disability consultant also recommended the employer install a sit/stand desk to address the employee's physical needs long-term. The flexible schedule and workstation adjustments helped the employee successfully transition back into her role and eventually resume a full-time schedule.

UNDERSTAND RECOVERY MAY BE ONGOING

Whether an employee has returned to work part time or full time, he or she may experience physical and emotional effects from treatment. For example, after treatment, an employee could experience depression, feel overwhelmed by financial concerns or worry about workplace dynamics.

These additional symptoms or stresses can impede an employee's ability to successfully return to work. Understanding the additional factors that may be at play can help clients and their disability consultant be mindful of accommodations that support the employee fully. Addressing an employee's entire situation can help expedite their return-to-work timeline and enhance their productivity in the workplace.

Cancer can be a tough diagnosis, but it makes a big difference when an employee knows he or she is not alone in navigating their return to work. Likewise, losing an employee for an unexpected period of time can be stressful for a client, but when they understand how their disability carrier can help, concerns can be minimized. Together, your client, their employee and disability carrier can collaborate on a return-to-work plan that meets everyone's needs and paves a path for success. ★



Sandy Witt is a disability and productivity consultant with the Workplace Possibilities program at Standard Insurance Company. By meeting with employers and understanding their work culture and needs, she matches on-site consultants with employers and oversees services that help injured and ill employees stay at work or return to work as soon as possible.

Socially Responsible Investing Ratings Can Boost Your 401(k)'s Value

By ROBERT C. LAWTON

Recently Morningstar, creator of the Morningstar Star Ratings for mutual funds, introduced Sustainability Ratings to gauge an investment's adherence to SRI principles. 401k plan participants, millennials especially, have become interested in socially conscious and impact investing. A recent U.S. Trust survey found SRI factors are important to 93 percent of millennials when making an investment decision. Companies are even finding that their 401k plans may have greater value to employees if they begin sharing Morningstar's Sustainability Ratings for their 401k investment options.

WHAT ARE SRI AND ESG?

ESG is an acronym that stands for environmental, social and governance. These factors include the environmental impact of the company, how the company interacts with its employees, customers and communities, and how the company is managed and led. These criteria represent the major non-financial items used to evaluate an investment option. ESG factors make up the core of a socially responsible investing (SRI) approach. You may have heard SRI described as impact investing. There is a difference. Impact investing is a subset of SRI that attempts to generate positive social good in addition to the goals typically outlined in an SRI approach. For example, impact investing may target organizations that use clean technology, help feed the hungry or house the homeless.

MORNINGSTAR'S SUSTAINABILITY RATING

For more than 20,000 investment options (ETFs and mutual funds), Morningstar has now debuted what it is calling a "Sustainability Rating." It is the intention of Morningstar, via its

Sustainability Rating, to help investors measure the extent to which an ETF or mutual fund's underlying investments are managing ESG factors.

Investors and 401k plan participants should be able to have a high level of confidence in the Sustainability Ratings that Morningstar shares. Morningstar will calculate its Sustainability Ratings by using company ESG rating information provided by Sustainalytics. Both



Morningstar and Sustainalytics are in the business of selling information -- not advice or products.

Morningstar's Sustainability Rating scale will parallel its mutual fund star ratings scale in that the best score an investment can achieve is a 5. Different from the star ratings, the Sustainability Ratings will be represented by globes.

DOL GIVES SRI A BOOST

In October of 2015, the Department of Labor (DoL) issued new guidance in Interpretive Bulletin 2015-01 that many feel opened the door to wider adoption of impact investment approaches and SRI in general. Prior DoL

pronouncements seemed to indicate that SRI was not something that retirement plan fiduciaries should consider. In announcing the Bulletin, DoL Secretary Thomas Perez stated that non-retirement plan ESG investments have grown from \$202 billion in 2007 to \$4.3 trillion in 2014. By issuing Bulletin 2015-01, the DoL was attempting to remove the perceived stigma surrounding SRI in retirement plans.

WHAT PLAN SPONSORS SHOULD DO NOW

Investment advisers who work with 401k plans should begin sharing Morningstar's Sustainability Ratings in his/her performance reports. Update your employer education programs to discuss Morningstar's Sustainability Ratings so employers can share this information with their employees. Companies may want to begin considering Morningstar's Sustainability Ratings when they choose new mutual fund investment options for their 401k plans.

