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SERVING CALIFORNIA'S LIFE/HEALTH PROFESSIONALS & FINANCIAL PLANNERS

MARCH 2017

2017 TRANSITIONS VISION ACADEMY

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If the Hat Fits...

by STEVE SILKIN

At the recent expo of the San Diego Association of Health Underwriters, event chairman Sean Greene was wearing a red trucker hat, modeled on Donald Trump's campaign headwear, emblazoned with a similar message: Make SDAHU Great Again.

He was chatting with the folks at the booth next to ours. They were all Latino and work for Simnsa which specializes in cross-border insurance policies.

Who doesn't love a good laugh! I sure do. (And who knows? Maybe a big wall will be good for cross-border health insurance sales. Anything's possible, right?)

But seriously, folks: It was a privilege and pleasure to meet so many of you at the convention.

Especially Jeff Welty of Colonial Life. First we chatted about business, of course: He mentioned that sales at his office had doubled last year, a thrill he only heard about from colleagues because he had to take most of that time off. Why? Because he was shedding 110 pounds so that he wouldn't die. Today, thanks to stomach surgery, he looks like he's in shape for a marathon. And will likely live to see his grandkids grow up.

Speaking of marathons, that's what Hector Lazaro does – he runs marathons. We compared some notes on long-distance running. Pretty sore the next day, huh? Nope, he said, it's like nothing happened. What's his secret? An ice bath after the race. So he runs 26.2 miles and then jumps into a bathtub full of ice. I like running, too. I'm going to skip the ice bath, though.

Lazaro runs to raise funds for

Strength United, which supports victims of domestic violence. He's not the only do-gooder at SDAHU, though. I was also impressed with the association's philanthropy wing. So impressed that I offered \$40 bucks for an \$85 bottle of wine at the silent auction. No one outbid me, so I am now the proud owner of a 2010 Wind Gap Sonoma Coast Syrah. And I know my money is going to an excellent cause. The wine will go to a good cause, too – accompanying a lovely dinner, very soon.

Crest Trail, too. (Made famous by the recent book and movie, "Wild.") Oh, and by the way: The last part of that hike was completed with a broken foot – he cracked the middle metatarsal, then had it splinted and bandaged by a highly unqualified non-professional. But Ormsby wasn't going to give up. He finished the hike anyway.

* * *

And our funny client story contest continues. Please send me the funniest thing that's happened to you at work.

Please put "Attn: Funny Client Story" in the subject line and email to editor@calbrokermag.com. Win valuable prizes!

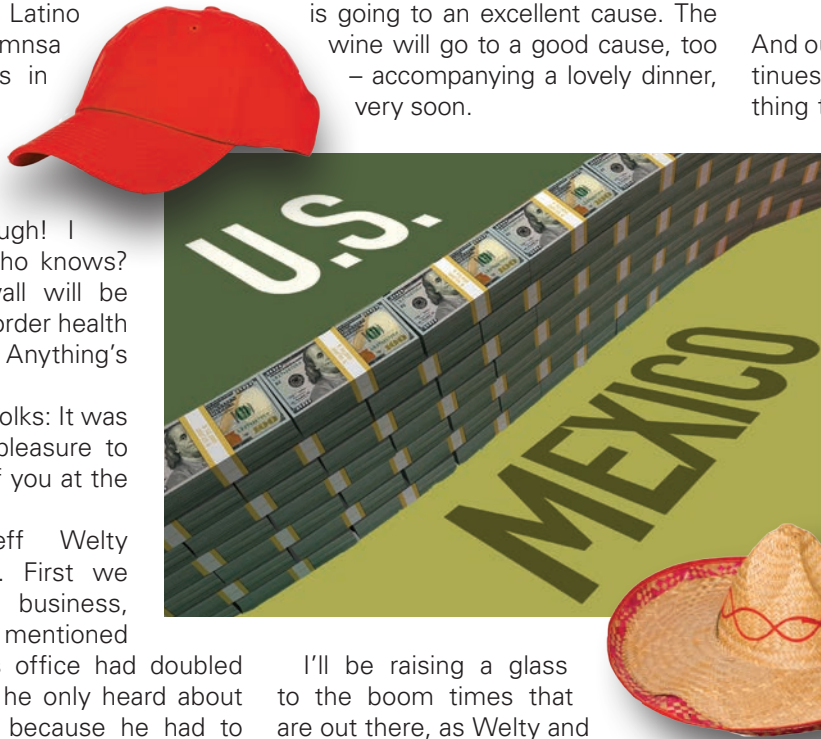
* * *

Love the hat, I told Greene, thinking that might remind him he was wearing it while chatting with his Latino pals who sell cross-border insurance. "It reminds me of something – Fake American Snakes to Bend? Am I getting that right?"

He looked me square in the eye and said: "I don't know what you're talking about."

At the podium later, he acknowledged he'd heard "some complaints" about the hat, but said he was not wearing it to make any statement beyond his desire to improve SDAHU. I hope he didn't think I was complaining. I wasn't complaining. I loved it. I think he should wear it everywhere. Like Ormsby: Never give up.

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I'll be raising a glass to the boom times that are out there, as Welty and Lazaro explain on Page 38. Let's all enjoy them.

* * *

I also went to Orlando for the Transitions company annual meeting. Transitions makes those lens coatings that turn your prescription eyewear into sunglasses when you step outside. I was pleased to meet Jonathan Ormsby, a strategic account manager at the company. During our chat about how Transitions does what it does and why you should care (Page 12), I found out that Jonathan has done some hiking. And by some hiking I should specify: The Appalachian Trail. Took him six months. But that's not all: The Pacific

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THE AFFORDABLE CARE ACT: Understanding What Broke

by MARK G. FONTENOT

Was the Affordable Care Act a net positive or a net negative for the country? To fully understand the ACA, step back and look at the goals on a broad scale.

There's no doubt that the Affordable Care Act fulfilled part of its goal; more Americans got health insurance. California is considered to be a landmark state in how effectively Obamacare was implemented. Federal data shows that the number of working-age adults with no coverage here dropped from 24 percent to only 11 percent, making California the state with the fourth largest decline in citizens without healthcare.

However, the second goal was in the title: affordable. At first glance, the ACA created a marketplace of affordable insurance. At implementation, the premiums, or the amount paid monthly for insurance coverage, were indeed affordable. Rules were enacted to level the disparity in premiums, with subsidies given in certain cases. Women could no longer be charged a higher premium for simply being women, and people with pre-existing conditions such as diabetes and asthma could not be denied coverage. The rules created a marketplace that gave coverage to those who were falling through the cracks in our previous model.

