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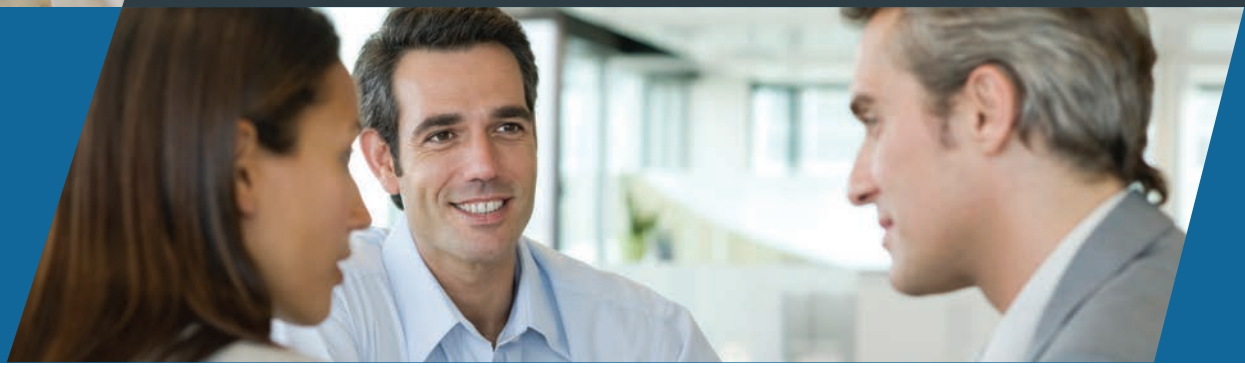

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FIVE HEALTH ISSUES PRESIDENTIAL CANDIDATES AREN'T TALKING ABOUT *(But Should Be)*

by Julie Rovner of KHN.org

References to the Affordable Care Act — sometimes called Obamacare — have been a regular feature of the current presidential campaign season. For months, Republican candidates have pledged to repeal it while Democrat Hillary Clinton wants to build on it and Democrat Bernie Sanders wants to replace it with a government-funded "Medicare for All" program. But much of the policy discussion stops there. Yet the nation in the next few years faces many important decisions about health care — most of which have little to do with the controversial federal health law. Here are five issues candidates should be discussing, but largely are not:

1. Out-of-pocket spending: Millions more people — roughly 20 million, at last count — now have health insurance, thanks to the new coverage options created by the ACA. But most people are also paying more of their own medical bills than ever before. And they are noticing. A recent Gallup survey found health costs to be the top financial problem faced by adults in the United States, outpacing low wages and housing costs. Employers, who still provide coverage to the majority of those with insurance, are also battling rising costs. They have been passing at least part of that along by raising workers' share of costs — including premiums, deductibles and the portions of medical bills they must pay — far faster than wages have been rising. Meanwhile, even in the most generous plans offered to those who buy their own coverage through the ACA's marketplaces, the portion of health care costs borne by consumers has left many unable to afford care.

As insurers have shortened their lists of "in network" doctors and hospitals, another out-of-pocket spending problem is becoming more common: The "surprise medical bill." Those are bills for services provided outside a patient's insurance network that the patient did not know was out-of-network when he or she sought care. Some of the candidates — notably Clinton and Sanders — have talked about the issue. But serious discussion about ways to ensure health care services remain broadly affordable have been overshadowed by the fight over the fate of the federal health law.

2. Drugs — more than prices: Rising drug prices at the pharmacy counter have also proved problematic for patients. And both Republican and Democratic candidates have discussed proposals to address the cost of prescription drugs. But there is more involved in this issue than the prices paid by patients. Drug makers point out their industry is a risky one, and the big rewards on breakthrough drugs offset the losses for those that never make it to the pharmacy. But at what point does the cost to society for a drug, like new treatments for hepatitis C that tally more than $80,000 for a course of treatment, become prohibitive?

Meanwhile, scientists are rapidly approaching the point of being able to develop specific drugs for specific individuals, a trend known as "personalized medicine" or "precision medicine." But even if everyone could be screened so that they would only get the expensive drugs that will help them specifically, how could those costs be spread over society as a whole? And how fast should promising drugs be brought to market? Some decry the lengthy testing required for Food and Drug Administration approval. They say people are dying who could potentially be helped. But others are equally concerned that putting a drug on the market too soon poses risks to the public.

3. Long-term care: Every day, another 10,000 baby boomers turn 65 and qualify for Medicare. An estimated 70 percent of people who reach that threshold will need some sort of long-term care. It's not cheap. The annual cost of these services can range from approximately $46,000 for a home health aide to $80,000 or more for a bed in a nursing home.

Yet Medicare, the health program for the elderly and some disabled, does not pay for most long-term care services. Medicare has both nursing home and home care benefits, but they are temporary and limited to those with specific medical needs. Most people who need long-term care don't need special medical interventions, just help with "activities of daily living." In contrast, Medicaid, the joint state-federal health program for people with low incomes, paid just over half of the nation's estimated $310 billion tab for long-term care in 2013, the most recent year for which this information is available. But you either

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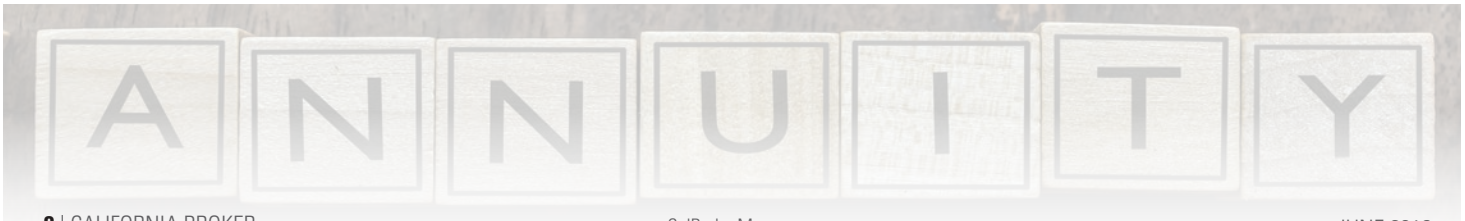
American Equity	A-		A-	ICC13 MYGA (Guarantee 5) (Q/NQ)	S	2.70%*	5 yr.	None	9%, 8, 7, 6, 5, 0	Yes	$10,000 (Q) & $10,000 (NQ)	3.00%, age 0-75 & 2.10%, age 76-80**
				ICC13 MYGA (Guarantee 6) (Q/NQ)	S	2.90%*	6 yr.	None	9%, 8, 7, 6, 5, 4, 0	Yes	$10,000 (Q) & $10,000 (NQ)	3.00%, age 0-75 & 2.10% age 76-80**
				ICC13 MYGA (Guarantee 7) (Q/NQ)	S	3.15*%	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**
				*Effective4/13/16. Current interest rates are subject to change on new issues. **Commission may vary by issue age and state. See Commission Schedule for details								
American General Life Insurance Companies	A	A+	A+	American Pathway Solutions MYG (*Guarantee Return of Premium) (Q/NQ)	S	2.05%*[a] 2.25%*[b]	5 yr.	None	8%, 8, 8, 7, 6, 5, 4, 3, 2, 1, 0	Yes	$10,000 (Q&NQ)	1.5% age 0-75 .75% age 76-85
				*CA Rates Effective4/05/16. First year rate includes 1.50% interest bonus. a (less than $100K ; b (100K or more)								
American General Life Insurance Companies	A	A+	A+	American Pathway Fixed 5 Annuity (*Guarantee Return of Premium) (Q/NQ)	S	1.20%*[a] 1.40%*[b]	5 yr.	None	9%, 8%, 7%, 6%, 5%, 0%	No	$5,000 (NQ) $2,000 (Q)	2.00% age 0-85 1.00% age 86-90
				*CA Rates Effective 3/14/16. Includes 2.00% 1st year bonus, 1.00% base rate subsequent years. a (less than $100K) b(100K or more)								
American General Life Insurance Companies	A	A+	A+	American Pathway Fixed 7 Annuity	S	1.85%*[a] 2.05%*[b]	5 yrs.	None	9%, 8%, 7%, 6%, 5%, 4%, 2%, 0%	No	$5,000 (NQ)	3.00% age 0-85 1.50% age 86-90
				*CA Rates Effective 3/14/16. First year rate includes 4.0% bonus 1st year. a (less than $100K) b(100K or more)								
Great American Life	A	A+	A+	SecureGain 5 (Q/NQ)	S	2.10%	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 2/15/16. Includes .25% first-year bonus and is for purchase payments over $100,000. Escalating five-year yield is 2.10%. For under $100,000 first-year rate is 1.95%. Escalating rate five-year yield 1.95%.												
Great American Life	A	A+	A+	SecureGain 7 (Q/NQ)	S	2.40%	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 2/15/16. Includes 1.00% first-year bonus and is for purchase payments over $100,000. Escalating seven-year yield is 2.29%. For under $100,000 first-year rate is 2.30%. Escalating rate seven-year yield 2.19%.												
Great American Life	A	A+	A+	Secure American (Q/NQ)	S	1.50%*	1 yr.	N/A	9%, 8, 7, 6, 5, 4, 3	No	$10,000	5.75% 0-70 4.65% 71-80 4.40% 81-89
*Effective 2/15/16. Eff. yield is 2.52% based on 1.50% 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 1.50%. Surrender value interest rate 1.50%. Accepts additional purchase payments in first three contract years. COM12255												
The Lincoln Insurance Company	A+	AA	AA	MYGuarantee Plus 5	S	1.00%*	5 yr.	None	7%, 7, 6, 5, 4, 0	Yes	$10,000 (Q/NQ)	
				**Rates Effective 5/1/16 for premium less than $100,000 and are subject to change								
The Lincoln Insurance Company	A+	AA	AA	MYGuarantee Plus 6	S	1.25%*	6 yr.	None	7%, 7, 6, 5, 4, 0	Yes	$10,000 (Q/NQ)	
				*Rates Effective 5/1/16 for premium less than $100,000, 1.40% for premiums greater than $100,000. . Both rates are subject to change								
The Lincoln Insurance Company	A+	AA	AA	MYGuarantee Plus 7	S	1.40%*	7 yr.	None	7%, 7, 6, 5, 4, 3, 2, 0	Yes	$10,000 (Q/NQ)	
				**Rates Effective 5/1/16 for premium less than $100,000 and are subject to change								
The Lincoln Insurance Company	A+	AA	AA	MYGuarantee Plus 8	S	1.40%*	8 yr.	None	7%, 7, 6, 5, 4, 0	Yes	$10,000 (Q/NQ)	
				*Rates Effective 5/1/16 for premium less than $100,000, 1.55% for premiums greater than $100,000. Both rates are subject to change								
North American Co. for Life and Health	A+	AA-	A+	Gaurantee Choice (Q/NQ)	S	2.60%*[a] 2.85*[b]	5 yr.	None	10, 10, 9, 9, 8	Yes	$2,000 (Q) $10,000 (NQ)	2.50% (0-80) 1.875% (81-85) 1.25 (86-90)
				*CA rates effective 5/10/16 – a (less than $200K) b(200K or more)								
Reliance Standard	A+		A	Eleos-MVA	S	3.25%*	1 yr.	None	8%, 7, 6, 5, 4	Yes	$10,000	3.25%**
				*Effective 2/13/16. Includes 1.50% 1st yr. bonus. Min. guarantee is 1.00%. **Reduced 20% ages 76-80, and 40% ages 81-85								
Reliance Standard	A+		A	Apollo MVA (Q/NQ)	S	4.20%*	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 2/13/16								
Symetra Life, Inc.	A	A	A	Custom 7 (Q/NQ)	S	2.65%*	7 yrs.	N/A	8%, 8, 7, 7, 6, 5, 4, 0	No	$10,000	Varies
				*Effective 4/29/16. 2.15% base rate with no guaranteed return of purchase payments. Plus 0.50% bonus for $250,000 and above.								



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FOR YOUR FAVORITE CLIENT: A New Life Insurance Option

by Jason Garza

Looking for a great deal is as American as baseball, John Wayne, and muscle cars. We like to win. We work hard. We are unflinchingly optimistic. Perhaps that is why we, as a country, find discussing the possibility of us leaving this great life unexpectedly and not on our own terms so difficult. Aristotle once quipped, "Human nature is drawn to the attractive impossibility rather than the less attractive probability." Perhaps this is why stocks and real estate or even sports betting among friends will always drown out any conversation over responsibility and security i.e. life insurance.

Financial advisors discount the benefits of whole life insurance in favor of term life policies for many obvious reasons. If you consider the source of the overwhelming majority of these sales, it is done through mostly agents who are new to the industry and are struggling to survive their first three years. The path of least resistance inevitably wins. Although life insurance sales have faltered over recent years by double digits, whole life remains the top-selling life insurance product when measured by premium volume. Yet, sales of IULs now stand as a close second in popularity–almost matching term sales. Many producers have focused on the sexier aspects of this kind of insurance, boasting about its equity-linked upside performance combined with its downside protection. And after all, anything that can distract from the "What happens if you ceased to exist tomorrow?" conversation is always noticeably welcomed by both sides of the table.

To say the least, many investments and household name companies have faltered and failed this past decade

"Whole life remains the top-selling life insurance product when measured by premium volume."

and once again whole life was there to provide families and businesses with the much needed source of funds. We need not go over all the benefits of whole life insurance because I am assuming that, if you are reading this, you know them already. Also, you probably will only continue reading this until your morning coffee runs out. So let's get to the point shall we?

Most of you brokers out there have made a decision to sell one or the other and have fine-tuned your process and pitch. After all, no matter how important and essential life insurance is, it still needs to be sold. Interestingly enough, you usually dedicate your time and efforts to one or the other. The facts and statistics support it. Advisors now have the option with a new type of life insurance out there. It recently accomplished the feat of combining the best of both worlds into an evolved hybrid of sorts. The general public is now, for the most part, informed and passingly familiar enough with the concept of indexed products to realize that it works. Consumers also love their dependable and guaranteed whole life. What if you could take the traditional whole life insurance policy and add the upside potential based on the performance of the S&P 500 Index? You can.