Many employees are interested in making life decisions that reflect their respect for the environment, social justice and sound governance. It's wise for employers to acknowledge this and make the 401k plan more relevant to them. ★



Robert C. Lawton, AIF, CRPS is the founder and President of Lawton Retirement Plan Consultants, LLC. Mr. Lawton is an award-winning 401(k) investment adviser with over 30 years of experience. He has consulted with many Fortune 500 companies, including: Aon Hewitt, Apple, AT&T, First Interstate Bank, Florida Power & Light, General Dynamics, Houghton Mifflin Harcourt, IBM, John Deere, Mazda Motor Corporation, Northwestern Mutual, Northern Trust Company, Trek Bikes, Tribune Company, Underwriters Labs and many others. Mr. Lawton may be contacted at (414) 828-4015 or bob@lawtonrpc.com.

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The Right Kind and Right Time Frame for Life Insurance

By RICHARD M. WEBER

Let's face it—we all know the reality: term insurance is cheap; by comparison, permanent insurance is expensive. As a consulting insurance expert, I face the challenge of getting clients to take action and buy the amount of life insurance their circumstances really suggest. It's an even greater challenge when comparing the cost of term life insurance to permanent insurance, even when the latter is the "right" kind of insurance for their lifetime. As we in the life insurance industry know, term is at its best when it provides families and businesses the desired protection for a specific and defined period of time. We also know that families rarely have enough of that protection. The other reality is that when it comes to lifetime solutions – when the desire for this unique form of financial protection doesn't go away – term doesn't work; it is simply not designed to be affordable for a lifetime.

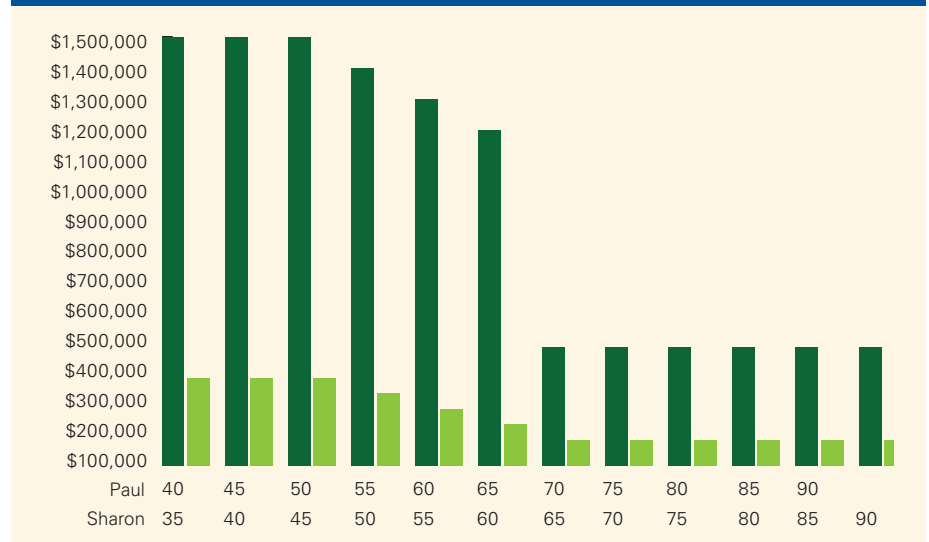
Here's an example. Typically the 11th year's guaranteed renewal premium of a 10-year term policy is 15 to 20 times the initial period of guarantees. And it rapidly increases from there on an annual basis. We'd always attempt to have our client apply for a new policy, but sometimes it's not possible to obtain new coverage, and the client is stuck in a progressively unaffordable term policy. And that may be all that we can do. For many in our economy, the luxury of choice to insure for a lifetime simply isn't possible.

While immediate "luxury of choice" may exist with only a relatively few who have earned it the old-fashioned way, many of our clients start out wanting large amounts of financial protection for their family and significant potential for increasing income over their working lives. If that describes your clients, then as income and disposable income improve, they will have a number of options to begin allocating resources

toward the objective of "retiring in the style to which they'd like to become accustomed." How would we work with those clients to advise and facilitate a schedule for gradual conversions of term—customizing to their budget and resources? First, we'd set a target for the ultimate amount of lifetime insurance they'd find useful. In addition to the other diversification choices clients will want to consider through their unique

less than \$8,000 a year for 401K allocations via salary withholding. Fortunately, the couple appreciates the difficulty of maintaining a reasonable standard of living if either of them gets disabled or dies prematurely, and they are in the 11th year of 20-year, \$1 million and \$400,000 term policies respectively on him and her. They also have acquired policies for \$4,000 and \$1,500 per month of long-term disability.

CHART 1



risk tolerance, investment experience, and time horizon, I advocate a custom-designed portfolio of different styles of permanent insurance that fulfills their expectations for value, annual outlay, accumulation of cash values and death benefit. It's called efficient choices.