What wasn't discussed at the time was the real cost of using a plan purchased through the ACA. That's because although the premiums are affordable, the policies sometimes carried high deductibles. People were expected to pay out of pocket for about \$1,700 before insurance kicked in.

For a typical consumer, that could mean financial disaster. A full 70 percent of Americans live paycheck to paycheck with less than \$1,000 in savings. Thus, even a relatively minor healthcare issue such as a broken bone requiring a surgical procedure

suddenly becomes a financial crisis, as the patient is billed that deductible amount. This means that despite having insurance, patients are left with expenses they didn't anticipate.

Vicious Cycle

This begins a vicious cycle that negatively affects hospitals and other healthcare providers as well. As patients couldn't pay, financial crises hit hospitals. Some are cutting staff, while some hospitals and clinics are closing.



Healthcare debt is a complex issue. From the moment a patient registers with a provider, there are multiple back-end systems at work that do everything from track medical records, initiate a code for reimbursement, and bill insurance and patients. There's also an adjudication process where insurance pays an amount, but the provider may resubmit that same claim – changed or not – and receive further payment. The patient gets real pieces of paper – explanation of benefits or bills – but it's not always clear what is owed to the provider and what insurance has paid or will pay. Sometimes co-pays are collected at the time of service but sometimes they are billed. One deductible applies for seeing Doctor A, but a different deductible applies for Doctor B. The examples can continue, but this quick overview illustrates how fractured and difficult the process

is for even healthcare professionals to understand.

At the end of the day, patients can be stuck with unaffordable bills. Some choose to pay the debt with a credit card, while others borrow money from another source. But most would say the same thing: they didn't see this coming because they didn't fully understand what high deductible plans would cost to use. Others may understand, but can't afford the higher premiums that are charged for lower deductibles. Therein lies the conundrum: how do we make affordable healthcare actually affordable?

The Right Policy

Understanding the complexity of the problem at a governmental level is key for policy change, but right now we need to focus on how to reduce the anxiety that millions of Americans feel when they must use their health insurance. Teaching people how to choose the right policy for themselves based on usage rather than cost is important. Highlighting the cost of an unanticipated healthcare expense can provide sobering knowledge. Promoting other forms of payment for healthcare, such as a Health Savings Account or even a traditional savings account, will better equip consumers with the cushion they may need for a healthcare crisis. Developing flexible payment options for people who do incur debt is paramount.

The ACA came, and it is now going. However, what the next step is remains to be seen. Regardless, people are in debt now, and we can assume debt will continue for years as any changes are implemented and tested. ★

Mark G. Fontenot is chief executive of CirraGroup, a healthcare financial technology company in Lafayette, La.

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	Bests	Fitch	S&P									
American Equity	A-	A-		ICC13 MYGA (Guarantee 5) (Q/NQ)	S	2.50%*	5 yr.	None	9%, 8, 7, 6, 5, 0	Yes	\$10,000 (Q) & \$10,000 (NQ)	3.00%, age 18-75 & 2.10%, age 76-80** 1.50% age 81-85**
				ICC13 MYGA (Guarantee 6) (Q/NQ)	S	2.65%*	6 yr.	None	9%, 8, 7, 6, 5, 4, 0	Yes	\$10,000 (Q) & \$10,000 (NQ)	3.00%, age 0-75 & 2.10% age 76-80** 1.50% age 81-85**
				ICC13 MYGA (Guarantee 7) (Q/NQ)	S	2.80%*	7 yr.	None	9%, 8, 7, 6, 5, 4, 3, 0	Yes	\$10,000 (Q) & \$10,000 (NQ)	3.00%, age 0-75 & 2.10%, age 76-80** 1.50% age 81-85**
*Effective 2/6/17. Current interest rates are subject to change on new issues. **Commission may vary by issue age and state. See Commission Schedule for details												
American General Life Insurance Companies	A	A+	A+	American Pathway Solutions MYG (*Guarantee Return of Premium) (Q/NQ)	S	2.50%** 2.70%** ^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 Effective 2/8/17. First year rate includes 1.50% interest bonus. a (less than \$100K) ; b (100K or more)												
American General Life Insurance Companies	A	A+	A+	American Pathway Fixed 5 Annuity (*Guarantee Return of Premium) (Q/NQ)	S	1.60%** 1.80%** ^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 2/8/17 Includes 2.00% 1st year bonus, 1.00% base rate subsequent years. a (less than \$100K) b (100K or more)												
American General Life Insurance Companies	A	A+	A+	American Pathway Fixed 7 Annuity (*Guarantee Return of Premium) (Q/NQ)	S	2.30%** 2.50%** ^b	7 yrs.	None	9%, 8%, 7%, 6%, 5%, 4%, 2%, 0%	No	\$5,000 (NQ)	3.00% age 0-85 1.50% age 86-90
*CA Rates Effective 2/8/17. First year rate includes 4.0% bonus 1 st year. a (less than \$100K) b (100K or more)												
Great American Life	A	A+	A+	SecureGain 5 (Q/NQ)	S	2.50%	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 1/27/17.. Includes .25% first-year bonus and is for purchase payments over \$100,000. Escalating five-year yield is 2.50%. For under \$100,000 first-year rate is 2.35%. Escalating rate five-year yield 2.35%.												
Great American Life	A	A+	A+	SecureGain 7 (Q/NQ)	S	2.80%	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 1/27/17. Includes 1.00% first-year bonus and is for purchase payments over \$100,000. Escalating seven-year yield is 2.69%. For under \$100,000 first-year rate is 2.70%. Escalating rate seven-year yield 2.59%.												
Great American Life	A	A+	A+	Secure American (Q/NQ)	S	1.65%*	1 yr.	N/A	9%, 8, 7, 6, 5, 4, 3	No	\$10,000	5.75% 0-70 4.65% 71-80 4.40% 81-89
*Effective 1/27/17. Eff. yield is 2.67% based on 1.65% first year rate, 1.00% available portion of 10% annuitization bonus (available starting in contract year two) and 0.02% interest on available portion of bonus at the rate of 1.65%. Surrender value interest rate 1.65%. Accepts additional purchase payments in first three contract years. COM12255												
The Lincoln Insurance Company	A+	AA	AA	MYGuarantee Plus 5	S	1.90%** 2.05%** ^b	5 yr.	None	7%, 7, 6, 5, 4, 0	Yes	\$10,000 (Q/NQ)	
*Rates Effective 2/1/17 (a-for premiums less than \$100K, b-for premiums \$100K or more), and are subject to change												
The Lincoln Insurance Company	A+	AA	AA	MYGuarantee Plus 6	S	2.10%** 2.25%** ^b	6 yr.	None	7%, 7, 6, 5, 4, 0	Yes	\$10,000 (Q/NQ)	
*Rates Effective 2/1/17 (a-for premiums less than \$100K, b-for premiums \$100K or more), and are subject to change												
The Lincoln Insurance Company	A+	AA	AA	MYGuarantee Plus 7	S	2.20%** 2.35%** ^b	7 yr.	None	7%, 7, 6, 5, 4, 3, 2, 0	Yes	\$10,000 (Q/NQ)	
*Rates Effective 2/1/17 (a-for premiums less than \$100K, b-for premiums \$100K or more), and are subject to change												
The Lincoln Insurance Company	A+	AA	AA	MYGuarantee Plus 8	S	2.30%** 2.45%** ^b	8 yr.	None	7%, 7, 6, 5, 4, 0	Yes	\$10,000 (Q/NQ)	
*Rates Effective 12/1/17 (a-for premiums less than \$100K, b-for premiums \$100K or more), and are subject to change												
North American Co. for Life and Health	A+	AA-	A+	Gaurantee Choice (Q/NQ)	S	2.45%** 2.70%** ^b	5 yr.	None	10, 10, 9, 9, 8	Yes	\$2,000 (Q) & \$10,000 (NQ)	2.00% (0-80) 1.50% (81-85) 1.00% (86-90)
*CA rates effective 1/5/17 - a (less than \$200K) b(200K or more)												
Reliance Standard	A+		A	Eleos-MVA	S	3.55%*	1 yr.	None	8%, 7, 6, 5, 4	Yes	\$10,000	3.25%**
*Effective 12/2/16. Includes 1.50% 1st yr. bonus. Min. guarantee is 1.00%. **Reduced 20% ages 76-80, and 40% ages 81-85												
Reliance Standard	A+		A	Apollo MVA (Q/NQ)	S	4.45%*	1 yr.	None	9%, 8, 7, 6, 5, 4, 2	Yes	\$5,000	4.00% to age 75**
Includes 2.00% 1st yr. bonus. Min. guarantee 1.00% **Reduced 20%, ages 76-80, and 40% ages 81-85. Effective 12/2/16												
Symetra Life, Inc.	A	A	A	Custom 7 (Q/NQ)	S	3.20%*	7 yrs.	N/A	8%, 8, 7, 7, 6, 5, 4, 0	No	\$10,000	Varies
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2017 TRANSITIONS VISION ACADEMY