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Jason Garza is national brokerage manager for the Guardian Life Insurance Company of America for both life insurance and disability insurance. For more information, call 619-684-6261.

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LAAHU University Day Round Up

by Leila Morris

In April, 500 agents converged at the LA Convention Center for Los Angeles Health Underwriters (LAAHU) University Day. In opening remarks, Covered California's executive director, Peter Lee, explained why California's exchange is in much better shape than many other state exchanges. While other states could face large rate increases, California has attracted a large number of members with a low health risk. Lee said, "Other states stumbled on policies. We said that every market plan will be an ACA plan. That makes for a common risk pool. Our plans are listed as the lowest cost overall; we have a combined directory of our plans; we provide access to a formulary; and we have patient-centered design with many visits not subject to a deductible." Lee added, "We are committed to agents. You are the reason that we are ahead of the nation." During a panel discussion, Kurk Wheland, sales director of Covered California said, "We are not talking about whether we should have agents. We are talking about how we can work with you to sell more and how we can engage you more effectively."

Covered California recently approved its Qualified Health Plan model contract for 2017. As Michael Lujan noted in his California Health Underwriters (CAHU) president's blog, these agent-friendly requirements will apply to on-exchange and off-exchange business:

- Agents must be paid; zero is not an allowable commission rate.
- Carriers must pay agents for special enrollment. (Lee noted that commissions will be the same for special enrollment as they are for open enrollment).
- Carriers must recognize agent-of-record change requests.
- Carriers cannot pay different commissions based on plan-type or metal tier.
- Carriers must notify the agent-of-record of late payment at same time they notify the enrollee.

Lee said that, in 2017, all enrollees will have a primary care doctor, even those in PPOs. He said that Covered California will focus more on cracking down on fraudulent applications under special enrollment period requirements. David Fear Jr., broker sales consultant at Shepler & Fear General Agency said that things in Sacramento are easier this year. At least there are no bills to kill agents. He noted that CAHU opposes AB 2436. It requires plans to disclosure to a consumer the prescription drug's cost in Germany, Mexico, and Canada. Health plans don't have this information. A better way would be to ask drug manufacturers for this information since they produce the products, suggests CAHU.

LAAHU also featured a panel of health plan executives who discussed the individual market. The following is a Q&A moderated by Chuck Underhill of Underhill insurance.

WHAT CHANGES DO YOU EXPECT IN PRODUCT DESIGN IN THE NEAR TERM?

Renee Casserly of Blue Shield of California: We are close to being finished with 2017 products. During the next 24 months, we will continue to work with covered California. As we get our legs under us, we will get more creative on the off-exchange products – the alternative off-exchange products. We are getting creative with benefits when it comes to finding the right price positioning for those who are not eligible for subsidies on the exchange. We will also focus on robust development of ancillary products.

Steve Shearer, regional vice president, Individual and Small Group Sales, Anthem Blue Cross: It is standardized benefits nowadays, so it's

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very hard to do something unique like we used to do prior to the ACA. In the coming years, we will try to find ways in the off-off exchange market to position products that appeal to certain demographics. I don't think that you are going to see any drastic swings or surprises over the next 24 months.

Kurk Wheland, director of Sales for Covered California: People are talking about patient-centered design. That will guide our negotiation with plans going forward. It has affected the model contract with carriers. We are moving toward plans that keep consumers healthy and remove barriers to managing chronic diseases and getting needed drugs. Managing chronic diseases affects the overall cost of health care.

Holly Bui, general manager of California for Oscar Insurance: Carriers are focusing on how we can make preventive care more accessible and affordable in a world with high deductibles. If people have high deductibles, how do you create free or at least low copay primary care and preventive care to manage patient costs. We want to figure out a plan design that helps people with diabetes to manage their costs.

WHAT IS THE LATEST ON SKINNY PROVIDER NETWORKS?

Holly Bui of Oscar: Network sufficiency is not just about the number of providers. The consumer should be able to find the highest quality care in their address. We want to create a network that is based on quality and gives members the right information about cost and quality. As a member, you don't want to see a list of 100 or 500 completely indistinguishable physicians. You want to know who is the best doctor to treat your condition. If that person does not exist in our network, we try to find that person to add to our network.

Kurk Wheland of Covered California: In the first year, we saw a lot of narrow networks. Since then, we have seen the networks expand. We look forward to seeing more options for rates and networks with full network availability. We are also looking at narrow networks that offer an integrated model or a different payment methodology like reimbursement based on quality.

Steve Shearer of Anthem Blue Cross: Network is in the eye of the beholder. It either works for you or it doesn't and it doesn't in a lot of cases. We go through a statewide approval process throughout any geography we are in. We analyze whether we have enough carriers in a given area. The answer is yes, we do. If you look in a region like LA, we have all the big providers around here. When you get into the Northern California regions, the providers get a little more sparse. We do have a sufficient network across the state. I don't think that you will see any drastic changes in networks. We are looking to expand opportunities where we can with the right pricing structure. We look for opportunities on the HMO side that offer a little bit more of a regionalized interaction as well.

Renee Casserly of Blue Shield of California: The North is challenging. There will be some turbulence in the network. I would not define the network environment as stable even in Southern California. We are focusing on quality scores. A facility that is highly sought after sometimes has very low quality scores. We still have some paths to clear. But it is better than it was and I do think it will improve. It will take improvement from the providers and the carriers to get us there.

WHERE DO YOU SEE THE MARKET GOING FOR INDIVIDUAL AND FAMILY PLAN PRODUCTS?

Steve Shearer of Anthem Blue Cross: For 2017, reinsurance and risk corridors go away. Those were two factors that were benefiting the carriers. On our individual block, we have seen substantially higher utilization trends in some areas. I don't think that we will see anything drastic. Whenever or not we talk about a rate build up, a critical component is the providers and the facilities, which all renew at different times. Nobody has a crystal ball. We have to look at the dynamics of providers in the UC system, Sutter, Scripps and Sharp in San Deigo, and St. Joseph in Orange County.

Kurk Wheland of Covered California: In the first year, we had an average rate increase of 4.2%. But when you look at it regionally, it is up or down. In some areas, rate increases are much higher than that. We have been able to do an active purchase with the carriers, which is different than in a lot of states. We are expecting an increase of 2% to 4% over the next couple of years.

Renee Casserly of Blue Shield of California: With rates, we deal with the rising costs of healthcare. It will be an unstable environment due to fraud, healthcare cost increases, and guaranteed issue.

Holly Bui of Oscar Insurance: The fact that reinsurance is going away will put 2% to 3% on top of cost trends. That will be something new to expect for 2017. We need to change underlying provider costs.

HOW HARD IS IT TO BE INNOVATIVE IN A POST-ACA ENVIRONMENT?

Renee Casserly of Blue Shield of California: It is hard to be innovative in a cost environment. I am pleased with the stance of Covered California to look at quality of care. Until we get that focus there, it will be very difficult to be innovative.

Kurk Wheland of Covered California: We are having conversations with health plans on how to change healthcare from a fee-for-service system to a quality-based system. That is where the innovation needs to come. We will continue to see innovation. The exchange is creating competition. Standard benefit plans and patient-centered design are affecting rates on and off the exchange.

Holly Bui of Oscar Insurance: There has been a lot of innovation when it comes to looking at how you pay providers and how they provide care. When we talk to providers, the conversation has changed. It is now a conversation of partners across the table on how to lower the cost of care for members. We are thinking through how to bring technology to healthcare. For example, Oscar provides free and unlimited phone calls with doctors. It is a much easier and more cost effective way to provide access. We need to be thinking about ways that people can access care at a lower cost.

(Continued on Page 15)

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LAAHU University Day Round Up

BROKER OUTLOOK

We interviewed brokers at LAAHU to get their take on the selling through Covered California's shop exchange and branching out their sales of voluntary benefits.

PETER GILHEANY OF GILHEANY INSURANCE SERVICES:

- Voluntary Benefits: In light of the ACA, there is a need to have more voluntary benefit offerings, especially dental and vision. Critical illness has become more popular. If you have a bare-bones health policy, you want to add on something meaningful. Having ancillary benefits is very important for brokers.
- The Shop Exchange: I have not used the shop exchange, but I am considering it. I am well aware of how it works. I have used the Covered California individual plans. But I am not really sold on the Shop plans.
- Covered California: Selling the individual plans under Covered California has gotten a lot better in terms of customer service when you call the broker hotline. It was horrendous when it first rolled out.

DAWN MCFARLAND OF M&M BENEFIT SOLUTIONS INSURANCE SERVICES:

- Voluntary Benefits: I am a GA for worksite benefits. So I help brokers add those offerings. There needs to be other sources of revenue for the broker and choices for their clients. That's what is going to keep agents alive in the market. Over the past couple of years, I have noticed a big improvement in the open mindedness of brokers. Brokers are more interested and more excited about the opportunities to look at different products. In the past, they had several years to try to learn and decipher the ACA for their clients. Now they finally have a handle on that. The most successful brokers are caring individuals. Commissions matter, but their primary goal is to help people.
- Telemedicine: Telemedicine is becoming more and more popular. Telemedicine would decrease the amount of copays for office visits. Kaiser is coming out with technology that allows you to do things like heart rate and blood pressure tests at home. When it comes to your annual wellness physical, you need to go in. But telemedicine can help with the majority of the office appointments that take half an hour to 45 minutes.

STEVEN C STASOISKI SCS TAX AND INSURANCE SERVICES COMPANY:

- Life Insurance: I sell individual and family plans, small group, and Medicare. Brokers are looking for additional streams of revenue because health insurance commissions have been cut so much in the past three years. I am starting to explore life products. We would offer life insurance on an as-needed basis if a clients asked questions about life insurance. We engage in discussions and try to determine whether those products are a good fit for them. For me, it will take some time to get up to speed to sell life insurance because I have a rule that I do not sell a product that I am not comfortable selling to my mom. Life products are complicated and sophisticated. I am also a tax accountant so I can only hold so much information and be an expert at so many things. Being a tax accountant does help you sell life insurance, which is why I am exploring it. Also being a tax accountant helps with navigating the Affordable Care Act. Taxes and health insurance have become more interwoven.
- The Shop Exchange: I have no plans to sell through the Shop Exchange. I am less enthusiastic about Covered California than I was three years ago. There seems to be an inverse relationship with time and compensation. I spend four times the amount of time enrolling and processing an application, which generates one quarter of the compensation. It is a new system. It is not the most efficient system. There is a lot to learn and improve upon.

STEVEN GRISWOLD OF GRISWOLD & GRISWOLD:

- Voluntary Benefits: I am always looking for new products and services to offer. It is becoming very commoditized, so we have to keep abreast of products and services to make ourselves stand out. For the past two years, we have really been vamping up our voluntary sales. I try to get it in with every group we sell. From the standpoint of the employer's aggregate-loss control, accident coverage works very well. Hospital indemnity helps with rising deductibles.
- The Shop Exchange: I have a few groups with Shop. I just have a sour taste from dealing with covered California on the individual side. But Pinnacle is doing a pretty good job administering the group for the Shop. I will probably be writing more through that. ★

Leila Morris is senior editor of California Broker Magazine.

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The Winning Trifecta: PEOs, Brokers, and Their Clients

by Jay Starkman

Insurance agents used to see professional employer organizations (PEOs) as nothing more than competitors. But those days are behind us. Sure, many PEOs are constantly looking to pry away clients from brokers. But a growing number of PEOs are partnering with insurance brokers and paying commissions that are equal to, if not greater than the commissions for brokers in the open medical or workers' compensation insurance markets. A few PEOs are completely dedicated to partnering with insurance brokers, and are protecting the broker with non-trespassing and broker-friendly broker-of-record policies. This is a good thing because the PEO industry is becoming stronger and stronger, and for good reason.

PEOS ARE BOOMING

Driving the PEO industry is the demand for solutions in human resources and employee benefits amid an ever-changing legislative environment. The PEO industry is thriving as more businesses outsource the management of their human resources, compliance, benefits, payroll, safety, HR technology, and other essential areas. Nearly 1,000 PEOs are operating in the United States, providing services to more than 3 million worksite employees, according to a recent study by the National Assn. of Professional Employer Organizations. These numbers will continue to rise given the increasingly dynamic compliance landscape. Many small and mid-sized companies are unprepared or don't have the expertise, time, or resources to manage HR internally.

Change is the new normal when it comes to state and federal overtime pay and other wage and hour regulations. Employers must have a game plan to manage potential changes to their workforce. They also need to think more broadly about their human capital strategy and the costs and benefits involved in keeping labor costs affordable. A maze of new healthcare regulations for employers with 50 or more full-time employees is constantly in the news. The new list of administrative tasks is extensive, including mandatory annual reporting to the IRS and benefit notifications to employees.

Hot-button issues in the headlines include sweeping LGBT-related legislation, social media and privacy concerns, and evolving rules governing marijuana use. Businesses must remain vigilant to ensure ongoing legal compliance. This is especially true for multi-state employers since these laws often differ from state to state.

In July, the Small Business Efficiency Act (SBEA) goes into effect. Passage of the law has been a watershed event for the industry and a signal of more growth ahead. The SBEA authorizes changes to the Internal Revenue Code to establish Certified Professional Employer Organizations (CPEOs). This certification process will further legitimize the booming industry. CPEOs must meet certain background and experience requirements, and satisfy independent financial review requirements, among other things. The SBEA gives certified PEOs authority to collect and remit federal employment taxes, eliminates the wage base restart for PEO clients that join or leave a PEO relationship, and holds that certified PEO customers qualify for specified federal tax credits.