Let's consider Paul—a recent client who is 40 years old and earns \$80,000 a year as a middle manager with a regional auto parts wholesaler. He's married to Sharon—a 35-year-old paralegal making \$30,000 working half-time until their 10- and 12-year-old children enter high school. While their combined income is above the national median, it's been difficult to balance all the current financial demands of running a household. Saving for retirement has been restricted to

Paul and Sharon are ready to re-prioritize their budget to significantly increase annual savings allocations for retirement, and they've been able to free up \$10,000 now—with the expectation of another \$20,000 a year when Sharon returns to full-time work in five years when their youngest is a freshman in high school. They've also identified they want to maintain the combined \$1.4 million of death benefit protection until each turns 50—with progressive reductions to a lifetime amount of \$500,000 on Paul and \$200,000 on Sharon. They consider this as the legacy that—at a minimum—will give their children more flexibility when planning their retirement.

THE STRATEGY WE WOULD DISCUSS WITH THE COUPLE IS SEEN IN CHART 1

With the \$10,000 additional savings allocation for the next five years, we'll recommend 50 percent into risk-appropriate mutual funds or ETFs while at the same time re-underwriting their current term insurance to new policies that will save money now and allow for later conversion to whole life or some form of universal life insurance as appropriate to their targeted lifetime coverage. When the next update to savings comes in five years, the universal forms of life insurance policies can absorb additional planned premiums to better assure each policy sustains to age 100 or later.

Focusing in on the consumer's dilemma of "what kind of policy is best

risk tolerance will tend toward whole life and/or traditional current assumption policies in which the insurance company assumes some of the investment risk for a middle-ground risk tolerance.

To the surprise of most first-time buyers, universal life insurance policies don't have required premiums. Instead, agents calculate them based on a policy illustration of "current assumptions" in response to the client's natural question: "What's it gonna cost?" The typical problem with calculating a non-guaranteed planned premium is the tendency for the agent and/or consumer to assume overly-optimistic crediting rates in preparing the illustration. Since the chosen assumed (but not guaranteed) crediting rate is calculated as a constant for all years of the illustration,

for all years with minimal, assumed planned premiums, we invariably recommend a combination of guaranteed policies – whole life and guaranteed death benefit universal life – as well as appropriate risk-based current assumption policies. And there's even an intriguing hybrid exclusively offered by The Guardian®. Its Index Participation Feature (IPF), allows whole life policy dividends – typically paid to policy owners most years – to be credited with earnings that are indexed to the stock market, while at the same time providing a substantial 4 percent minimum guarantee even when the measured index is negative.

There are many choices; the right balance of efficient choices will be dictated by budget and risk tolerance and is the sophisticated approach to life insurance.

Issues surrounding the appropriate kind of life insurance can be made simplistic, e.g. "Buy term and invest the difference!" But life rarely imitates cliché. Clients lifetime uses of life insurance are best indicated by their own unique set of circumstances. Then, supported by your financial resources and addressing their desire to provide for family and heirs, a more sophisticated approach can be pursued to consider risk tolerance and the opportunities for additional asset accumulation with specific tax advantages from life insurance designed for a lifetime.

Commercials with risky images proclaim, "Kids: don't try this at home!" Similarly, do-it-yourself insurance decisions rarely work out in the long-run. That's why clients need the help of a life insurance professional. ★

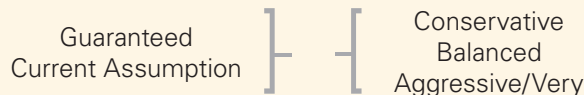


Richard M. Weber, MBA, CLU, AEP, is president and principal of The Ethical Edge, Inc., a consulting firm providing fee-only analytics and services to insurance firms, family offices, and high net worth individuals.

Dick reviews new and existing policies for policy-holding clients from several dozen of the top carriers. For the past decade, Dick has provided his consulting services to many carriers, including The Guardian Life Insurance Company of America®. He makes recommendations based upon his relationships with the companies and the integrity of the products and people that back them.

CHART 2

Which Policy is in My Best Interest



for my circumstances?" we find it useful to consider how financial planners make strategic asset allocation recom-

we recommend introducing more reasonable expectations by utilizing initial illustration crediting rates as follows:

CHART 3

Calculating a Planned Premium for Current Assumption-style policies

	Traditional Universal (UL)	Index Universal (IUL)	Variable Universal (VUL)
Initial illustration rate	3%	5%	6%

mendations to new clients.