CHARTING VISION BENEFITS

IT'S EYE TIME **BLUE LIGHT PROTECTION A GOOD SELL FOR BROKERS**

by STEVE SILKIN

There once was a rapper named Dr. Geek, a large African-American man with eccentric headwear who quickly became famous for his free-stylin' on the Venice Boardwalk in Los Angeles. He became the pitchman for BluBlocker sunglasses, and a generation of TV viewers saw the wacky late-night ads featuring Geek wearing a stylized black sombrero and rhyming about the virtues of the lenses that add clarity to your vision and protecting your eyes.



At about the same time, in 1990, a company called Transitions Optical was born, selling lens coatings that eventually became the leader in what is now known as the photochromatic eyewear industry. The lenses darken in the sun, turning prescription glasses into shades.

Since then, mobile devices became part of daily life in the form of smartphones and tablets. The screens generate blue light – on the far end of the visible light spectrum. The blue light was found to cause eyestrain. Meanwhile, the eye has been also exposed to blue light from the sun – much more

so than from devices – and photochromatic lenses offer protection for that, too.

In industry jargon, through new awareness of blue light from the sun and from mobile devices, the phenomenon falls into the category of “top of mind,” and more and more people are concerned about the problem each year.

Thus, say the folks at Transitions, a broker can sell the benefits of photochromatic lenses as high value as a supplemental benefit that employees will appreciate.

“Obviously, full coverage is easier to sell,” said Cory Lawson, associate marketing manager at Transitions. And it’s good for Transitions sales, too; the more people who have photochromat-



ic coverage, the more likely they are to use the benefit and buy Transitions glasses.

"Insurance always plays a role," he said.

He also noted that, despite the silly ads, BluBlocker glasses are effective protection against ultraviolet and blue light. The big advantage of Transitions, however, is the combination of prescription lenses with photochromatic protection; that means a wearer doesn't need sunglasses and prescription lenses; one pair will suffice.

Dr. Geek died in 2014 but is commemorated on many Internet sites, especially those concerning the culture of Venice Beach; the BluBlocker ads don't run anymore, though.

Transitions buys the lenses from lens

academy, at the end of January, also featured a panel addressing the challenges and opportunities of adding vision plans to employee benefits. John Lahr, vice president of provider relations and medical director at EyeMed Vision Care in Mason, Ohio, said that he expects to see eye care continue to grow into a benefit that will be seen on the same par as dental.

"But a lot fewer employers offer vision," he said.

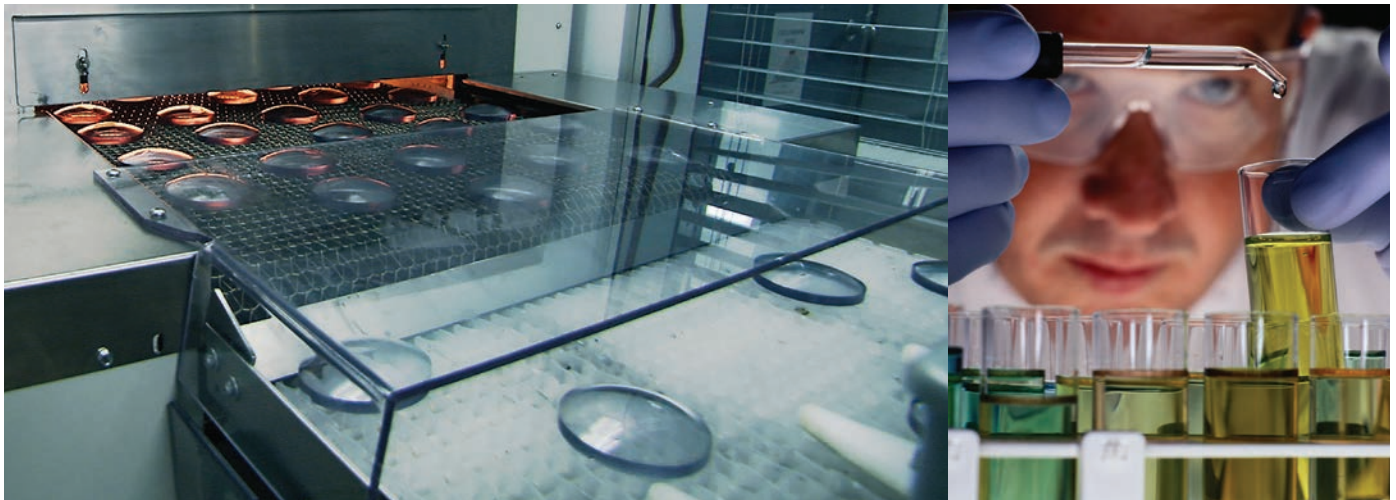
C. Scott Haney, chief financial officer at Davis Vision, a vision plan in San Antonio, said his company is enthusiastic about covering photochromatic lenses.