THE WIN-WIN-WIN PARTNERSHIP (BROKERS, PEOS AND CLIENTS)

A partnership between an insurance broker and the right PEO creates a win-win-win solution. With a PEO, the broker brings a solution that helps their clients. Business owners have access to additional resources to help with legal challenges, risk management, compliance, and more. The Affordable Care Act brings a plethora of burdens to employers. Clients that engage a PEO get solutions to many compliance challenges, from regulatory duties to time consuming employment and tax-related reporting.

The broker gains a strong defense against other PEOs (and even other insurance brokers) that target the broker's clients. Once in a PEO relationship, the broker's client retention and commissions can increase. While the PEO gives up revenue in commissions paid to the insurance agency and the PEOs sales force, what used to be a competition between agent and PEO can be a collaboration, with increased growth potential for both.

Not all PEOs are equal, even those that work with brokers. Beware of partnering with a PEO that has a sales force that sells directly against the broker. In addition, Employers Service Assurance Corp. (SAC) certification indicates the quality of the PEO and provides bonded protection for the client. SAC is an industry watchdog, similar to the FDIC for the banking industry. Finally, some PEOs feature unfavorable rules for dealing with brokers, including production and exclusivity requirements, as well as commissions that decline over time. When deciding whether to partner with a PEO, a broker should look at the PEOs entire distribution model, rules, and SAC accreditation. ★

Jay Starkman is CEO of Engage PEO. For more information, visit www.engagepeo.com.

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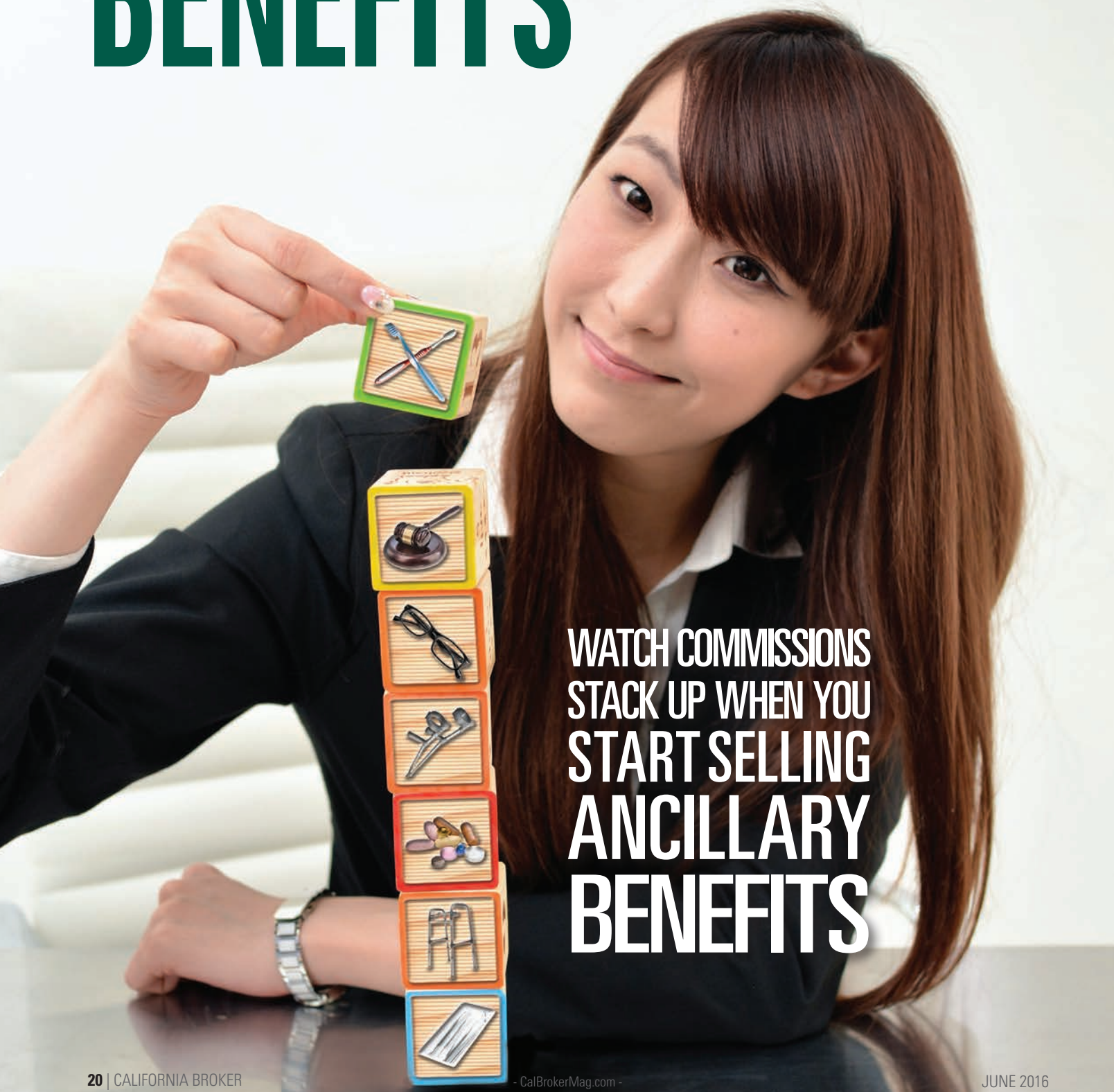
BLOCKBUSTER BENEFITS

Today's voluntary offerings are more diverse than ever. The articles in this issue will help you maximize voluntary offerings so your clients can attract and retain talent.



WATCH COMMISSIONS STACK UP WHEN YOU START SELLING ANCILLARY BENEFITS

BLOCKBUSTER BENEFITS

SMART ECONOMICS: Stretching the Pharmacy Dollar

by Bryan Statham

A tightly managed pharmacy benefit plan can save 20% to 30% over an unmanaged plan. With the pharmacy benefit representing about 20% to 25% percent of an employer's health plan cost, are you sure you're really stretching your pharmacy dollar? Drug spending is going up thanks to inflation and new drug therapies, including specialty pharmaceuticals. Total drug trend increased 6.4% in 2015. This was largely driven by a specialty spending increase of 17.8% in 2015 and about a 10% inflation rate in drug prices. Today, 38% of drug spending is for specialty medications, with the number expected to increase to 50% by 2018 and continue to grow thereafter. In the coming years, the specialty drug trend is expected to remain at 15% to 20% while brand drug price inflation is projected to be 10% to 12%.

The components of pharmacy benefits are ever-changing with the expanded use of specialty medications, heightened scrutiny of compounds, fewer blockbuster brand drugs losing patent protection, and poor economics in pharmacy contracts. Are you using smart pharmacy economics when navigating the complex pharmacy landscape?

It's not just about understanding the market in terms of numbers; it's also about understanding how to use those

numbers to help self-insured employers meet the objectives of their pharmacy program. It's imperative to have a plan that stretches the pharmacy dollar as employers face rising cost trends, drug cost inflation, and limited budgets.

The first step is having clear view of your client's prescription drug program. How do they stay ahead of the pharmacy trend curve? Are they confident that the pharmacy contract is competitive? The pharmacy contract holds the answers, but it is only as strong as it's foundation. Contract language can have a dramatic effect on pharmacy costs for employers. Here are some key questions to ask when evaluating a pharmacy arrangement:

- How long is the contract term? Does a multi-year contract have a market check provision that allows an employer to get price improvements throughout the term? Multi-year contracts are practical for many larger employers with extensive RFP processes. But one-year contracts help mid-market employers address factors like healthcare reform, the rapidly changing pharmacy marketplace, and stale pricing. A one-year contract allows for greater flexibility and assurance that pricing remains competitive.
- Can the pharmacy contract be audited? Once the pharmacy contract is in place, an audit is necessary to confirm the integrity of the arrangement and verify that the contract meets all of the agreed-upon financial terms and conditions.
- Does the pharmacy contract include rebate sharing? A good benefit design drives members to use generics first. When a brand drug is clinically necessary, driving members to a formulary brand drug will generate pharmaceutical rebates. A portion of these rebates may be shared with the employer to help reduce plan costs. Properly negotiated rebate sharing can save 8% to 11% of an employer's total gross pharmacy spending.
- Do specialty drugs have guaranteed discounts and rebate sharing? Specialty drugs are among the most expensive. While specialty medications represent just 1% of prescriptions, they represent one-third of 2015 drug spending. Specialty drug spending is projected to account for 50% of employer pharmacy costs by 2018. It is important for the contract to include guaranteed discounts and rebate sharing for specialty drugs to help contain costs.
- Does your contract include guaranteed purchase discounts on prescription drugs? If so, are guaranteed rates offered at the individual client level or at an aggregated client book-of-business level? When guarantees are offered at the client level, clients get full reconciliation against their own claims. When a client is in a book-of-business guarantee, the better performing programs offset under-performing programs, which reduces the effectiveness of the guarantees at the client level. When properly enforced, contract guarantees can offer significant and immediate savings for employers.
- Is there an annual reconciliation process to ensure that all financial terms and conditions are met? If so, what is the process to be made whole? An audit may identify retrospective problems. But it is also important to know whether the contract will be reconciled to all financial terms and conditions annually and whether any shortfalls are paid to the employer in a reasonable period of time.
- Is there flexibility to customize clinical programs, pharmacy networks, and other benefit design options? Having a full toolbox of cost-saving options, including clinical programs, pharmacy networks, benefit design options, etc., allows for a tailored plan that caters to the needs of each employer.

A strategy that maximizes outcomes, contains costs, and avoids common contract pitfalls helps employers manage their pharmacy arrangement and avoid unintended financial consequences. Smart economics involve securing more competitive pricing and implementing programs to better manage drug costs. To stretch the pharmacy dollar to the fullest, the pharmacy strategy should ensure that all aspects of pharmacy benefits align for optimal outcomes and the best financial performance, from the pricing terms, contract, and rebates, to clinical and drug utilization programs, and an appropriate benefit structure. Also to help contain costs, there should be continued oversight of the pharmacy programs along with management of performance guarantees and assistance with drug utilization programs. In this complex world, it has never been more important for employers to review their pharmacy program. It is imperative to give the pharmacy benefit the same due diligence as the medical plan. ★

"A strategy that maximizes outcomes, contains costs, and avoids common contract pitfalls helps employers manage their pharmacy arrangement and avoid unintended financial consequences."

"There should be continued oversight of the pharmacy programs…In this complex world, it has never been more important for employers to review their pharmacy program.

RxBenefits, based in Birmingham, Ala., is a privately held pharmacy benefits administration company, focused on consultants and their mid-market self-insured clients. Founded in 1995, lines of business include: pharmacy benefits administration, pharmacy consulting, pharmacy audits, and health services.

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BLOCKBUSTER BENEFITS

IT'S TIME TO CLARIFY WHAT YOU NEED TO KNOW

Retail In Vision Networks

by Al Tyler

It's no longer a question of whether a vision network should have retail options. Consumers have answered that question affirmatively. Retail has become an important player in many areas of health care. Because vision was ahead of the curve, we have insights into why retail matters as well as the misconceptions that have persisted. The following need-to-know points will help evaluate vision networks:

1. THE MOST APPEALING VISION NETWORKS OFFER RETAIL EXPERIENCES THAT APPEAL TO A WIDE SPECTRUM OF MEMBERS

Just like at the top mall in your neck of the woods, not every vision retail brand is designed for every consumer. It's about offering a range of experiences through diverse retail and independent providers. Some members want a Nordstrom or Macy's. In the vision world that equals LensCrafters. Some prefer a family-friendly option with style. That's the space that TargetOptical fills. Because there will always be employees who want a practical, price-over-style option like Sears Optical, a competitive vision network covers that base, too. Then there are members who like to buy local. If they still want the hours and inventory associated with retail, they want a neighborhood favorite like a Pearle Vision franchise or a smaller regional chain.

Then, there's the consumer who prefers to shop online. Vision is adapting to them with ContactsDirect now and Glasses.com.

2. THE BEST EYE DOCTORS PRACTICE AT INDEPENDENT AND RETAIL LOCATIONS

When vision retail first emerged in a big way, people worried that retail docs wouldn't offer the same clinical experience as a doctor of optometry (OD) in an independent practice. People used to ask that question about pharmacists, too. But today's consumers have moved past those misconceptions. Managed vision care's universal credentialing standards ensure that network providers meet the same educational and clinical standards regardless of where they practice. Vision retail actually offers many ODs the opportunity to operate their independent location next door to a popular dispensary to leverage retail's extended hours and extensive inventory. More eye doctors are joining a franchise operation to run their own show with the help of bulk buying and business acumen. It's not unusual for a doctor at LensCrafters to also practice in an area independent practice.

3. RETAILERS CAN OFTEN AFFORD THE LATEST TECHNOLOGY SOONER

Once retail met vision, innovation in diagnostic and lens-fitting technologies flourished. Inventors need a market that's able to invest in new ideas and make them mainstream consumer expectations. Retailers who invest in new technology can scale the costs and help educate consumers about what's next through marketing. Once an idea gains wide acceptance and starts shaping expectations, the economics often start to work across smaller operations, too. On-site labs, digital exams, AccuFit technologies, and even digital lens selection tools are available to millions more Americans because vision retailers can pioneer these innovations.

4. THE MORE CHOICES AVAILABLE, THE MORE UTILIZATION PATTERNS START SHIFTING

You've probably noticed a few things with utilization if you've ever moved a sizable group to a vision plan that had ample independent and retail choices. There's disruption – the good kind. Because there are more options, more people enroll; more people use their benefits; and more stay in-network.

There's a lot of people who see a long-time independent doctor for exams who shop for eye wear at a retailer. The key thing to remember is this:

If you can't offer employers a network that mirrors their employees' preferences, don't be surprised if they decide to keep shopping. ★

Al Tyler is a regional vice president at EyeMed Vision Care. He is based in Los Angeles.