Typically, in their first interview with a prospective client, the planning focus will turn to assessing risk tolerance in the typical categories of conservative, balanced and aggressive allocations. As we might expect, speculative options are not going to be attractive to someone with a conservative risk tolerance. In fact, when it comes to the various types of life insurance, such a client is going to be drawn to policies with substantial guarantees such as whole life or those current assumption policies offering a guaranteed death benefit. Similarly, a client with an aggressive risk tolerance will perhaps be drawn to a combination of whole life and investment-based current assumption styles of insurance such as indexed or variable polices. A balanced

These are not arbitrary numbers. With today's extremely low fixed-income returns, an insurer's bond portfolio cannot reliably support a traditional universal life policy with more than a 3 percent projection for the foreseeable future. For IUL and VUL—policy styles whose crediting rate depends on direct or indexed performance of the stock market—extensive volatility research with sophisticated financial modeling tools provide the "safe" initial illustration rates indicated in Chart 3. Then, as experience is gained with the UL, IUL, or VUL policy, adjustments can be made to the funding level with an eye toward conservative projections to sustain the policy for all years.

Further, because the current assumption style of policy is typically not guaranteed and is unlikely to sustain

LEGAL INSURANCE

THE VERSATILE BENEFIT EMPLOYERS MIGHT NOT KNOW THEY NEED

By DENNIS HEALY



Voluntary benefits have evolved in the last few decades to provide a wide variety of options that can help employees deal with major catastrophic events (think disability, critical illness and cancer) that are potentially not covered by their health insurance benefits. Yet, only 27 percent of employees right now report high satisfaction with their benefit offerings.

WHAT'S THE DISCONNECT?

Perhaps it's that employees now expect a more robust benefits package that can help with more of their

medical, emotional, financial and legal needs. They want benefits that they can use in their everyday lives, on a regular basis — not just when they are sick, injured or elderly.

For example, long-term care insurance can help them with the eventual costs of assisted living, home health aides and nursing homes, but what about everything they should be doing now to help prepare for that time — creating and maintaining an estate plan that includes a will, trust and other legal documents that make their wishes clear?

Retirement plans can help them save for the future, but what about the

financial help they need now to get out of debt, pay off student loans, or learn how to budget and spend wisely so they aren't living paycheck to paycheck?

Disability insurance gives employees the peace of mind to know they'll be provided for if they get sick or injured, but what about the legal documents they should have in place before that happens to make sure their wishes for medical care are carried out if they're unable to communicate?

Employers who want to be more proactive about their employees' health and well-being are turning to other

voluntary benefits like legal insurance to fill in gaps. In the past 20 years, the percent of employers who offer a legal benefit to their employees has grown from 13 to 25 percent. These are the employers who understand the many advantages legal insurance can provide that complement and support other voluntary benefits to provide a more complete package for employees.

They recognize that financial and legal issues are intertwined, so when an employee meets with a financial planner or tax advisor for help, he or she should also be using an attorney to make sure their investments reflect their overall estate plans. They recognize that helping employees provide for their children or support their parents means giving them not only financial benefits but also the ability to set up legal documents like guardianships or powers of attorney with the help of a professional.

SEEING THE VALUE IN LEGAL INSURANCE

When employers are choosing what to include in their benefits package, many of them tend to go with the more traditional voluntary benefits. One reason is because they aren't as familiar with legal insurance and may need additional education about the benefits for them and their employees.

Employers may not realize, for example, that legal insurance is one of the few voluntary benefits that is useful to every single employee. No matter an employee's age, relationship status or background, every single person encounters legal situations. ARAG recently conducted a study that found three out of four Americans experience at least one legal event every year.

Providing employees access to a legal insurance plan will help them save money on attorney fees, which average \$343 an hour. When you consider the average number of attorney hours for something like a real estate transaction is six hours, the fees add up fast. But with legal insurance, network attorney fees could be 100 percent paid in full for most covered matters.

IMPROVE THE BOTTOM LINE

Not only does legal insurance save employees money, it also decreases

the time and stress they have to spend dealing with these issues — which impacts their productivity at work. American businesses lose more than \$300 billion every year because of employees' stress-related issues. By providing employees a benefit that saves them money on attorney fees (reducing financial stress) and connects them with professionals who can help with stressful situations in life such as divorce, caregiving and debt, employers are also benefiting their own bottom line.

Once employers understand this and add legal insurance to their benefits, they see the value firsthand. In fact, 97 percent of employers with ARAG legal insurance retain the plan from year to year.

WHAT'S THE ROI?

Employers will want to know what implementing a new voluntary benefit is going to take on their end. They want to make sure the time it takes is going to pay off. We've found that implementing the legal insurance plan takes a total of only six hours. By providing a dedicated client manager for employers, making our customer care representatives available to assist plan members and eligibles, and developing a communication plan for clients, we greatly reduce the administrative burden placed on the employer.