"Anytime something new comes along, like blue light technology, we welcome it," he said.

not sure if their current eyewear offers that protection, and only one-fifth of them knew that the sun was a source of blue light. Hence the need for marketing programs such as the Transitions Academy.

The company is continuing its marketing efforts with new ad campaigns and a program called Healthy Sight Working for You. The efforts are designed to lead consumers from awareness to action.

"We have people of all ages saying harmful blue light protection is important to them, but aren't necessarily taking action," said Drew Smith, a Transitions Optical director. "They aren't talking to, or hearing from their doctors, and many don't know whether they



Transitions lens-coating process; a Transitions lab technician.

manufacturers, coats them, sells them back to the lens companies, which then sell them to laboratories, which then sell them to eye care professionals, which then sell them to consumers. As such, the company's key players are optometrists. Transitions competes with other prescription eyewear photochromatic lens companies, such as SunSensors, a division of Mitsui in Japan, and Rodenstock, a German eyewear company.

The company started as a joint venture between PPG in Pittsburgh, Pa., and Essilor in Paris. It is now wholly owned by Essilor, and Transitions is headquartered in Dublin, Ireland. Transitions offers an academy every year in Florida. The academy keeps eye care professionals up to date on its products and honors its MVPs. This year's

Lahr said he expected vision coverage would continue as an "add-on for the foreseeable future." He also noted that brokers would have to realize that coverage that includes photochromatic lenses would be more expensive.

Increasing Awareness

The Transition Optical survey, "Employee Perceptions of Vision Benefits," was conducted by Wakefield Research in Arlington, Va. It found that most people asked believed that blue light protection was an important feature in eyewear, but younger people are more concerned. The study showed that 83 percent of millennials believed blue light protection is important, while 75 percent of boomers did. Oddly enough, however, only one-fourth of millennials said that they are

have protection in their lenses. This creates an education opportunity for vision plans, brokers and employers."

But it's not just about sales. Everybody involved, whether insurers, brokers, eyewear companies and eye care professionals are in the business of helping people.

Daniel Mannen, chairman of VSP Global, a vision plan in Rancho Cordova, Calif., said that the company is working to raise awareness of the need for eye coverage. But even if employers offer eye care and employees sign up for it, a remaining challenge will be getting the patient to the doctor.

"Only when they use the benefit does the magic happen," he said. ★

Steve Silkin is the managing editor of California Broker magazine.

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*2017 Transitions *Employee Perceptions of Vision Benefits Survey*. Wakefield Research for Transitions Optical, Inc.

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WHAT MAKES THE SKY SO BLUE? AND WHAT HARM CAN IT DO TO YOU?



By JONATHAN ORMSBY

Today's employees hear more about the harmful effects of blue light, but they might not understand what blue light is and why they need to protect their eyes from it. By knowing the basics of blue light, benefits brokers can be better positioned to educate employers on vision plan options.

What is blue light? The light you can see is called visible light. There is also light that you cannot see, such as ultraviolet light. Blue light – also known as High Energy Visible Light – is at the far end of the visible spectrum, close to ultraviolet light. Not all blue light is harmful. The harmful portion of blue light is only at the far end of visible light.

Where is blue light? Often associated with electronic devices and screens, harmful blue light is actually present from other sources both indoors and outdoors. Fluorescent lights emit blue light. But the largest source of harmful blue light is the sun, which emits more than 100 times the intensity of electronic devices and screens.

Why is it bad for you? The cornea and lens of the eye, which help filter out UV light, don't block out enough blue light. As a result, this high-energy light passes through to the retina of the eye. Long-term exposure to harmful blue light has been linked to increased risk of developing age-related macular degeneration. This serious eye disease causes loss of central vision, and is the leading cause of vision loss in adults over 50.

Scattering Sky

Blue light scatters more easily than other visible light and is not easily focused by the eye, so it can also reduce contrast and contribute to eye fatigue and eyestrain. Blue light from the sun, scattering through the atmosphere, is what makes the sky blue on a sunny day.

With the proliferation of digital devices—which also emit blue light—

harmful blue light exposure is now even greater indoors. Blue light from computer screens and digital devices can decrease contrast, leading to digital eyestrain. Given the high use of digital screens and devices on the job, it is not surprising that digital eyestrain is the top office-related complaint in the United States, according to the National Institute for Occupational Safety and Health.

Blue light exposure late at night can also interfere with sleep patterns. Sleeping trouble can lead to health problems, not to mention a potential decrease in focus and productivity at work.

How to protect your eyes from blue light? There are many steps people can take to reduce exposure to harmful blue light. It's easy to suggest that people could just avoid being out in the sun, or could turn off their digital devices – but those are obviously not realistic options today. More reasonable solutions are to apply screen protectors, or filters, to digital devices, or to make changes to the digital device settings. But the preferred option by far among eyeglass wearers is to wear glasses with built-in protection.

Harmful blue light protection can be built into eyeglass lenses – offering round-the-clock protection. Transitions lenses, for example, have always filtered harmful blue light, and also block 100 percent of ultraviolet rays. These lenses block at least 20 percent of harmful blue light indoors – which is up to two times more than standard clear lenses. They block more than 85 percent of harmful outdoor blue light. Anti-reflective treatments, in addition to cutting down glare, can also filter harmful blue light. ★

Jonathan Ormsby, an 11-year-veteran of the optical industry, is a strategic account manager in Portland, Ore., for Transitions Optical.