BLOCKBUSTER BENEFITS

HELPING EMPLOYEES ACHIEVE Better Medical and Dental Outcomes

by Dr. Cary Sun

Good oral health is part of wellness, yet many employees don't take full advantage of preventive dental care benefits. Many adults who don't get regular checkups even though they have dental benefits are concerned about the cost, afraid of the dentist, or simply assume that an absence of pain means an absence of problems, according to a recent study by Cigna. Most dental benefit plans cover preventive care visits every six months with no or low out-of-pocket costs. It's important to help clients understand how education and tools can help employees overcome obstacles to care. The longer the wait is between dental visits, the more likely an oral health problem is to develop. Small problems may become more complicated and more expensive to treat, leading to the very situation employees and employers want to avoid.

WHAT'S AT STAKE?

Oral health can decline quickly with age for people who miss regular checkups. Sixty-three percent of people 26 to 34 who visit the dentist no more than once a year say their oral health is very good or excellent. This falls to 55% for people 35 to 44 who see the dentist no more than once a year and drops to 33% for those 45 to 54.

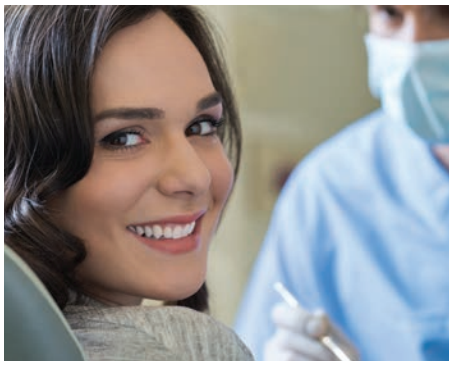
Also, consider how good oral health can affect certain medical conditions. For example, preventive dental checkups may be even more essential during pregnancy. Hormonal changes during pregnancy can worsen certain oral health conditions, such as gingivitis and gum disease. All infections in the mother, including tooth decay and gum disease, may pose a risk to the baby's health as well. However, 43% of pregnant women don't go for a dental checkup even though 76% say they suffer from oral health problems during pregnancy, such as bleeding gums or toothaches. Why don't pregnant women with dental benefits see the dentist? Cost is a primary reason cited among those surveyed.

This misconception and fear about out-of-pocket costs for preventive dental checkups is too pervasive to be ignored. Encouraging clients to communicate with employees about the low cost and importance of preventive services may lead to more employees managing their oral health. With more than half a million babies born annually in California alone, better oral health education may have significant results even if only considering the expectant mother demographic.

Now add to this demographic other employees with medical conditions like diabetes, heart disease, and stroke. In 2013, Cigna published a national study analyzing its own medical and dental claims, among other factors. The study found an association between untreated periodontal disease and higher medical costs among people with those three conditions. For example, the average annual medical savings for those who had one of these medical conditions, but got appropriate periodontal care was as follows:

- Diabetes: $1,292
- Heart disease: $2,183
- Stroke: $2,831

Average medical savings per-person, per-year were $1,020 for people with periodontal disease who got appropriate care, regardless of whether they had an underlying medical condition.



EDUCATION AND COMMUNICATION

Some employees who avoid dental checkups are afraid of the cost or afraid of the dentist because they don't know what to expect. Employers can help eliminate cost surprises by providing access to oral health cost transparency tools that are personalized to an employee's coinsurance and deductible.

More information about each network dentist, including other patients' reviews and photos, can put employees at ease. Many consumers read movie reviews before buying a theater ticket or read restaurant reviews before making a reservation. So reading dentist reviews before making an appointment can be reassuring to an employee and encourage appropriate dental care. Giving employees more information, upfront, about each dentist's professional history, affordability (based on the employee's plan), and patient experience can help eliminate surprises before, during, and after a dental visit.

Recommend that your clients communicate about oral health more often than during open enrollment season. Oral health becomes more relevant

to employees depending on personal events throughout the year. For example, expecting mothers have a strong interest in good oral health even if they don't see the dentist during pregnancy. This is evidenced by their interest in participating in maternity oral health programs offered through their dental benefits. The Cigna Healthy Smiles for Mom and Baby study found that the majority of expecting mothers are very interested in participating in an oral health maternity program. Seventy-four percent of women who don't have these programs available to them – or perhaps aren't aware of the offering – would like them. The study reveals a correlation between participating in these programs and improved dental hygiene among pregnant and new mothers:

- 62% brush their teeth at least twice a day versus 76% of women who are participating or who have participated in a dental benefit maternity program.
- 48% floss at least once a day versus 81% of women who are participating or who have participated in a dental benefit maternity program.
- 55% rate their oral health as very good or excellent during pregnancy versus 74% of women who are participating or have participated in a dental benefit maternity program.

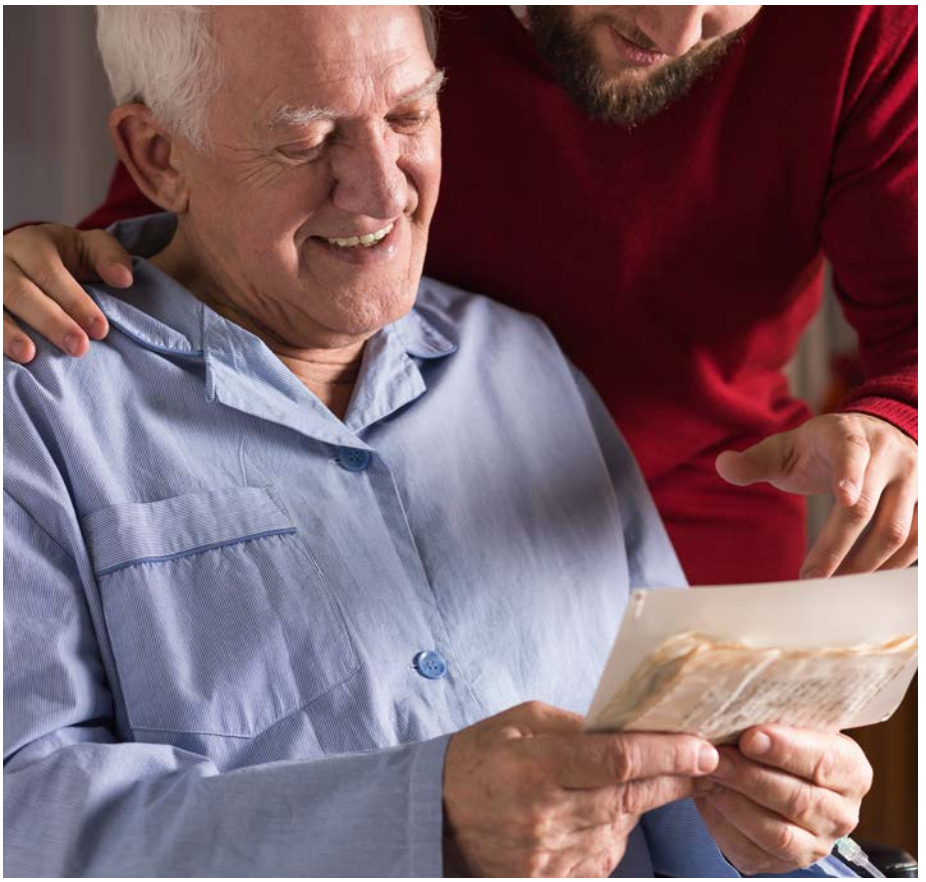
If efforts to promote improved oral health in just one employee population can have such notable results, consider what the return-on-investment could be on promoting oral health among all employees. Employers can encourage employees to make more proactive health and wellness decisions by providing integrated medical and dental programs, targeted oral health education programs, as well as cost and quality comparison shopping tools. ★

Dr. Cary Sun is Cigna's Western regional dental director. He oversees the clinical operations and quality management activities of the region. Dr. Sun obtained his D.D.S. degree from the UCLA School of Dentistry. All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, and Cigna Dental Health, Inc. and its subsidiaries, including Cigna Dental Health of California, Inc.

BLOCKBUSTER BENEFITS

BREATHE NEW LIFE INTO YOUR BUSINESS WITH Critical Illness Insurance

by Roxanne Anderson



Critical illness insurance is nothing new. It's been around since 1983. But only recently has there been a major uptick in interest in this type of coverage. Forty-five percent of employers with 500 or more employees offered group cancer or critical illness insurance in 2015 — up from 34% in 2009. This number could climb as high as 73% in 2018, according to a 2016 Willis Towers Watson survey. More and more companies are realizing that offering critical illness insurance is extremely beneficial. And that's not just true for businesses. Brokers can make big bucks this month, next month, and in the months ahead by having this product in their portfolio. What happened to create these favorable marketing conditions? Let's take a look.

THE DOMINO EFFECT

Over the past several years, critical ill-

ness insurance has soared in popularity as employers have shifted health care costs onto employees. In 2015, the average deductible for all covered workers was $1,077, up 67% from $646 in 2010 and 255% from $303 in 2006, according to a report by the Kaiser Family Foundation. The number of workers with deductibles of $1,000 or more nearly doubled from 2010 to 2015, increasing from 27% to 46%.

As one would expect, employees have not happily embraced higher out-of-pocket expenses. So, many employers are enhancing voluntary health benefits to offset risks for employees and increase satisfaction and retention. By doing so, companies can offer employees a wide selection of products to fill in their coverage gaps. What's more, they can often do so at no additional cost, making a product like critical illness insurance very attractive to all parties.

UNPARALLELED CONSUMER INTEREST

As weird as it may seem, advances in medicine and technology have also helped make critical illness coverage more attractive. From 2003 to 2012, the cancer death rate dropped 1.8% a year for men and 1.4% a year for women, according to a 2015 study by the National Cancer Institute. In addition, the relative rate of stroke deaths declined 33.7% from 2003 to 2013, according to a 2016 study by the American Heart Assn.

These statistics are stellar from one perspective, but not so great from another. Out-of-pocket costs for a critical illness can be as high as $14,444, and lost income can be as much as $50,600, according to a 2014 MetLife study. In other words, battling a critical illness could be just the tip of the iceberg. Someone who is lucky enough to survive a critical illness may suffer major financial damage due to high medical bills and restricted income. Medical bills are at fault for about 57% of personal bankruptcies, according to a 2013 NerdWallet study.

To stave off debt, some older adults dip into, or sometimes deplete, their retirement savings and end up paying extra due to resulting taxes, fees, and reduced health insurance subsidies. Other adults don't even have enough, or near enough, of a nest egg saved to cover all the costs. Forty-one percent of those surveyed in the MetLife study said they were living paycheck to paycheck.

Consumers, especially younger adults, are starting to realize that the only way they can combat the cruel costs associated with a critical illness is through the precautionary purchase of critical illness protection. Unlike health savings accounts, long-term care insurance, and disability insurance, critical illness insurance provides beneficiaries with a lump-sum payment they can use for any expense.

NEW AND IMPROVED PRODUCTS

In 2010, the ACA absolved critical illness insurance of the underwriting and benefit mandates that apply to major medical coverage. Combine that tidbit with the fact that numerous businesses and consumers are growing interested in critical illness insurance, and it's no wonder why more and more insurers have started offering new and/or improved critical illness products.

Originally, this type of insurance only paid out for one occurrence of a listed condition. Moreover, a beneficiary's policy was terminated upon this payout. Now, insurers offer polices that cover a wider variety of conditions and allow beneficiaries to receive multiple payouts if they suffer from a re-occurrence or another condition entirely.

As a result, the critical illness industry is seeing impressive growth. From 1999 to 2014, critical illness policy premium revenue swelled from $8 million to $381 million, according to a report by Gen Re. There was a 15% increase from 2013 to 2014 alone. Insurers have experienced a wealth of success by adapting their offerings to prevail in the ever-evolving health insurance market. Now, it's your turn to add this golden product to your portfolio and claim your share of the profit pot.

HOPPING ON THE BANDWAGON

Though critical illness insurance has been around for three decades, it's still a relatively new and mysterious form of coverage to many people. However, due to legislative changes, societal advancements, and industry-related improvements, critical illness insurance is one thing businesses and consumers want and need.

In the Willis Towers Watson survey, 92% of American employers said that they expect voluntary benefits and services to be vital to their employee value proposition throughout the next three to five years. Furthermore, approximately three-quarters of those surveyed in the MetLife study who didn't own or hadn't heard of a critical illness policy found the idea appealing.

"Though critical illness insurance has been around for three decades, it's still a relatively new and mysterious form of coverage to many people."

What does all this mean for brokers like you? It's your time to shine selling critical illness products. As an insurance professional, you have the knowledge and credibility to educate business leaders and consumers and make the sale. Build bridges with businesses by offering to be their personal consultant. This will open up many new avenues for you to expand your business.

When someone is fighting a critical illness, the last thing they should have to worry about is whether they have enough money to fund the battle. Be the one to stand up and offer this profitable form of protection and get ready to reap the rewards. ★

Roxanne Anderson is a digital copywriter at Ritter Insurance Marketing. She has a B.A. in English from Elizabethtown College. Ritter is a national Field Marketing Organization that solves the distribution needs of more than 75 insurance companies in the senior life and health insurance markets. An industry leader in technology, Ritter has developed proprietary services, including a customized CRM system and Medicare quoting system, to help their agents serve their clients faster, better, and smarter. For more information, visit RitterIM.com.

BLOCKBUSTER BENEFITS

THE OPIOID ABUSE EPIDEMIC: How Chiropractic Benefits Can Mitigate An Employer's Risk

by Joel Stevans, DC

Our nation's opioid epidemic is a complex problem that requires comprehensive solutions. When chiropractic care is the treatment of choice for musculoskeletal conditions, patients fill significantly fewer prescriptions for muscle relaxers and other pain medications – most notably opioid medications, according to studies in large commercially insured populations and Fortune 500 companies. "Chiropractic physicians are well positioned to play a vital role in the conservative management of acute and chronic pain. They offer complementary and integrative strategies, and guidance on self-care that can provide needed relief for many who suffer from pain," said past president of the American Chiropractic Assn., Anthony Hamm, DC. In fact, more than 33 million adults get chiropractic care every year.