That six-hour investment pays off in increased productivity — each employee who participates in the legal insurance plan saves an average of eight and a half hours (and nearly \$2,000) when dealing with one legal issue thanks to the work done by their ARAG attorney.

A MORE VERSATILE VOLUNTARY BENEFIT

As employers continue to realize they need a more comprehensive benefits package to remain competitive, they will be looking for options beyond the traditional voluntary benefits. Legal insurance is easy to implement and maintain, affordable and provides more value to employees. It can provide support for not only legal issues but also financial, identity theft, caregiving and other issues that employees will encounter at some point in their lives. To use a toolbox analogy, legal insurance is the adjustable wrench, more versa-

THE MOST COMMON LEGAL ISSUES EMPLOYEES DEAL WITH INCLUDE:

- Creating a will or trust.
- Traffic tickets or moving violations that could lead to license suspension.
- Child custody, child support and other family law issues.
- Divorce.
- Dealing with debt collectors.
- Property line and other neighbor disputes.
- Bankruptcy.
- Issues with bad contractor work or incomplete auto repairs.
- Buying or selling a home.

tile than other wrenches because it's built to adapt and help people in many different situations. Make this essential tool part of your client's toolbox today. ★



Dennis Healy is a member of the ARAG® executive team. He has more than 25 years of insurance industry experience, with a primary focus on the sale of group voluntary benefit products to employer groups of all sizes through brokers, consultants and employee benefit exchanges.

Recent Claims Department Trends

By ART FRIES

As a disability claim consultant, I'm sorry to report that I've been seeing a trend to delay payment of claims through various harassing methods with the purpose of "floating money." I believe these tactics allow the insurance company to hold on to money and earn interest on that money before they have to pay funds for legitimate disability claims. In addition, there are some other harassing techniques that anyone servicing clients should be aware of. These techniques are being used on existing disability claims for the purpose of terminating the claim.

USING P.O. BOXES

Sometimes the claims department doesn't provide a street address to submit claim forms, but instead provides a post office box. This increases the chance that a claimant will send in the claim forms without requiring a signature of receipt. Quite obviously, you can't get someone to sign off if it's a post office box. This means there's no evidence that the insurance company receives the claim form and there's ample opportunity for the claim department to say they "never received the forms." Often the claimant will not follow up for a month or more. They will then be forced to complete a new set of claim forms

and secure another attending physician statement, which causes more delays. This delay tactic can buy the insurance company an additional two months or more holding on to funds meant for the insured claimant.



MEDICAL FILES

In prior years, disability company claim department secured medical records through outsourced companies as follows: The outsourced company would call the doctor's office and ask the required fee to secure medical records

for the claimant. They would then make an appointment to be at the medical office with the payment along with a copy of a signed authorization from the claimant (provided to the insurance company with the initial claim application). This enabled the company to secure a complete copy of the medical files. Typically, the "photocopy service" would bring their own equipment to the doc's office. At one time it was a portable photocopy machine, then microfilm. In more recent years, it was a laptop computer. This process was quick and effective and enabled the insurance company to secure medical records in a timely fashion. Now most of the claim departments use an outsourced service that faxes a cover memo and the signed authorization to the medical office requesting the medical records with no payment. If there are only several pages of medical records, the doc's office might fax back the records. But say there are 20 pages...or 60 or 80 pages of medical records.

In this case, the doc's office will typically ignore the request or toss it in the patient file/computer file or possibly in the waste paper basket. Now multiply this procedure by the claimant having multiple medical providers – six or seven or more. You can see how long a claim department can

delay matters as it relates to securing medical records. What previously took several weeks can now take several months or more before the medical records are received by the insurance company. In this scenario, the insurance company saves money two ways. They cut no check to the medical office and they reap the benefits of many months of delay.

ATTENDING PHYSICIAN STATEMENTS

For many years, claim departments only requested one attending physician statement (APS). Now I'm seeing more and more claim departments requesting an APS be completed by all of the claimant's medical providers listed on the initial claim forms. I am also seeing the same thing on "continuation forms" for existing disability claims. This is a great opportunity for the insurance company to secure conflicting opinions, creating further delays. Some physicians may not even agree to provide a APS. This great opportunity can provide the claim department three reasons for denial or termination of a disability claims: 1) no support of the claim from one or more doctors; 2) conflicting opinions; 3) no return of forms (APS).