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by Steve Silkin **INSURANCE
INSIDER NEWS**

View From the Top Surveying the Landscape of Small Groups

Opportunities and Challenges

Participating in the Conversation:

STACY MORRIS

Vice President / General Manager
Ben-E-Lect & Employer Driven Solutions

SCOTT BOORE

Vice President of Sales, More Health

ED WALKER

President, ArmadaGlobal

The world of small group benefits changed dramatically when more companies fell into that designation; it now applies to employers with up to 100 workers, instead of 50. California Broker Magazine asked several professionals who service this segment of the industry about the challenges and the opportunities they face today. Among the opportunities cited: the need for these companies to attract and retain talent and benefits remain a key factor in that equation. Among the challenges: rising premiums. Find out more in the conversation on the following pages.



What has changed in the past year?

Stacy Morris: In 2016, the Affordable Care Act definition of small group employer increased from 50 to 100 employees. One significant impact of this change is that the ACA's small group rating limitations will apply to employers with 51-100 employees. These employers were previously considered "large" employers so their rates were set using various factors such as claims history, industry and location. In

'We... restructured our plans and found ways to successfully offer stop loss plans for those who would be affected by this new definition of small group. This particular change was the trigger for a new breed of small group stop-loss plan rating in which we have found tremendous success.'

addition to counting full-time employees, employers also must count full-time equivalents to calculate employer size. Groups with a total of 100 or less (counting both full-time employees and full-time equivalents) will be considered small employers.

This meant that we needed to be sure plans were structured to accommodate the changing needs of our employer clients based on the new classification. We strategized, restructured our plans and found ways to successfully offer stop-loss plans for those who would be affected by this new definition of small group. This particular change was the trigger for a new breed of small group stop-loss plan rating in which we have found tremendous success.

Ed Walker: This change affects roughly 14 percent of all California employment, or 33,000 employers and 2.3 million employees.

Scott Boore: Nothing changed and

yet everything has changed. I think most people were truly surprised at the outcome of the election. It will be some while yet until we have a handle on what the changes in healthcare will be and when they will be put in place.

What are the challenges?

Scott Boore: I believe the true challenge may be to not overreact. Change is coming but seems to be the norm these days.



Ed Walker

Ed Walker: Employers are faced with higher costs and fewer options. They're experiencing premium hikes, for instance, between an 18 percent and 38 percent increase. This mostly stems from the required small group community rating, a complex variation of age rating, versus the more lenient composite rating of the large group market.

Another challenge is that there are fewer plan choices made available to the small group market compared to the large group, with some carriers not offering plans in the small group market at all. Small group plans tend to be more expensive and have higher deductibles and out-of-pocket costs. Administration of benefits costs more, too. All of these changes are causing disruption for both employers and employees—and translating into more costs for both.

Stacy Morris: In addition to the increasing amount of audits we are faced with, premiums are expected to rise again in 2017. For the small group market, premiums will increase by a larger margin -- double digits in most places. For a third party administrator, this is an environment we have to step into and provide a solution. Small employers can't handle further increases so we must be aware, know which plans are affected and have a proposal in place where an employer can easily identify the right plan option to fit the employer's needs.



Stacy Morris

What are the opportunities?

Scott Boore: Opportunities are always there. Even in times when it seems that everything is in flux. It is never a bad time to take stock and review your plans to ensure that your

'Opportunities are always there. Even in times when it seems that everything is in flux. It is never a bad time to take stock and review your plans to ensure that your goals are being met.'

goals are being met. Are your plans staying in line with your budget? Are they providing for the needs of your employees? Are they easy to understand and implement? Are they competitive within your market?

Stacy Morris: Any small employer who is currently in business is an opportunity. The fact that 50 percent to 70 percent of members in any size group don't use their plan in a given year is what makes the previous statement true. We help the employer take advantage of that fact. Employers are demanding alternative solutions to the traditional options. They also are finding value in the transparency that comes with these solutions.

Ed Walker: Brokers and consultants are used to turning to consumer accounts to backfill coverage, but now they are realizing the power of supplemental plans, especially expense re-

"...supplemental is the type of solution that employers are looking for as a way to backfill coverage without breaking the bank...almost half of employers nationwide expect supplemental benefits to be vital to total rewards in 2018.

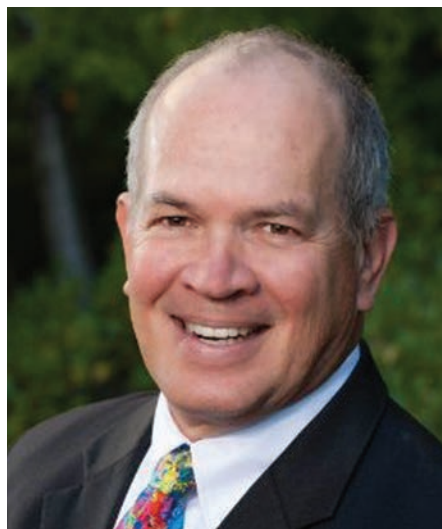
imbursed insured plans, to off-set the huge coverage gaps being created. These types of supplemental plans can add a much-needed boost to their portfolio, especially since these plans can help all types of employers – both small and large group.

Although this redefinition hasn't been ideal, it has required consultants to get up to speed quickly on what's becoming the new future of group benefits. It's not just about primary coverage anymore. Consultants need to strategically look at both primary and secondary coverage together. The supplemental insurance market is growing by leaps and bounds, and currently worth more than \$7.1 billion. And supplemental is the type of solution that employers are looking for

as a way to backfill coverage without breaking the bank. In fact, almost half of employers nationwide expect supplemental benefits to be vital to total rewards in 2018.

What ancillary products are most popular with small groups?

Scott Boore: Short-term disability and critical illness have long been popular with smaller group. But more and more companies are looking for additional options that can help them both attract and maintain talent. Second opinion plans, a product that has previ-



Scott Boore

ously only been offered to very large companies, are now available to small- and mid-sized groups. Such plans can help both employers and employees by reducing costs and creating better health outcomes.

Stacy Morris: The most frequently purchased ancillary benefit for small groups is dental insurance. Many studies have shown a strong connection between dental care and overall health. Our Freedom Dental Plans allow employers to choose from multiple plan designs, so the employer has the freedom to select the plan that best fits their individual needs along with alternative network options. Our new business rates have not increased since 2011. While we've seen the trend in increasing rates, we've been improving benefits.

Have you developed any new sales and marketing approaches?