Research shows that opioids are no more effective than Tylenol, Advil, or generic ibuprofen for common types of pain in the workplace, such as soft-tissue injuries and musculoskeletal problems. Opioids, which are usually in pill form, were originally intended to manage severe pain from surgery or trauma and to control chronic pain. Examples of opioid medications include Vicodin, Percodan, Lortab, Darvon, Dilaudid, and OxyContin.

However, with increasing frequency, opioids are being prescribed as the first medications for common conditions, such as headaches and low back, neck, knee, and shoulder pain. There has been a 10-fold increase in the use of opioid analgesics during the past 20 years, according to the Centers for Disease Control and Prevention (CDC). The growing prevalence of opioid use is of great concern because this class of medication carries a very high risk of abuse and addiction. According to the CDC, 2.1 million people in the United States have substance use disorders related to prescription opioid pain relievers. More than half of chronic abusers start innocently, receiving their pills from doctors' prescriptions (27.3%) or

friends and family (26%). The severity of the prescription drug abuse problem can be blamed on several factors including drastic increases in the number of prescriptions, greater social acceptability of using medications, and aggressive marketing by pharmaceutical companies. These factors have created the broad availability of prescription medications, particularly opioid analgesics. All told, opioid pain relievers are in the most commonly abused class of prescription drugs.

OPIOID ABUSE IS A SIGNIFICANT PROBLEM IN THE WORKPLACE

About 80% of companies have been negatively affected by prescription drug use or abuse in the workforce, according to a study the National Safety Council (NSC). The study finds the following:

- 23% of U.S. workers have used prescription drugs on a recreational basis.
- Even employees who are compliantly using prescribed doses of opioids may be too impaired to work, especially in safety-sensitive positions.
- When patients have more than a one-week supply of opioids, early in the course of treatment, the risk of disability doubles one year later.
- Average direct and indirect health care costs are four times greater for workers who are prescribed even one opioid compared to similar workers who are not prescribed opioids.
- Direct healthcare costs are eight times higher for patients who abuse opioids compared to non-abusers due to multiple visits to emergency rooms, doctor's offices, and clinics as well as doctor-shopping, prescription costs, and the use of rehabilitation facilities.

There are risks of dependence and addiction even when opioids are taken as prescribed. But, the risks are greatly magnified when opioid prescriptions are not in accordance with evidence-based recommendations. Unfortunately, this happens more often than expected. A recent NCS survey of 201 family medicine or internal physicians reveals the following:

- 99% of doctors prescribe highly addictive opioids for longer than the three days recommended by the CDC.
- 74% of doctors believe, incorrectly, that the most effective way to treat pain is to prescribe morphine and oxycodone, which are both opioids.
- 99% of doctors have seen a pill-seeking patient or have seen evidence of opioid abuse, but only 32% have referred the patient to drug treatment.
- 67% of doctors base their prescribing decisions partly on patient expectations.
- Only 32% of doctors screen for a family history of addiction, which is a strong indicator of potential abuse.

These and other findings have prompted the Food and Drug Admin. to conclude there should be compulsory training for physicians on the risks of prescription opioids, and that this training must be initiated. Beginning in fall 2016, more than 60 medical schools will require students to get educated on CDC guidelines for prescribing opioids for chronic pain. At the beginning of the year, President Obama proposed $1.1 billion in new funding to address the prescription opioid abuse epidemic. These are just a few of examples among many national and state efforts to reduce the risk of abuse, misuse, addiction, overdose, and death due to prescription opioids.

"…Employers can mitigate their risks by having clearly written drug policies that cover prescription opioid medications. They should also offer employee education, supervisor training, employee-assistance programs, and drug testing for opioids. There is emerging evidence that offering chiropractic care to employees can augment these strategies."

WHAT ROLE CAN CHIROPRACTIC PLAY?

Chiropractic is a health care profession that focuses on the relationship between the body's structure and its functioning. Chiropractors are not licensed to prescribe medications. They use a variety of non-drug treatments including hands-on manipulations of the spine or other parts of the body to alleviate pain, improve function, and support the body's natural ability to heal itself.

Scientific evidence indicates that chiropractic treatments are helpful for conditions that are common among working adults. These include, but are not limited to, back pain, migraine, neck-related headaches, neck pain, upper- and lower-extremity joint conditions, and whiplash disorders, according the National Center for Complementary and Integrative Health. The Joint Commission revised its pain management standard to include chiropractic services. The Joint Commission certifies more than 20,000 health care organizations and programs in the United States including every major hospital. Clinical experts in pain management, who provide input to the commission's standards, affirmed that treatment strategies may consider both pharmacologic and non-pharmacologic approaches to pain. Evidence from population based studies supports this strategy. The Foundation for Chiropractic Progress issued a statement expressing the value of evidence-based, drug-free chiropractic care as a safe and effective alternative for pain management.

Experts agree that employers can mitigate their risks by having clearly written drug policies that cover prescription opioid medications. They should also offer employee education, supervisor training, employee-assistance programs, and drug testing for opioids. There is emerging evidence that offering chiropractic care to employees can augment these strategies. ★

Joel Stevans, DC is the chief clinical and quality officer at Landmark Healthplan of California of California. Landmark has been providing access to chiropractic and acupuncture since 1985. Its mission is to make high quality, fully credentialed chiropractors and acupuncturists available to Californians at affordable rates. Landmark offers a wide range of fully insured chiropractic, acupuncture and combined chiropractic and acupuncture benefit plans to California employer groups. For more information, call 800-638-4557 or visit http://www.lhp-ca.com.

Mastering the Medicare Market

by Leila Morris

We interviewed Yolanda Webb, CHRS, CAHU Medicare Chair, NAHU Medicare Advisory Council, Inland Empire Association of Health Underwriters.

WHAT ARE THE TRENDS ABOUT AGENTS GETTING INTO THE MEDICARE MARKET? HAS IT BEEN PICKING UP IN THE PAST FEW MONTHS?

In the past couple of years, especially in the past year, Medicare agents have had become more knowledgeable about Social Security, HSA, and how little HR people know about Medicare. For example, should the employee enroll in Part B, and if they don't, what will happen. Yes, it is picking up; so many agents are having too add Medicare products because of the loss of IFPs.

FOR BROKERS WHO START SELLING MEDICARE, DOES IT USUALLY BECOME A SMALL PART OF THEIR BUSINESS OR A SIGNIFICANT PART?

Because Medicare is so complicated and there is so much continuing certification every year, it probably does start out small. As time goes on and more education and sales are made, your business grows. Remember that more people are turning 65 everyday than any other age market. For sure, there is no shortage of clients, but the real test is that the Medicare agent stays compliant, stays informed, and knows their products.

HOW DO MEDICARE COMMISSIONS COMPARE TO COMMISSIONS WITH OTHER HEALTH PLANS?

You will always have higher commissions from group plans, no doubt. However, with your Medicare business, you will never have more loyal clients than as you do in the senior market; they will stay with you and will always refer friends and family. In my experience, because it is so personal to them, they remain forever grateful.

WHAT IS THE BEST WAY TO GET LEADS FOR MEDICARE CLIENTS?

Client referral is always best. However, agents seek clients through senior centers, hospitals, and doctor offices. They set up meetings through mailers. These methods require the agent to report the event to the carrier/CMS.

WHICH MEDICARE PRODUCTS ARE MOST POPULAR?

Depending on your location, Part C Advantage plans seem to be very popular because of the cost and how the plan bundles health and Rx. But that's not always the case. Some parts of California don't offer many carrier choices of Part C. Therefore, you see a lot of Medicare supplement plans or Medi-gap plans being sold. For lack of a better word, they are PPO plans with no Rx included.

HOW DO YOU DETERMINE WHICH PRODUCTS TO SELL TO WHICH CUSTOMER?

As I stated before, you have to know the product because everyone has different needs. Every agent must be certified to sell a particular carrier product, so the more certifications you have, the more you can sell. When you ask questions of the clients, you will get a clear picture of their needs. Always go over with the client their medications and whether their doctor is in the network. Determine whether your client is a special-needs client. If so, their plan should address those special needs, such as diabetes and heart problems, just to name a couple.

WHAT ARE THE BEST RESOURCES TO COMPARE MEDICARE PLANS?

Visiting Medicare.gov is probably the best way for a client to look at the facts of each carrier's benefits. Secondly, agents can present several options to fit a client's needs.

ASIDE FROM ALL OF THE REGULATORY REQUIREMENTS THAT COME WITH SELLING MEDICARE, ARE THERE ANY OTHER ISSUES THAT MAKE SELLING MEDICARE DIFFERENT?

The biggest difference is that the client trusts that you will show them a plan that is right for them, not your pocket book. Moreover, since you will probably keep the client for life, let us make sure we do right by them.

WHAT ARE YOU DOING FOR THE NEW AND EXPERIENCED MEDICARE AGENT?

Maggie Stedt and myself from the Health Underwriters, have put together a Medicare Summit, to better educate the agent and introduce them to an association that will always have their best interest at heart. This year will be our sixth year doing these summits. We have grown from a small venue that hosted about 80 to 100 agents to about 500 agents we are expecting this year. The Medicare Summit is held throughout the state of California and across the country. Maggie and I have a vision that all Medicare agents be part of the National Association of Health Underwriters. By building our association, we can make a difference in the lives of our agents and our clients. We are working very hard to prove to the Medicare agent/broker that, by being a member, they will bring more value to their clients. Our next Summit is August 8 and 9. If any agents would like more information on the Summit or the Association, please don't hesitate to contact Maggie Stedt or Yolanda Webb at the Orange County Association of Health Underwriters or Inland Empire. I would like to thank California Broker for their continued support of our vision. ★

Leila Morris is senior editor of California Broker Magazine.

MASSMUTUAL INTRODUCES MOBILE APP FOR BENECLICK! BENEFITS EXCHANGE

MassMutual's new BeneClick! Mobile App supports BeneClick!, the first benefit exchange that combines insurance protection, healthcare coverage, and retirement savings plans on a single platform. For more information, visit massmutual.com.

INDIVIDUAL DENTAL & VISION

Starmount Life Insurance is offering fully insured individual dental and vision plans. Multiple plan designs are available with different annual maximum options and a national dental network with more than 270,000 access points. An optional fully insured vision rider may be elected providing coverage for eye exams and eyewear and a national vision network including independent providers and retail chains. The Starmount plans are available for individuals age 19+ with no maximum issue age. Plans are underwritten and administered by Starmount Life Insurance Company. Benefits and availability may vary by state. For more information, contact Kellie Bernell at Kellie.Bernell@NGIC.com or 805-341-7843.

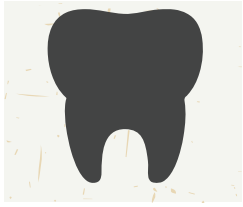
RETIREMENT PLANS WITH NEW FLEXIBILITY

The Guardian added 21 investment options to its lineup of retirement products. The additional options increase the breadth of asset classes for plan sponsors. The additions include the American Funds Target Date Retirement Series, and offerings from other fund families including American Century and T. Rowe Price. Natural resources, utilities, and sector funds from Dreyfus and Franklin Templeton have also been added. Each fund's investment allocation gradually transitions from a growth-oriented approach to a more income-oriented focus as the fund approaches and passes its target retirement date. For more information, visit MyRetirementWalk.com.

VOLUNTARY PERMANENT LIFE

The Guardian is offering portable voluntary permanent life insurance. The coverage builds tax-deferred cash value, has premiums that are guaranteed never to increase, and does not require a medical exam. It can be fully paid up by age 65, so the employee has no additional premiums upon retirement. For more information visit guardiananytime.com.

DENTAL PROVIDER COST COMPARISONS



Delta's dental care cost estimator tool allows consumers to compare dental costs among dentists who are part of the Delta Dental network (Four out of every five dentists are part of the network). For more information, visit deltadental.com.

INDIVIDUAL MEDICAL BRIDGE PLAN

Colonial Life is offering Individual Medical Bridge, a hospital confinement indemnity insurance plan. It helps workers pay expenses not covered by major medical, including deductibles, co-payments, coinsurance, and other out-of-pocket medical and non-medical costs. The plan provides benefits for hospitalization, outpatient surgery, diagnostic tests, doctor's office visits, emergency room visits, ambulance transportation, and other expenses due to a covered accident or covered sickness. For more information, visit coloniallife.com.

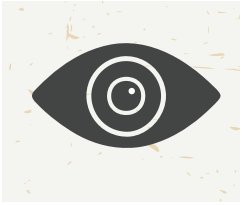
STREAMLINED ENROLLMENT

The Guardian and Maxwell Health launched the Guardian BenefitsCenter. The multi-carrier Guardian BenefitsCenter will streamline the administration of benefits, human resources, and payroll functions for brokers and human resource administrators who serve small-to-mid-size employers. The platform makes it easy to quote, procure, and enroll employers and employees across all types of benefits, from medical insurance to Guardian's suite of benefits which include dental, vision, life, disability, accident, cancer, critical illness and hospital indemnity. Employees can access all of their benefits through a mobile app. Employees get a healthcare concierge (healthadvocate.com), telemedicine (teladoc.com), and identity-theft prevention. Guardian BenefitsCenter is being introduced through select Guardian brokers starting in the second quarter of 2016 with a full launch scheduled for 2017. For more information, visit GuardianLife.com.

FINANCIAL GOAL CALCULATOR IN SPANISH

MassMutual launched a mobile-friendly Spanish-language financial goal calculator on MassMutual.com/Latino. It was developed to address the top four financial concerns of consumers surveyed in MassMutual's State of the Hispanic American Family study: income, savings, retirement, and debt. For more information, visit massmutual.com/latino.