MORE CLAIM REVIEW

In addition to your claim representative who controls your claim, there are various "layers" of individuals such as nurse practitioners, accountants, physicians, occupational consultants, and others who specialize in various aspects of reviewing your claim. These individuals have never seen or spoken with the claimant. One of these specialists (often a physician) will try to contact one of the treating physicians to "trick them" in such a way that the doctor provides an opinion that is in conflict with the claimant's medical records. Or they may try to request from the claimant's doctor permission to secure an F.C.E. (Functional Capacity Evaluation) by someone hired by the insurance company even though policy contractual language may not permit such a test. The training -- education and ability to interpret raw data correctly-- by a physical therapist or occupational consultant performing an F.C.E. can also influence opinion pro-

vided to the insurance company.

MASSAGING THE FILE

Even long-term disability claims may not be safe from termination. Claim review people get moved around, promoted or leave the company whereby a new claim rep is involved with the claimant's file. Usually they do not have time to read the entire claim file from the beginning. They may call a claimant who has been submitting a continuation form/progress report and a continuation attending physician statement on a semi-annual or annual basis and tell them they should

"I've been seeing a trend to delay payment of claims through various harassing methods with the purpose of 'floating money.' I believe these tactics allow the insurance company to hold on to money and earn interest on that money before they have to pay funds for legitimate disability claims."

be submitting these forms more frequently. The claimant may have had an I.M.E. (Independent Medical Evaluation) 6 months prior or 1 year prior but because the claim rep only glanced at the file they are not aware of it. So they will tell the claimant that another I.M.E. is going to be done. There are other harassing techniques used by claim reps, but these are two good examples.

MORE USE OF SOCIAL MEDIA TO CREATE A GOTCHA'

Insurance companies have used video surveillance techniques for many years, especially in connection with musculo-skeletal claims involving cervical, thoracic and lumbar areas. Claims related to shoulders, arms and hands/fingers are also quite common. But

even depression claims have not escaped the wrath of video surveillance. The purpose of these techniques is to gather information that shows the claimant doing something that may be in conflict with their claimed medical symptoms. This could be detrimental to the claim, which in turn can be the basis of a denial or termination. However, these investigative techniques have become increasingly expensive. But social media such as Facebook, LinkedIn, Twitter, Google, Snapchat and other platforms are available to insurance company claim departments. They enable the claim department to view how you are conducting your personal life, etc., and to determine if there are any conflicts with your claimed medical condition. So a claimant now has to give more thought to how much time they spend on these platforms and what they say. I've often wondered how an insurance company has found out about my client's vacation time frame and even when long distances are involved. Cyber checks might save an insurance company vast sums of money when there is no longer a necessity to pay outsourced video surveillance people sums of money to track a "high monthly benefit" claimant going on an Asian or European vacation. Maybe drones will be used in the future to capture a claimant's activities even. Your guess is as good as mine, but this method of surveillance is certainly being considered and may be commonplace in the future.

As a disability claim consultant for the past 22 years, I have seen many changes and those I have discussed are some of the more challenging ones. Yet, they cause me to stay a step ahead of the insurance companies and offer combatant tools to my clients so that their disability claim is paid and solidified over the long haul. ★



Art Fries is a disability claim consultant providing advice on a national basis in the U.S. He is located in Nipomo, California. He can be reached at (800) 567-1911 or email: friesart@hotmail.com His web address

is: www.afries.com

A VERY BELATED CONGRATS TO WARNER PACIFIC'S FABIENNE DIMARTINO

In September, LAAHU hosted The LOVE Couture fundraiser. The annual fashion show, held at the Westlake Village Four Seasons, raised a lot of welcomed funds for the Valley Community Healthcare Clinic. In addition, one woman in the insurance industry was selected to be honored for all the contributions she's made to the industry. This year, it was Warner Pacific's Fabienne DiMartino! We've been trying to get in touch with Fabienne, but have had zero luck. So instead we'll simply pass along a few words of praise about Fabienne from LOVE Couture committee member and event organizer Naama Pozniak:



"Fabienne is an inspiration in the health insurance industry. Not only is she a beautiful person, she is intelligent and has a strong knowledge of the health industry. She can communicate with anyone from the CEO to staff personnel with such confidence and ease. In this ever-changing health insurance climate, she talks to people one on one or in a group setting without making anyone feel less knowledgeable.

She loves to empower women of any age, but loves to work with younger women who are coming up in what is traditionally a male dominated industry. She guides these women to believe and know they are worth more. She stands beside and teaches them.

I have had the opportunity to work with Fabienne for the past 6+ years so I have seen how she can make a difference. She listens wholly, she steers you in the right direction and she is always positive! I have been in many group meetings with her when the clientele does not understand the topic and may be afraid to ask questions (for fear of looking dumb). At the end of these group meetings, no one has either been afraid to ask their question or not completely understand the topic after hearing her speak.