Ed Walker: Our recent broker poll shows that consultants are struggling with three interconnected issues: having fewer plan choices to offer, keeping clients happy with coverage levels, and dealing with increased costs. More and more consultants are seeing how they can leverage supplemental plans to address all these issues. Plus, with the right supplemental plans, they can differentiate their benefit offerings in the market and even open doors to decision-makers with current accounts or prospective ones.

Scott Boore: No new approaches. Listening, asking questions and offering solutions are still the most successful approaches. Companies are looking for problem solvers not sales people. Collaboration, working together to find a solution – that's what works.

Stacy Morris: For many employers, and for many years, the only cost control strategies have been to either increase deductibles or shift more of

"...for many years, the only cost control strategies have been to either increase deductibles or shift more of the premium increase to employees. Many employers are not willing to accept these options."

the premium increase to employees. Many employers are not willing to accept these options. One of the plans we administer assists the employer in purchasing a group plan with higher deductibles, but lower premiums than they would otherwise buy. Employers then use part of the huge premium savings to provide benefits to its employees, for charges applied to the carrier deductible, if and when the benefits are actually used. ★

– Compiled by Steve Silkin



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How to Keep Your Senior Business Going Strong All Year Long

by ROXANNE ANDERSON

After the annual enrollment period, you can work on expanding your reach and attracting new clients in the senior market. Here's how you can prevent the end of the lock-in period from locking down your Medicare business growth.

There are certain Medicare products you can keep promoting. Special needs plans, for instance, open the door to an abundance of sales opportunities. These Medicare Advantage products are available to individuals who are dual-eligible or those who qualify based on a chronic illness or institutional care. You can sell them post-enrollment because those eligible for a special needs plan have a special election period to join one.

Medicare Supplements are also particularly valuable to have in your portfolio. They can be sold year-round. And people who are unhappy with their new Medicare Advantage plan can request to disenroll and join Medicare Parts A and B during the Medicare Advantage Disenrollment Period, which runs from Jan. 1 to Feb. 14. These individuals may want a supplements policy to fill the coverage gaps of Part A and B.

What's more, you can also continue to sell Medicare Advantage and Part D plans outside of annual enrollment by using special election periods. There are many ways Medicare-eligibles can qualify for an Medicare Advantage or Part D special election. Just make sure your clients know they should advise you if they experience any of the qualifying life events so you can help them determine if they can, and should, switch plans.

Selling non-Medicare products can also spark Medicare sales and help you maintain a thriving business in the senior market.



If you limit yourself to selling only Medicare-related plans, you're limiting your clientele. Selling ancillary products, life insurance, and annuities allows you to connect and form relationships with more shoppers, whom you may be able to help when they need Medicare coverage later. It also opens the door for you to receive more referrals from satisfied clients.

Moreover, cross-selling non-Medicare products to clients you've already helped into Medicare plans can help you retain those clients and build their loyalty to you. Shoppers tend to stick with businesses that they feel treat them well.

Follow Up

One study shows that 78 percent of shoppers who had a previous relationship with their insurance sales representative bought life insurance. However, the organization also states that 35 percent of prospects who didn't buy life insurance reported they were still shopping and sales representatives should have followed up with them.

Follow-up calls or appointments show prospects you're prepared and willing to help them meet their coverage needs when they're ready for you.

Similarly, follow-up calls or appointments show current clients that you care and you're dedicated to helping them find the insurance products that work best for them.

As an agent, it's a good habit to schedule follow-up calls or appointments with your prospects and clients at the end of your initial meeting. When you're scheduling these events, you'll want to try to follow up with clients you've helped into a new Medicare Advantage plan sometime next December or January. Some clients may not like their new plan, and may want to switch to original Medicare and a Medicare Supplement during the disenrollment period.

Finally, track down leads. Hosting educational events and seminars is a great way to get your name out there and build your reputation as a knowledgeable, friendly, local support system for the newly Medicare-eligible or confused Medicare enrollees. In addition, if you don't want to leave the comfort of your own home, there are several lead sites out there that will send you a list of leads for a fee. However, if you go this route, it's important you do your research to find a good provider so you stay compliant.

Consider working with a field marketing organization; they offer lead programs and prospecting lists, among other potential opportunities.

Even though the Medicare enrollment period may make this line seem like a seasonal business, people have different needs year-round. There are several products you can sell throughout the year to help them meet those needs and maximize your senior market success. ★

Roxanne Anderson is at Ritter Insurance Marketing, a field marketing organization in Harrisburg, PA.



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Landscape Offers Opportunities and Challenges to Brokers

by VANESSA VIZARD

The landscape in 2017 for Medicare Advantage stakeholders is being influenced by a number of trends. Those include the new administration, the emphasis on value-based payment models, star rating initiatives, the Medicare Access Reauthorization, increased regulations, and the ever-growing competition for market share from major health plans. Healthcare and network providers are facing the greatest impact from these key influencers.

While the Medicare Advantage environment may seem bleak for some, brokers will have a special opportunity to capitalize on the challenges other stakeholders are facing. Knowledgeable brokers have the ability to develop partnerships with healthcare providers to educate them on how their services can help improve their Risk Adjustment Factor scores and increase their capitation under the value-based patient model.



Another major opportunity for brokers in 2017 is the alternative payment method under Medicare Reauthorization of 2015, known as Macra or the Permanent Doc Fix. Reporting for Macra begins in 2017 and many providers are not aware of how the act affects them. Under Macra, providers can receive increases or penalties on revenue, providing an opportunity for brokers to educate and work with providers. The goal is to move their fee-for-

service patients, who can often drive down their revenue, onto a managed care health plan.

Working closely with providers in 2017 to reach their members is a great opportunity, yet there are other factors contributing to the explosion of the market. Those include the thousands of baby boomers becoming eligible for Medicare each day, making the Medicare Advantage market a sweet spot in the insurance industry. Due to the rapidly growing demographic, Medicare Advantage enrollment rises year after year, and is expected to grow another 4 percent in 2017.

According to data from the Health & Human Services Department, Medicare Advantage enrollment has increased by 95 percent since 2005 and is growing faster than traditional Medicare. Medicare beneficiaries are increasingly more receptive to enrolling in Medicare Advantage plans due to the supplemental benefits offered.

Although there is a plethora of opportunity for brokers in the space, there is also plenty of competition. It will be critical for brokers to stay current with market trends and become the expert in their field to remain competitive and benefit from the present opportunities. Brokers who remain with the status quo will only have mediocre results.