HR GUIDANCE ON-DEMAND



Mercer introduced Mercer PeoplePro, which offers expert HR and benefit advice through online chat or telephone. It is offered for an hourly rate or at a project level. The consultants on PeoplePro have retired from full time work or have chosen a non-traditional work schedule. They can address rewards and compensation, engagement and communication, health and wellness, pensions and savings, HR technology and effectiveness, and business growth. For more information, visit MercerPeoplePro.com. ★

ARE SOCIAL MEDIA AND INTERNET MARKETING Failing to Deliver?

by Corey Weiner

Here is what to do when social media and Internet marketing are not netting new customers for your insurance agency: Do the opposite of what your industry peers are doing; simplify marketing and lead-generation programs; and modify the inputs necessary to recognize more short-term new business activity and revenue.

SOCIAL MEDIA

Want-ads for cheap social media and digital marketers are popular on freelance web sites like Fiverr as well as on LinkedIn and CareerBulder. Use logic for a moment. Is a worker who gets $20 to cut and paste web content qualified to promote your firm on the Internet? And don't say, "Well, it's better than nothing." That's an awful attitude to have about getting customers and revenue. Social media marketing is hardly easy or cheap, as the editor of Target Marketing magazine and other credible people (with no sales agenda) have pointed out. Many agencies hire a marketing consultant to handle social media postings.

"Is a worker who gets $20 to cut and paste web content qualified to promote your firm on the Internet?" And don't say, "Well, it's better than nothing."

So here is what you do when social media is not producing sales leads: Hire an influential person or organization in the same or related industry to cross-promote ads, offers, and news.

It's simple and practical. Anyone can do web content marketing and search engine optimization (SEO).

AUTOMATED E-MAILS AND CONTACT MANAGEMENT SOFTWARE

Auto-responders and e-mail marketing software make it fast and easy to send news updates and announcements. The more established providers, such as Constant Contact and GoDaddy, advertise free introductory offers on television. Sending mass e-mails is the easy part. It involves communicating with existing customers and contacts. So here is what you can do instead of being the 20th financial agency of the week to send auto e-mails to existing customers and clients. Focus on the part of Internet marketing that services cannot sell a subscription for. The more rare thing is to identify and communicate with someone else's customers.

"...when social media and Internet marketing are not netting new customers and revenue, simplifying the demand generation programming is the low-tech maneuver that a quality manager would put to work."

Agencies use promotional e-mail marketing to get new clients and assets and recruit producers. Direct e-mail marketing involves having a third-party marketing service create ads, banners, text messages and send them, to perfect strangers in bulk. But response rates and clicks are minimal. What is worse is that marketers would not be in business very long if their e-mail lists and bulk e-mails were exclusive. So advisor A pays for 50,000 e-mails. Then B calls and orders 50,000. Then C and D follow suit. E-mail lists are finite, meaning, the same 50,000 people got e-mails four times that day from A, B, C, and D. Also, marketers tend to re-use graphic templates and formats.

Here is what you can do when bulk e-mail promotions to cold lists don't create new business:

- Test headlines relentlessly for maximum opens and clicks.
- Identify someone with a contacts list, and pay that person and organization to deliver promotional e-mails legitimately via their social media, via e-mails in a customer relationship management system, or wherever.
- Make sure that the working agreement is exclusive to avoid repeating the situation in the above example.

PAY-PER-CLICK ADVERTISING ON SEARCH ENGINES

Much of insurance search-engine marketing is like commercial fishing in the ocean. Insurance products make up a big universe. AIG, Nationwide, and MetLife spend huge money preparing large crews to go out for months, dropping nets for miles. They kill everything that moves for a month because a lot of fish get caught in those nets. So here is what you can do if you don't have the budget, the manpower, or the patience of a MetLife, Marsh, or Wells Fargo:

- Abandon PPC ads on search engines and just about everywhere. Chances are that only one in 1,000 Internet users will see your ad and click on it.
- Narrow the universe of consumers for a particular type of insurance and asset allocation, for example.
- Contact publishers, organizations, or any party who influences a group and run specific ads to specific people who already have and buy those lines of insurance.

BRAND MESSAGING

Most of those who are responsible for lead generation never actually sold the financial products they market. Here is what you can do instead of spending endless time on fruitless brand messaging meetings and brainstorming sessions: Adopt Japanese quality management. Spare the organization from paying everyone's salaries for adding ideas to the pile. Take the time to evaluate markets and client profiles to offer them what they want and wish they had. If there are disagreements about which product and combination of products customers want and wish they had, asking clients is a viable strategy. Control the questions and answer options so everyone hears the same questions the same way and chooses from the same handful of simple answers.

WHAT NEXT?

It goes against what a lot of sales trainers encourage, but someone who is savvy in insurance and risk and investments knows that not all products are equal or interchangeable. A would-be client who clicks on an ad or sits in an appointment is supposed to have something to gain that's better than what they have. If not, what's the point in trying to sell them on switching policies and investments and rolling over their qualified plan?

Media pundits claim that social media is the be all, end all. But readers know that it isn't true – just like readers knew that the media was wrong about encouraging consumers to buy their dream houses with no-interest adjustable-rate home loans a decade ago. Think of cheap, easy Internet marketing as sort of like that. For example, a zillion people are online clicking their little mice. Somebody has to want to switch insurance policies, mutual funds, or want to know that special risk underwriting exists for a given situation. Consider the immortal words of Gordon Gekko in the 1987 movie, Wall Street, "I don't throw darts at a board, kid. I bet on sure things." So when social media and Internet marketing are not netting new customers and revenue, simplifying the demand generation programming is the low-tech maneuver that a quality manager would put to work. It involves playing at a different level. ★

Corey Weiner has worked on lead and demand generation for Merck & Company, GlaxoSmithKline, Wyeth-Aerst, Novartis, New York Life Advanced Markets, Sun Life of Canada, John Hancock USA and Manulife, Prudential and AXA Equitable. And four plus years as a consumer behavior researcher for the renowned Nielsen Company qualifies Corey to troubleshoot sales and lead generation programming for advertisers favoring short-term new business activity and revenues over brand awareness. For more information, call 888-913-1419 or visit linkedin.com/in/weinercorey.

WHY EMPLOYERS SHOULD OFFER CLIENTS Long Term Care Insurance Benefits

by Joel Ray

Planning for long-term care (LTC) is not easy, considering that it requires equal mental and financial preparation. Long-term care insurance (LTCi) is increasingly being treated as a crucial factor by a large number of people. Employers that offer this benefit become more attractive to potential employees.

ARE EMPLOYERS OFFERING LTC COVERAGE TO EMPLOYEES?

With an increase in awareness and need for long-term care planning, an increasing number of employers are offering LTC coverage. Not only does this make the organization more attractive to employees, but it also helps in drastically reducing attrition. In less than a decade (from 1990 to 1999), the number of companies offering this benefit has gone up from 58 to a staggering 2,000.

Eventually, this may even become a permanent value benefit offered to employees. The federal program is raising awareness among a very large number of people about the need for long-term care insurance. The announcement of the federal long-term care insurance program has increased the spectrum of people eligible for LTCi to about 20 million!

BENEFITS OF LONG TERM CARE INSURANCE FOR EMPLOYEES

The benefits of offering long-term care insurance to employees are several, and the most important ones include the following:

- **It's the Crux of Retirement Planning:** It would not be an exaggeration to say that long-term care insurance forms the crux of retirement planning. This is primarily because it prevents the retirement kitty from being eroded toward the cost of long-term care services. Health insurance covers only illness, but long-term care can become a chronic need for everyday tasks, considering the fragility that comes with old age and the increase in average lifespans. Thus, if an employer is offering long-term care benefits, it has an immense psychological and financial impact on employees planning for retirement.
- **The Tax Relief is Immense:** On the face of it, it may seem like long-term care insurance is adding an extra cost to the company, but the federal tax code extends tax benefits by way of allowing it to be deducted as an expense by companies. As an add-on benefit, employees are also allowed tax relief for the premium paid toward a long-term care insurance plan.
- **It Helps with Unburdening the Caregiver:** Primary care giving takes a huge toll on the personal and professional lives of employees. These pressures naturally have an adverse impact on the employers too, in terms of productivity loss (due to regular absenteeism and bifurcated attention of an employee who is also a caregiver back home) as well as financial loss (cost of replacing manpower in case the employee quits). In such situations, a long-term care insurance benefit offered by an employer goes a long way in freeing up the psychological, physical and financial burden on the employee. This offers the dual benefits of improving productivity on one hand, and increasing employee retention on the other. It also contributes greatly to employee satisfaction with the organization.

"The need for long-term care can hit sooner or later, with no warning, and must be planned for well in advance..."

A long-term care insurance plan helps to buffer the financial and physical strain."

SETTING UP LTC PROGRAMS AT THE WORKPLACE: WHY AND HOW?

The immense benefits in terms of productivity and employee satisfaction make it almost mandatory to have a long-term care program for employees. The cost benefit extends both ways in terms of the reasonable premium employees would need to pay as well as the tax easing for both employer and employee.

However, implementing and setting up such a program requires some groundwork in terms of building employee awareness about the benefits of such a program, and explaining how it can go a long way in easing the life of many in such an eventuality as long-term care. It's also important to have a variety of customised plans and not just a one-size-fits-all policy.

The need for long-term care can hit sooner or later, with no warning, and must be planned for well in advance. A long-term care insurance plan helps to buffer the financial and physical strain. ★

Joel Ray is an experienced financial advisor. His areas of specialization include retirement planning and risk management. For more information, visit www.LifeCentra.com.

Five Things You Should Know About Personal Accident Coverage

by Brian Vestergaard

It's no secret that there's been a dramatic shift in voluntary benefits in recent years. Voluntary benefits are no longer considered extras for a benefit package; they are now a mainstay. Industry experts expect even more employees to follow the trend of building customized benefit packages. Accident coverage should be on the short list of must-haves for brokers who want to build a strong product portfolio and earn extra money. As a top-five voluntary product, accident sales grew 9% in 2014, accounting for 12% of all voluntary sales, according to Eastbridge Consulting Group. Thanks to its versatility, accident coverage is valuable for each generation in today's diverse workforce. Here are a few things you need to know about adding accident coverage to your portfolio:

1. HOW IT WORKS

Accidents often come with a hefty price tag. Each year, one in eight Americans seeks medical care due to non-fatal accidental injuries, according to the National Safety Council. While medical plans typically cover a large portion of the medical costs, accident coverage protects families from unexpected out-of-pocket costs. The more flexible the product is, the better. Many accident plans reimburse policyholders directly for various medical costs like emergency room visits and X-rays, regardless of other medical coverage. And since life doesn't stop because of an accident, benefits can be used to cover things like deductibles and co-pays – even child care, lost wages, mortgage or rent payments, housekeeping, and much more.

2. IT'S GREAT FOR FAMILIES

As any parent knows, kids can end up with bumps and bruises whether they're on the sports field or just playing in the back yard. Sports and leisure activities account for 60% of injuries among children under 12, and almost 70% among children 12 to 17, according to the National Safety Council. Accident protection can cover entire families to provide more complete health coverage, help families handle unexpected expenses, and give parents peace of mind.

3. IT'S ALSO IMPORTANT FOR INDIVIDUALS

While accident insurance is great for families, don't forget that it's also valuable for individuals, especially those who are active. Let's say a single man with a high deductible medical plan (of at least $1,300) breaks his leg while riding his bike. It would be a very costly accident. Until he meets his medical deductible, he would pay out-of-pocket for his emergency room visit, X-rays, tests, physician charges, prescription painkillers, and other services. Accident benefits would cover many of these and other unexpected costs, saving him money and stress.

4. IT'S IN DEMAND AT THE WORK SITE

Just as benefit customization is gaining popularity, more employers want to offer a variety of benefit choices. Thirty percent of brokers say that accident insurance is in high demand among employers, according to a recent survey by Employee Benefits Advisor. The main driver for businesses is employee retention and recruitment. A strong workplace benefit package can boost morale and productivity by protecting the employees' well-being and eliminating financial stresses. Naturally, accident insurance and other voluntary benefits can help a client's bottom line since they are offered at little to no cost to the employer. It's simple and affordable financial protection.

"Accident coverage should be on the short list of must-haves for brokers who want to build a strong product portfolio and earn extra money."

5. IT FITS TODAY'S DEMOGRAPHICALLY DIVERSE WORKFORCE

As people look to more customized and flexible benefit plans, accident coverage helps each generation achieve health and financial goals. Millennials see the value in protecting their income and active lifestyles. The same can be said for Generation Xers, who may be looking to protect a growing family and make sure that unexpected costs don't get in the way of a mortgage, car payments, or other life expenses. According to LIMRA, six in 10 Gen Xers and Millennials say that income losses from an unexpected injury would have a significant financial impact on their household. Accident insurance still holds value for Baby Boomers when mobility issues become more common. It helps ensure that an accidental injury doesn't be-

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- ✔ Featured Speaker: Simon Reilly
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- ✔ Break out sessions

Ticket pricing:
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SVAHU
Silicon Valley Association of Health Underwriters

come too costly and take a toll on their lifestyle or retirement plans.

By now, you may be asking, "What about the value for brokers?" Strengthening your portfolio with accident insurance and other voluntary products can boost your earnings and grow your business even if you're tapping into the employer market for the first time.

"With so many resources available to purchase accident coverage, if you don't start talking to your clients about it, chances are that someone else will. "

Here's the takeaway: offering personal accident coverage can be a good retention strategy for mining your existing business. Consider asking to review your clients' medical plans and show where accident coverage will step up when medical plans fall short for families and active individuals. With so many resources available to purchase accident coverage, if you don't start talking to your clients about it, chances are that someone else will.