Most recently she was guiding us on a large prospect. At the end of the meeting when we said 'You make us

feel like we can walk into the prospect with confidence.' Her reply was 'Great! That's what I want.' She is kind, compassionate and a leader in the industry."

Thanks for taking the time to tell us about Fabienne, Naam! And, again, congrats to Fabienne!

COVERED CALIFORNIA FOR SMALL BUSINESS CONTINUES GROWTH, ANNOUNCES PARTNERSHIP WITH EASECENTRAL

A partnership with California Broker contributor EaseCentral is the latest advancement for Covered California for Small Business, which announced enrollment growth from 14,183 in 2014 to more than 40,000 as of Dec. 1, 2017. EaseCentral will include Covered California for Small Business in its integrated software platform. Em-



FOR SMALL BUSINESS

ployees of small businesses across the state will be able to log on and see the plan choices provided through Covered California for Small Business. The automated system should lead to cost savings and an improved enrollment process for agents and the small businesses they work with across the state. For more info go to <https://www.coveredca.com/forsmallbusiness/>

MEDICARE SUPPLEMENT ASSOC. AND SOCIETY OF CERTIFIED SR. ADVISORS TEAM UP

The American Association for Medicare Supplement Insurance and the Society of Certified Senior Advisors have announced plans to work together on the 2018 National Medicare and Senior Insurance Products Sales Summit, which will take place June 12, 2018, at the Marriott Grand Hotel in St. Louis.

The event will provide insurance agents with the opportunity to meet and learn from national experts conducting some 50 different educational workshops as well as to meet face-to-face with leading insurers, marketing and educational organizations at the

nation's largest expo for Medicare and senior insurance products. Those not able to attend can view recordings of workshop sessions online following the event.

The Society for Certified Senior Advisors offers the Certified Senior Advisor (CSA) credential, which is the leading certification for professionals serving older adults.

The American Association for Medicare Supplement Insurance organizes the June 12 free day for agents as part of the organization's national Medigap industry conference. For information and access passes for the free agent day, call the Association at (818) 597-3205 or visit <https://medicaresupp.org/2018-conference/>

HEALTH NET AWARDS \$4.2 MILLION TO DRIVE HEALTH WORKFORCE DEVELOPMENT AND IMPROVE QUALITY OF HEALTH DATA COLLECTION

Health Net announced it is awarding a combined \$4.2 million to 22 health-care organizations across California to help increase health workforce development and improve the accuracy of encounter data collection. Most organizations received between \$150k and \$250k. Find more info, including a full list of the grant recipients, go to <https://www.businesswire.com/news/home/20171205005446/en/>

LIMRA: WHOLE LIFE SALES FALL FOR FIRST TIME IN 14 CONSECUTIVE QUARTERS

After 13 quarters of consecutive growth, whole life insurance new annualized premium fell 4 percent in the third quarter 2017, according to the LIMRA U.S. Retail Individual Life Insurance Sales Survey. This decline, coupled with another double-digit decline in lifetime guarantee universal life sales, drove total new annualized premium down 2 percent in the third quarter. More info can be found at http://www.limra.com/Posts/PR/News_Releases/LIMRA__New_U_S__Retail_Life_Insurance_Premium_Fell_2_Percent_in_the_Third_Quarter_2017.aspx

BLOCKCHAIN WILL DISRUPT. READ UP ON IT NOW!

By now, you've undoubtedly heard of

blockchain. It's the ledger technology that makes digital currency like bitcoin possible. Ryan Neal at Investment News says blockchain will change the advisory business. His article calls on experts such as Ric Edelman, the founder and executive chairman of Edelman Financial Services. According to Edelman, blockchain is "...not a threat to the advisers being in business. It's a threat to the way advisers do business." Be sure to read Neal's entire article here: www.investment-news.com.



PUBLIC ACA SENTIMENT SPLIT

A November monthly tracking poll from the Kaiser Family Foundation found that half of those polled had a favorable view of the ACA, while 46 percent viewed it unfavorably. Partisan politics appears to drive the split in public opinion. A full 80 percent of Democrats said they supported ACA, while 81 percent of Republicans said they didn't. Kaiser Health News reporter Julie Rovner recently took a deeper look at the public's love/hate relationship with the health care legislation. She found that misinformation, confusion and the truth that the ACA doesn't benefit everyone all play a role in public sentiments over the controversial legislation. For Rovner's complete article, visit <https://khn.org/news/why-do-people-hate-obamacare-anyway/>