What will you do to keep your competition at bay? ★

Vanessa Vizard is marketing director at HRBC Insurance in Riverside.





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Associations: What Can You Get Out of Joining?

by YOLANDA WEBB

To join an association, or not to join? That is the question all insurance agents ask themselves at one point. After all, what can they do for you? Do they even listen?

Currently, there are hundreds of organizations for insurance agents, brokers and agencies that promise they are the best. But do they really deliver? Here are introductions to three prominent associations. You decide if joining is worth your money, and more impor-

and consumer choice using independent brokerage distribution. NAHU represents more than 100,000 licensed health insurance agents, brokers, general agents, consultants and benefit professionals through more than 200 chapters across America. Each of these organizations represent a different area of insurance, with different goals, purpose and missions.

NAIFA is one of the nation's largest associations in America. Members

value for the independent agent or broker. However, for the more diversified agent with licensing in the financial world this could be a perfect fit.

NAHU represents the life agent, health and senior product specialist. The clients of members range from Fortune 500 companies to the small business owner just getting started and needing information and guidance for group health coverage. Member education in the Medicare Advantage and Medicare Supplement is offered. All areas of health insurance are addressed to both independent agents and general agencies. The association provides its membership with professional conferences and networking, and continuing education is a priority. The group conducts advocacy efforts at the state and federal levels of government to advance the interest of health insurance professionals and to promote affordable and responsible health insurance solutions.



tantly taking time from business.

What are some reasons an agent would join an industry association? Continuing education, networking, access to clients, name recognition. Some may have an interest in the political aspects of an association. But first, do your homework.

The three under discussion here are the National Association of Insurance and Financial Advisors, or NAIFA; The National Association of Independent Life Brokerage Agencies, or NAILBA; and the National Association of Health Underwriters, or NAHU.

What Do They Do?

NAIFA was founded in 1890, and was originally called the National Association of Life Underwriters, or NALU. NAILBA promotes financial security

include financial Advisers, insurance agents, multiline agents and employee benefits specialists. The focus of the group is to protect your business, grow your business and promote ethical business conduct.

NAILBA serves as the national association of life, health and annuity insurance distributors, with more than 300 member agencies throughout the United States. Since 1981 this association has represented life brokerage agencies, protecting their interests. The primary membership is life brokerage agencies of premier insurance industry organizations promoting financial security and consumer choice through independent brokerage distribution. Since its main focus is agencies and may offer more to the financial advisor, this association may have limited

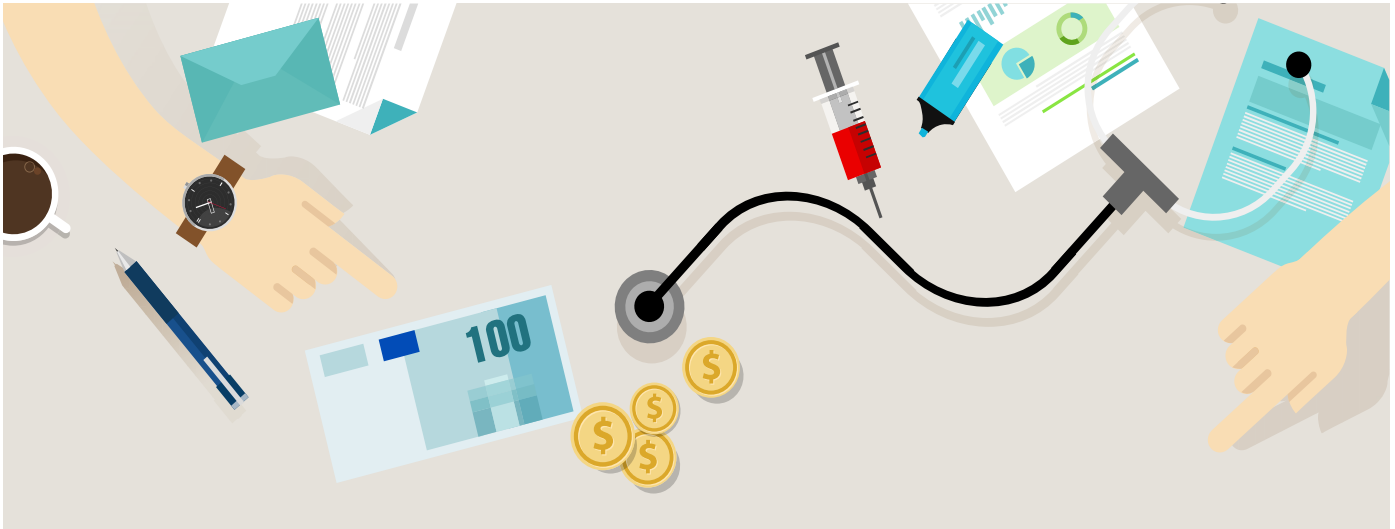
Goals and Vision

In conclusion, when deciding which association to join, I offer this opinion: Look at the goals and vision statement. Does it match with your plans to grow your business? Does it offer any promotion in your field of distribution? If at the end of the day you find that the association can fill some need for bettering you as an agent or agencies, then take the chance invest in yourself. Is it better to have more than yourself working toward success? All the associations listed above have stood the test of time. Now we need to get off the fence and choose which one is best for us. ★

Yolanda Webb is president of Webb Insurance Solutions in Chino, Calif., Medicare Chairwoman of California Association of Health Underwriters and a member of the Nahu Medicare Advisory Council.

POLITICS, CONSUMER DEMAND AND TAX ADVANTAGES POINT WAY TO GROWTH FOR HSAs

by MORGAN ANTHONY



Consumers are making it clear that they want a seat at the table when it comes to their health care. From choosing their own doctor, to choosing the right insurance plan, consumers want options to help them make smart, cost-effective decisions at their own pace.

And with health care costs on the rise for just about everyone, consumers are looking for ways to save. They are also looking for more financial control over their own medical care spending. To meet this need, employers are offering more choices to their employees, with Health Savings Account-qualified plans becoming more popular across the country.

While the majority of large employers are still offering traditional health plans — and most employees are still choosing those traditional health plans — a shift is clearly happening. A recent data report by Benefitfocus, a benefits management software company, shows 56 percent of large employers now offer an HSA-eligible plan alongside more traditional offerings. This is up from 52 percent a year ago. Now, six out of every 10 large group health insurance offerings now include an HSA-eligible plan, providing their employees with the increased options they want.