If you're ready to take advantage of this valuable opportunity, you'll need to be knowledgeable on the topic in order to properly consult your clients. I urge you to take a closer look and learn more about accident insurance. Look for client-friendly features like flexibility, affordability, and simple and efficient administration from enrollment to claims. Also look for things like communication resources to help engage your clients as well as online tools and support that make it easy for you to manage your book of business. Finding the right fit will allow you to create a strong customizable voluntary benefit package for you and your clients. ★

Brian Vestergaard (bvestergaard@yourlifesecure.com) is vice president of Sales and Marketing for LifeSecure Insurance Company, based in Brighton, Mich. LifeSecure offers long-term care and other supplemental health insurance products. LifeSecure is licensed in 46 states and the District of Columbia. Additional information is available at www.YourLifeSecure.com.

FIVE HEALTH ISSUES

(Continued from Page 6)

have to be very poor, or spend nearly all of your savings, in order to qualify. Private insurance for long-term care exists, but it is expensive, and remains uncommon — paying for just 8% of the 2013 bill. And private insurance for long-term care has been getting more difficult to purchase as insurers pull back from the products because of rising costs as people, especially women, live longer.

4. Medicare: Speaking of seniors, Medicare, which provides health insurance to an estimated 55 million people — 46 million older than age 65 and another 9 million with disabilities, is also in a financial bind. Medicare accounts for 14% of all federal spending, and that is expected to grow rapidly as those boomers reach their highest health-spending years. The program already accounts for one of every five dollars spent on health care in the U.S. Interestingly, Medicare spending has slowed dramatically in recent years. That has prompted a lively debate among health policy experts: How much is the slowdown due to the deep recession that caused spending to fall in all sectors of the economy, and how much to other factors that could continue even with stronger economic growth?

The Obama administration contends that changing the way Medicare pays health care providers, as begun in the ACA, has helped put the program on more sustainable footing. Many Republicans, however, led by House Speaker Paul Ryan, R-Wis., want to effectively privatize Medicare — which would transfer the risk for cost increases from the government to private insurers. But even smaller changes can kick up big political push back from those who rely on Medicare for their livelihoods. A recent Obama administration proposal to change the way the program pays for expensive drugs administered in doctors' offices or clinics has brought cries of complaint from both Democrats and Republicans.

5. Dental care: In 2007, a Maryland 12-year-old named Deamonte Driver died from a tooth infection that spread to his brain. That cast a harsh spotlight on the difficulty low-income Americans — even those with insurance through the Medicaid program — have getting dental care. Yet research has shown, repeatedly, that care for the mouth and teeth is inextricably linked to the rest of the body. Oral problems have been linked to conditions as diverse as heart disease, diabetes, and Alzheimer's disease.

Lack of dental care is particularly significant for children. Dental problems are common in youngsters, and in addition to discomfort, lead to school absences and poorer academic performance. Findings like that are one reason the federal health law made pediatric dental care an "essential benefit" for most insurance plans. But for complicated reasons, including the fact that dental insurance has traditionally been sold separately from other health coverage, many children insured under the law are not getting dental coverage. Coverage for adults remains spotty as well. According to the Centers for Disease Control and Prevention, one in every three adults has untreated tooth decay. More than 100 million Americans do not have dental insurance, the government reports. And more than a third (38 percent) of adults aged 18-64 reported no dental visits in 2014. ★

Julie Rovner, the Robin Toner Distinguished Fellow, joined KHN after 16 years as health policy correspondent for NPR, where she helped lead the network's coverage of the passage and implementation of the Affordable Care Act. A noted expert on health policy issues, Rovner is the author of a critically-praised reference book Health Care Politics and Policy A-Z, now in its third edition. In 2005, she was awarded the National Press Foundation's Everett McKinley Dirksen Award for distinguished reporting of Congress for her coverage of the passage of the Medicare prescription drug law and its aftermath. Prior to NPR, Rovner covered health policy for National Journal's CongressDaily and for Congressional Quarterly, among others. She has a degree in political science from the Univ. of Michigan. For more information, visit khn.org or e-mail jrovner@kff.org.


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Disability Income Insurance Landmines

by Larry Schneider

Field underwriting for disability insurance applications has never been easy in terms of getting that hard-earned application through the home office's processing cycle. Especially today, it is a much more difficult process to get a disability policy issued compared to other products.

Many agents are abandoning their quest to get higher compensation from this untapped market. They are selling the same old products, due to their lack of knowledge, which causes too many declines because of unexpected exclusions and or ratings.

First off, what is a landmine? A landmine is a health or other issue/condition/situation that, when submitted to an underwriter, will certainly cause any of the aforementioned results to occur. It might also occur if not recorded on the application and the attending-physician statement is the issue. Any of the above can explode in the agent's face in that the results will be unexpectedly unfavorable and the applicant will not be a happy camper. Why is the applicant going to be unhappy? At the very least, they went to a lot of trouble completing the application, taking an exam, providing financials, and going through an interview, all possibly in vain. The agent will probably be blamed for not knowing to not submit the application or not providing the landmine information that led to the outcome. The agent may lose the applicant as a client and not get any referrals.

What could the agent have done differently? Let's look at what it takes to get an application through the underwriting maze. The underwriter looks at the applicant's tax returns, evaluates occupation/duties, references the MIB, the MVB, and acquires medical records. All of these affect the decision of whether to issue as applied for, issue with an exclusion and/or a rating, or decline. Now let's look at what can be a landmine:

- Health issues (physical or mental)
- New business (less than a year)
- Occupation
- Working/traveling abroad
- Age
- Working from within the home
- Income
- Fraudulent statements

In order to avoid embarrassment for yourself and inconvenience for your client, it's important to recognize that going through normal channels for these dilemmas can be a waste of time for all concerned and may have some negative consequences. Why submit a questionable application to someone other than a brokerage that specializes in cases that are hard to place? At the very least, get your client a benefit period of at least five years or longer without an exclusion, etc. What about simply waiting to see if the client's medical condition goes away? Your client would have no coverage whatsoever, and waiting is not a guarantee that the condition will disappear. Even if it does, premiums will increase due to age. ★

Larry Schneider is a disability insurance specialist who has exclusively specialized in DI for over 40 years. He has published over 50 articles, is a claims consultant/expert witness, is a national resource for hard-to-place and standard applications (business and individual), and has written a two volume Disability insurance Encyclopedia. For more information, www.di-resource-center.com, email info@di-resource-center.com, or call 800-551-6211 or 703-615- 4747

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TRANSPARENCY: The Quest To Lower Health Care Costs

by Jane Cooper

The topic of rising health care costs has been around since the mid-1980s when managed care emerged as a strategy to attack increasing health care costs. HMOs paid doctors a fixed amount per-patient, per-month. Consumers had a primary care physician (PCP), and had to stay within their network. Our costs would be much lower today if the capitation of the HMO days survived. In 1997, I ran a regional health plan in New Orleans called "Advantage Health." The total medical costs per-member, per-month were $86.50. Compare that to today's figure of $520, according to the Milliman annual medical index. That's a 600% increase in 20 years for clinical services that did not improve 600%.

Only two factors truly affect health care costs: utilization (how many services are used/ordered by the physician) and cost per unit of services (what the patient, the employer or the insurance carrier pay for each service). In 2015 46% of workers had a deductible of more than $1,000 under their employer-sponsored plan, according to a survey by the Kaiser Family Foundation. That means that the average American has significant out-of-pocket costs for themselves and their families before their insurance plan pays the first dollar. We all know that people use more health care as they get older, take more prescription drugs, and generally drive up the health care cost curve. Focusing on the cost-per-unit of service puts things in perspective. Everyone who uses their insurance benefits has the power to affect these costs. Everyone of us can make a difference in what we pay for health care.

ENTER TRANSPARENCY

There are significant differences in the cost of services from one provider to another in the same market (Milwaukee, New Orleans, or San Diego). Consumers should compare costs among several providers for any elective procedure. Let's look at the cost differences for cataract surgery in Yorba Linda, Calif. For cataract surgery in the same network, there is a $2,838 difference between the highest and lowest cost option. The same physician practices in both facilities. If cost savings are so available, why aren't consumers beating down the doors to get this pricing information from doctors and hospitals? Who wouldn't want to save thousands on a procedure? While quality is very important to surgical procedures, it does not play a role in imaging, sleep studies, and other commodities.

There are several reasons why transparency is not used more often; and there are several ways for brokers and employers to break the barriers. Consumers aren't aware of cost differences. People don't pay attention to their health insurance benefits until they have to use them. Then there is a mad scramble to understand their benefits and navigate a complex system. Most people assume that they will be OK as long as they stay in network. They may be completely unaware of the missed opportunity to save money even after they get the explanation-of-benefits and large bill from the provider. Brokers: let your clients know about these significant cost savings.

Even in our online world, most patients believe that their doctor knows what is best for them. They just do what their doctor tells them to do or go where their doctor tells them to go. So, if your doctor says to schedule your MRI at the hospital where the doctor also happens to be employed, you may be hesitant say you want to research another option. Be aware that there are cost differences and plan to discuss options with your physician before they tell you which hospital to use.

Some consumers know that there are significant price variations, and they are courageous enough to take on their doctor. But it takes time to research and compare costs. Consumers sometimes end up at the highest cost provider because they have simply run out of time. But when that bill arrives, remorse sets in, and next time they find time to do the research.

Repairing health care in the United States is a complicated problem. State and national legislation fixes some things, but repeatedly increases costs. Consumers often face large bills that could have been avoided. Directing business to low cost/high quality providers is not the ultimate solution to correcting health care woes, but it is one effective strategy. After all, continuing to send market share to high cost providers will increase costs for everyone. We can all make a difference by taking a little time to shop around and make rationale choices. ★

Jane Cooper is founder, president & CEO of Patient Care, a national advocacy and transparency company. With more than 1 million members across the country, in 2015 Patient Care saved its clients and members more than $5.4 million in health care costs. Visit patientcare4u.com for more information.

Healthcare

THE DRIVERS OF HEALTH INSURANCE PREMIUM CHANGES FOR 2017

The American Academy of Actuaries offers an early look at what's driving changes in premium in the Affordable Care Act (ACA) individual and small group markets. Academy Senior Health Fellow Cori Uccello said, "Increased health care costs and the end of the ACA's transitional reinsurance program are two of the biggest factors pressuring rates higher. The one-year moratorium of the health insurance provider fee will partially offset these

increases." The issue brief identifies the following factors that will affect 2017 premiums:

- The underlying growth of health care costs: Although increases in health care spending are still relatively low, prescription drug spending is expected to increase faster than other medical spending.
- The sun-setting of the ACA's transitional reinsurance program: Each year, the gradual reduction in the reinsurance program has increased premiums. The final impact will occur in 2017 when projected claims are expected to increase 4% to 7% due to the program ending in 2016.
- The composition of the risk pool and any changes in the assumptions used in premium calculations: Insurers will revise their assumptions for underlying 2017 premiums if enrollment levels, risk profiles, or claims are different than expected when they developed 2016 premiums.
- The one-year moratorium of the ACA health insurance provider fee: This will lower premiums by 1% to 3%.
- The repeal of the ACA's original expansion of the small group definition, and modifications to provider networks: Premium changes for individuals will reflect increases in age, and changes in geographic location, family status, or benefit design. If a consumer's plan was discontinued, the premium change will reflect the increase or decrease resulting from being moved into a different plan. Average premium change information (released by insurers or states) could reflect consumers moving to different plans when their plan was discontinued.

Read the issue brief at actuary.org.

ER DOCTORS SAY THAT "AFFORDABLE" PREMIUM POLICIES MISLEAD PATIENTS

Ninety percent of emergency physicians say that health insurance companies mislead patients by offering affordable premiums for policies that actually cover very little, according to a survey by the American College of Emergency Physicians (ACEP). Ninety-six percent say that emergency patients don't understand what their policies cover for emergency care. Eighty percent of ER doctors say they are seeing patients with health insurance who have missed or delayed medical care because of high insurance costs – a more than a 10% increase over six months ago.

Jay Kaplan, MD, FACEP, president of the American College of Emergency Physicians (ACEP) says, "Each day, emergency physicians are seeing patients who have significant co-pays for emergency care of up to $400 or more. It might as well be $4,000 for some people…Insurance companies must provide fair coverage…and be transparent about how they calculate payments. They need to pay reasonable charges, rather than setting arbitrary rates that don't even cover the costs of care. Insurance companies are exploiting federal law to reduce coverage for emergency care knowing emergency departments have a federal mandate to care for all patients, regardless of their ability to pay. When plan reimbursements don't cover the cost of providing services, physicians must choose between billing patients for the difference or going unpaid for their services. The vast majority of emergency physicians and their groups prefer to be in network."

Dr. Kaplan says that health insurance companies are creating narrow networks of medical providers to increase profits, making it more likely for patients to go out-of-network. The survey of ER doctors also reveals the following:

- 62% of ER doctors say that most health insurance companies provide inadequate coverage for emergency care visits.
- More than 80% of ER doctors who are aware of reimbursement issues agree that insurance companies have reduced emergency care reimbursements.
- 60% of ER doctors say that, in the past year, they have had difficulty finding in-network specialists to care for patients with a quarter of them saying it happens daily.
- 91% of ER doctors say that a new rule by the Centers for Medicare and Medicaid Services (CMS) would make it harder to find specialists and follow-up care for patients. The CMS rule exempts health insurance companies from meeting minimum standards to ensure adequate networks.
- 79% of ER doctors who are familiar with the Fair Health database say it's the best mechanism to ensure transparency and make sure that insurance companies don't miscalculate payments.
- 87% say that insurance companies should pay the in-network rate when an emergency patient does not have access to an in-network facility or physician.