THE CARLYLE GROUP TO ACQUIRE BENEFITMALL

Global alternative asset manager The Carlyle Group announced that it has agreed to acquire employee benefits and payroll services provider BenefitMall. The transaction is subject to customary conditions and is expected to close by year-end. Financial terms were not disclosed. Dallas-based BenefitMall partners with a network of 20,000 brokers and CPAs to deliver employee benefits and payroll services to more than 200,000 small and medium-sized

businesses. For more info go to <https://www.benefitmall.com/>

KUDOS FOR MDRT

Association Media and Publishing recently honored the Million Dollar Round Table with six Excel awards for engaging content in digital media. MDRT received recognition for two educational videos, three episode podcast series and one blog post. The association also received a silver award for the MDRT podcast platform as a whole and bronze for the MDRT Blog. MDRT members can access the organization's content via the blog and MDRT Resource Zone, which houses multimedia resources that guide members on how to best advise clients, run their practice, achieve work-life balance and more. Nice work keeping your members informed, MDRT!



5 INSURANCE INDUSTRY TRENDS TO WATCH FROM SMART HARBOR

2018 is here. Ready for some predictions? Smart Harbor, a digital technology solutions provider for insurance, says watch these five trends this year:

1. All about the infrastructure-- Insureds' expectations for the always-on agency are real, and to serve clients anytime, anywhere, agencies need systems and processes that can efficiently handle business. Whether the agency is looking to grow, expand, or even exit, having a strong and flexible digital infrastructure is critical. This includes interactive websites with online chat and quoting capabilities, client portals and mobile apps, next generation agency management systems and integrated call centers for 24/7 services. Agents will be evaluating their infrastructures and expanding capabilities and services for clients.
2. Move from closed loop to open access-- In the insurance ecosystem, agents operate in many envi-

ronments, including regularly accessing multiple carrier websites, agency management systems, and customer relationship management systems. Many of these applications are closed, meaning they don't allow the free exchange of data, forcing agents to spend time on manual workarounds and double data entry. Agents will seek to partner with companies and implement tools that can bridge the gap between various systems, and choose applications that are built on open structures, meaning they "talk" to one another.

3. Pursuit of the paperless agency-- Though e-signature is nothing new—it has been around the industry for 20 years—a large number of agencies will finally implement e-signature and other e-document tools in 2018. To improve productivity and increase sustainability, more agencies will transition to an all-digital mentality when it comes to sending, receiving and signing documents. But they can't do it alone. Removing all paper from insurance transactions will require collaboration with carriers and be informed by regulators.
4. Synergistic partnerships increasing access to sales analytics-- The carrier/agent partnership is about to go beyond a provider/seller framework. Agents gather unique sales data such as target market behaviors, web preferences, and specific product interest that can help carriers improve sales and marketing efforts. Meanwhile, carriers have the technological infrastructure and expertise enabling them to provide education, training and best practice programs that can help agencies improve their digital capabilities. These two entities will foster deeper and stronger partnerships that will enable both the carrier and the agency to improve sales and grow their businesses.
5. Agents embrace artificial intelligence (AI)-- Machine learning, robotics, artificial intelligence – these tools may seem daunting and beyond the capabilities of agents who are just beginning to adapt digital solutions. But as they become

more commonplace, agents will appreciate the ease and benefit of using these technologies and even realize they might have been using some form of AI already. From automatic fill on certain forms to using machine learning to move key prospects to top of the workflow to installing chatbots on websites that can resolve claims and answer clients' simple questions, agencies will convert from trepidation to the implementation of AI that will drive key processes.

For more info, visit Safe Harbor online at <http://smartharbor.com/>

EVENTS

LAAHU ANNUAL CONFERENCE, LA CONVENTION CENTER, APRIL 11-12, 2018

LAAHU's annual conference promises to be information packed! To register, go to <https://events.r20.constantcontact.com/register/eventReg?oeidk=a07eewodf1fa7ba6db2&oseq=&c=&ch=>

Exhibit info is available at <http://files.constantcontact.com/84dc5768001/30825643-e858-475f-a480-e65d31379b8e.pdf?ver=1512598486000>

Sponsorship info is available at <http://files.constantcontact.com/84dc5768001/e0144eed-d033-4f10-8bac-2b1202f3fe88.pdf?ver=1512598535000>

IICF CASINO NIGHT -MAY 17, SAN FRANCISCO

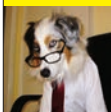
Join the Insurance Industry Charitable Foundation for a fun night of gambling and insurance industry networking while also raising money for community grants. The event takes place at The Rotunda, Union Square, San Francisco. Registration and sponsorship info available at <https://iicf.org/>

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