Kaplan said, "Health insurance companies have a long history of not paying for emergency care and…discouraging their customers from seeking it. For example, United Healthcare was sued successfully by the State of New York for fraudulently calculating and significantly underpaying doctors for out-of-network medical services. They used the Ingenix database, which forced patients to overpay up to 30% for out-of-network doctors. The company,

which, at the time, was led by the acting head of CMS, Andy Slavitt — paid the largest settlement to the state of New York and the American Medical Association. Part of that settlement created the Fair Health database." For more information, visit ACEP.org.

WHEN MIDSIZE EMPLOYERS OFFER HDHPs, 34% OF EMPLOYEES ELECT THEM

Thirty-four percent of employees who work for midsize employers would choose a high deductible health plan (HDHP) if given the choice, according to a report by Benefitfocus. Millennials over 26 are the most likely to opt in at 40%. Thirteen percent of employers offer at least one HDHP. Regardless of whether the plan is a PPO or HDHP, employees face higher out-of-pocket costs. With rising copays and coinsurance, the average family could spend nearly 40% more on health care than on food in 2016. To close the gap, many employers are funding health savings accounts (HSAs) and flexible spending accounts (FSAs). Yet adoption is low at large and midsize companies. On average, eligible employees contribute less than half the maximum amount allowed. Shawn Jenkins, Benefitfocus CEO, said that employers will drive more choice and innovation in benefits and in the plan selection process in order to attract and retain talent. He added that, as the market shifts toward consumer-driven health plans, employers must make it a top priority to offer decision support, education, and financial wellness resources. For more information, visit benefitfocus.com.

COSTS, NOT UTILIZATION ARE DRIVING CHILDREN'S HEALTH-CARE SPENDING

In 2014, rising prices were largely to blame for the growth in children's health care spending, according to a report from the Health Care Cost Institute (HCCI). Health care spending for children under employer-sponsored plans grew 5.1% a year from 2010 to 2014, reaching $2,660 in 2014. But the use of health care services declined from 2012 to 2014. HCCI senior researcher Amanda Frost said, "The decline in children's use of health care services is a relatively new trend… While we know that prices have fueled much of the spending growth in 2014, future research should examine whether these higher expenditures are leading to better health care outcomes for children."

For more information, visit healthcostinstitute.org.

In California

INSURANCE COMMISSIONER'S STATEMENT ON CENTENE'S ACQUISITION OF HEALTH NET

California Insurance Commissioner Dave Jones issued a statement on Centene's acquisition of Health Net. The following is a summary of his comments:

This transaction provides an opportunity to bring new capital and resources from a major national health insurer largely outside of California (Centene) to enable a California health insurer (Health Net) to continue to compete and offer consumers additional choices in California's individual, small group, and large group commercial health insurance market. The conditions for my approval of this merger include the following:

MERGER COSTS WILL NOT BE IMPOSED ON CALIFORNIA POLICYHOLDERS.

Health Net will maintain and grow its commercial line of business. There are growth commitments and investment requirements to ensure that Centene continues to invest substantially in Health Net Life and that both companies seek to expand Health Net Life's present competitiveness in California's individual, small group and large group health insurance markets.

Health Net Life will continue to offer products through Covered California.

Centene and Health Net must provide sufficient networks of medical providers and timely access to medical providers and hospitals.

Centene and Health Net must improve the quality of care delivered through their health insurance.

Health insurance rates will be developed using the same methodologies used before the merger, but with an agreement that rate increases will be kept to a minimum.

An adequate distribution channel for Health Net health insurance must be maintained.

Senior management for Health Net's California operations must remain in California and restrictions are placed on Centene's ability to re-domesticate or move Health Net out of state.

Centene will invest further in California by making a $200 million infrastructure investment by establishing a California call center, bringing new jobs to California.

Centene and Health Net will invest an additional $30 million in California's low and moderate income

Health Net has had declining market share and covered lives in its commercial health insurance business. The merger with Centene gives Health Net access to the capital and resources to compete in a California market that's dominated by three much larger health insurers (Kaiser, Anthem Blue Cross of California, and Blue Shield of California) and several other national health insurers (United Health Care, Aetna, Cigna).

PETERSEN HIRES REGIONAL VP

Petersen International Underwriters hired Todd Shield as a regional vice president of the firm. Shield previously worked at Assurity Life Insurance Company as manager of Disability Income Products. He is a nationally recognized personality of the disability insurance industry, and was elected the 2016 President of the International Disability Insurance Society. For more Information, call 800-345-8816 or email piu@piu.org.

BILL AIMS TO PROTECT CONSUMERS AMID HEALTH CARE MERGERS

This week, the Senate Health Committee will hear S.B. 932 (Hernandez). The bill would require state regulators to scrutinize proposed health industry consolidations to ensure that they are in the interest of consumers. The public would have opportunities to offer comment and feedback on the deals. The bill would prevent hospitals from making anti-competitive demands when negotiating with health plans and insurers. Hospitals, especially those with a large market share, would not be allowed to insist on contract

provisions that result in them being the only option for care. This bill has been introduced in the midst of a wave of pending health care mergers in California. Two of four major health insurance mergers have been finalized: Blue Shield of California acquired Care1st last year, and Centene's proposal to acquire Health Net was approved with conditions by state regulators last month. Two other health insurance mergers are still pending, Aetna-Humana and Anthem-Cigna. Other hospital and health mergers have also taken place, including the Daughters of Charity Health System purchase by an investment firm in 2015. Anthony Wright, executive director of Health Access California said, "Health industry mergers have led to price increases, less choice, and greater consolidation. Companies…almost always say that the merger will lead to efficiencies and savings, but they rarely… pass those [savings] to consumers, if [the savings] ever actually materialize. Companies that want to merge need to show that the merger causes no harm to consumers, and that consumers will actually benefit. Some of these health mergers are required to face public hearings and scrutiny while others fly under the radar. It's time to set a clear standard of…oversight for all these deals that have such a profound impact on the health system." For more information, visit health-access.org.

Employee Benefits

CRITICAL ILLNESS AND ACCIDENT COVERAGE ARE TOP GROWTH PRODUCTS

Over the next two to three years, voluntary critical illness insurance and accident/personal injury insurance are tied for first place as expected growth products for carriers. Hospital indemnity/supplemental medical, universal/whole life (UL/WL), and term life coverages round out the top five. Hospital indemnity/supplemental medical products are new to this list in 2016 while UL/WL jumped ahead of term life in this year's survey. Short-term disability fell out of the top five for the first time in four years. Critical illness leads the pack in growth products for the voluntary worksite market; hospital indemnity/supplemental medical is second; and accident coverage is third. Very few of the participating carriers rate any voluntary product as very profitable. However, AD&D, accident/personal injury and term life are listed most frequently. The majority of carriers say that their products have average profitability, which is similar to the 2012 and 2014 surveys. None of the respondents rated cancer insurance and long-term care insurance as profitable or financially attractive. For more information, visit eastbridge.com.

MOST EMPLOYEES ARE IN THE DARK ABOUT HARMFUL BLUE LIGHT

Fifty-six percent of workers are bothered by light at work, and 80% want more more eye protection from indoor or outdoor light, or both, according to a survey by Transitions Optical. In the past five years, harmful blue light has gained media attention amid the growing use of digital devices. As more employees learn about the consequences of exposure to harmful blue light, the desire for improved blue light protection is expected to increase. Jonathan Ormsby of Transitions Optical said, "Light protection is a significant issue for today's employees, so it's not surprising that concern over harmful blue light is top-of-mind…Also, the majority of employees increasingly place high value on premium lens materials and brands. Ensuring employees are informed about coverage of lenses that help reduce eye strain, like photochromics and AR treatments, can go a long way in terms of job satisfaction and productivity, as well as well-being." For more information, visit HealthySightWorkingforYou.org.

Life Insurance

SALES CLIMB FOR LIFE/COMBINATION PRODUCTS

New premium for individual life combination products rose 14% in 2015. It's a rebound from the decline in new premium growth in 2014, according to a LIMRA report. Karen Terry of LIMRA said, "Last year's decline… was mainly due to a shift from single premium products to limited pay products. While this shift continued in 2015, single premium products also exhibited strong growth in 2015. The growth was widespread, with a dozen companies reporting healthy growth in premium and policy count."

New premium totaled $3.1 billion in 2015, which represents 15% of all new premium collected for individual life insurance products. Products with chronic illness acceleration riders grew 38%, and represent 59% of the combination life insurance market. Products with long-term care acceleration riders were up 51% in 2015. But they only represent 28% of the market. There were more than 200,000 policies sold in 2015, which is a 37% increase.

With single premium, the customer pays the entire amount for the insurance in one lump sum. With limited payment, the customer pays at least two payments, but not for the rest of their life. A limited-payment life insurance policy has a limited number of higher payments by eliminating the life-long payments of the past. The majority of limited pay combination products have less than 10 annual premium payments, according to LIMRA. "We see more companies offering critical illness acceleration riders with their products with no up-front costs and often automatically attach these riders to specific products," noted Terry.

Sales of all product types increased in 2015. Whole life combination products saw the largest growth, increasing 30% in premium and 61% in policy count. Despite this strong performance, universal life combination products still hold three quarters market share by premium, policy count, and face amount. LIMRA has been tracking transitions in the long-term care insurance market, which is expanding to three distinct insurance products: individual long term care insurance, life insurance combination product, and annuity/LTC products. Collective sales for the three products in 2015 are almost $4 billion with more than 300,000 new lives covered. Due to the cost structure and the added life insurance protection, life combination products account for the majority of the estimated 2015 new dollars. For more information, visit limra.com. ★

CLASSIFIEDS

AD INDEX

Meet Mr. & Mrs. Reason and all the little reasons why we do what we do in a day.

We do it for the checkups. We do it for the aches, the pains, the schoolyard accidents, and the flu that's been going around. We do it for the pregnancies, the pulmonary exams, and the post ops.

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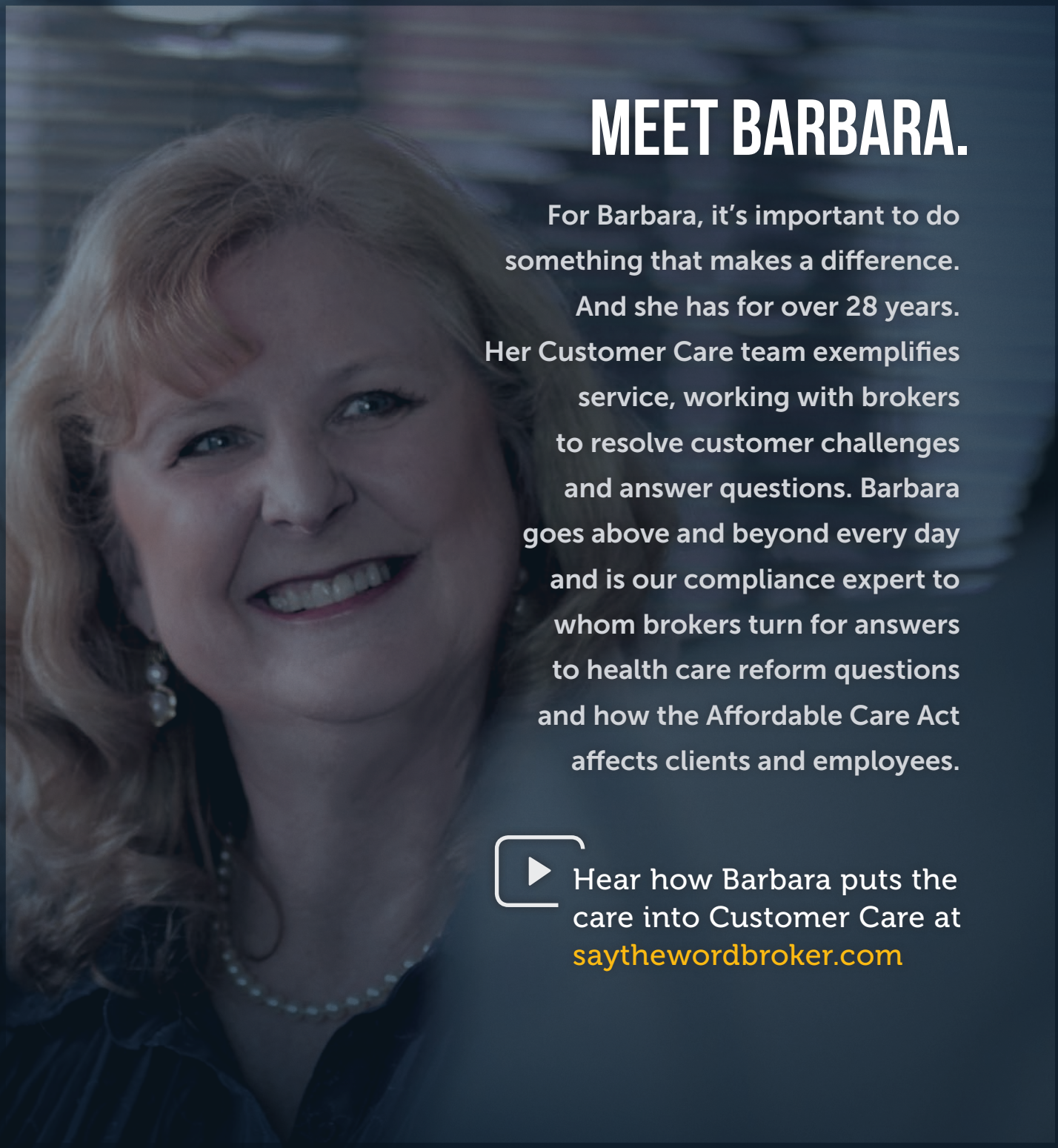

MEET BARBARA.

For Barbara, it's important to do something that makes a difference. And she has for over 28 years. Her Customer Care team exemplifies service, working with brokers to resolve customer challenges and answer questions. Barbara goes above and beyond every day and is our compliance expert to whom brokers turn for answers to health care reform questions and how the Affordable Care Act affects clients and employees.

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