Congress returned to session in 2017 and at the top of nearly every lawmaker's list was health care reform. As members of Congress from both sides of the aisle look to make changes to the Affordable Care Act, one thing remains common among potential solutions: HSAs.

The tax-advantage saving power of an HSA creates a way to relieve high premium costs and is one solution for reducing out-of-pocket health care costs for consumers.

In January, U.S. Sens. Rand Paul, Bill Cassidy and Susan Collins, among others, all introduced potential replacements for the Affordable Care Act. Although these plans have yet to be vetted and approved, the one constant throughout the proposed bills is the continued use of HSAs.

Whether health care legislation changes or remains the same, HSAs continue to grow in popularity among Americans. In fact, recent research shows that the number of Americans opening an HSA account as of July 2016 increased to 18.2 million, representing a 25 percent increase from last year's total. Plus, HSA contributions increased for almost every age group referenced in the report by Benefitfocus, with millennials saving up to 20 percent more than the previous year.

The tax advantage of HSA accounts is a big motivator to save and invest for many consumers. HSAs provide a cost-effective way for employees to tackle rising health care costs and, at the same time, get tax advantages. For the 2017 plan year, eligible employees contributed more on average to their HSAs with increases of about 5 percent for individuals and 2 percent for family coverage.

HSAs Are Here to Stay

We are all waiting to see how changes in health care policy may impact the insurance industry and the healthcare marketplace. With 2017 just getting underway, we may not have answers for a while. But right now, we can see changes in how consumers are choosing their health plans. We also can see that consumers want more control over their health care spending and saving, and employers are offering more options to their employees, particularly HSA-qualified plans. There's no doubt that HSAs are here to stay, and are expected to grow in the future. ★

Morgan Anthony is vice president of sales at SelectAccount, an HSA administration company on Yankee Doodle Road in St. Paul, Minn. Morgan. Anthony@SelectAccount.com.

How to Help Your Clients Address Questions About Disability Leave

By BRIAN KOST



When helping employers navigate the world of employee disability leaves, the number one question I hear from them is: “When can I expect my employee to return to work?”

For many of your clients, it can be tough to navigate the complexities of disability leaves and extended absences. That’s because an employee nearing the end of his or her disability leave, or another form of protected leave, may need additional assistance and accommodations to return to work.

Your client may have limited infor-

mation about the employee’s medical condition and may not know what questions they are able to ask an employee about his or her condition to determine what types of accommodations need be implemented.

As a broker, you can help put your clients on the right path to help an employee return to work by encouraging the employer to form a partnership with the disability carrier. Educating your clients about the benefits of working with a consultant from the carrier can help determine a course of action and help an employee return to

work successfully. The key to this is establishing contact between the disabled employee and the disability carrier’s consultant.

Legal Regulations

A consultant from a disability carrier can help consider legal regulations that need to be followed when implementing workplace accommodations. This includes the Americans with Disabilities Act Amendments Act, which requires an employer to provide reasonable accommodations for an employee with a disabling condition. Reasonable

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accommodations can include anything from extending medical leave to ergonomic accommodations or equipment, and vary depending on an employee's job function and medical condition.

To help ensure an employee receives the right type of assistance, consultants can help evaluate the employee's job function and work space, and contact the employee's medical team for more information about his or her condition. This approach can help

'Connecting your clients with their disability carrier can help position you as a resource that ensures your clients are getting the most from their benefits.'

your clients think through what types of accommodations could make sense and how to craft a plan to help an employee return to work successfully.

Disability consultants can communicate with employees directly. Consultants can check in with the employee while he or she is out on a disability leave to see how they are recuperating and set the groundwork for a return-to-work plan. In addition, consultants can talk with the employee's medical team to determine any limitations or restrictions the employee would need to follow when returning to work and what accommodations could be useful.

Also, consultants will stay in touch with employees after they return to work to ensure they are following all mandated medical restrictions and will inquire how the accommodations are working and if other accommodations would need to be considered to help the employee further.

Assessing and sourcing equipment

If an employee's accommodation includes adaptive equipment or workstation modifications, a disability consultant can provide recommendations on solutions that can help meet an employee's medical requirements. This assistance can even extend to finding the right vendors, sourcing equipment and working directly with your client's

facilities services team to get the accommodations installed.

Consultants can also advise your clients on how to help the employee recover while returning to work in a different capacity.

For example, a few outside-the-box ideas have included the purchase of a motorized scooter for an employee who had trouble making the long walk between campus facilities; a custom-crafted stool to help an employee who couldn't stand for hours at a time when working on a production line; and even the creation of a temporary telecommuting job for an employee who has the capacity to work from home for a few hours every day.

In many instances, a solution for an employee's medical condition may

be offered by a different employer-sponsored benefits provider, such as a disease management, wellness or employee assistance program. Disability consultants can serve as the liaison between programs and collaborate with other carriers to find the best solution for an employee, keeping your client informed all along the way.

Connecting your clients with their disability carrier can help position you as a resource that ensures your clients are getting the most from their benefits. ★

Brian Kost is senior director of the Workplace Possibilities Program at Standard Insurance Co. in Portland, Ore. He holds a master's degree in career and guidance counseling and is a certified rehabilitation counselor and ergonomist.





Life Settlement Underwriting Gets Up to Speed

Most insurance professionals have either represented a client in a life settlement, know someone who has been involved in a settlement case, or at least has a contact in the industry who can help should the need arise. There is a renewed interest within the life settlement industry to re-engage, educate, and promote the option as the market has somewhat recovered from the decline that occurred in 2008 due to major increases in life expectancy projections coupled with a significant withdrawal of institutional investors. The market for these purchases has stabilized in regards to pricing and underwriting, and

by SCOTT KIRBY

policy seller complaints are now almost non-existent. But it has still been an uphill battle to regain confidence among insurance professionals.

The life settlement option is a valuable consideration for seniors wanting to end premium payments while preserving some death benefits for their heirs. Meanwhile they have greatly benefitted from the billions of dollars they've received, which they've used for everything from supplementing retirement funds, to reinvesting in other financial products.

There are now two approaches:

Simplified underwriting: A current surge has institutional investors representing a number of pension funds, family offices, and life settlement opportunity funds entering the field. Last year marked a revolution in life settlement underwriting for several industry leaders. Most of the red tape between initial contact and pricing has been removed, and more cases are qualifying than in the past.

Underwriting a life settlement case has traditionally involved collecting about four years of medical records on the insured, engaging a third-party life expectancy company to review the records, and then assigning debits and credits that reflect the insured's medical history. This process could take up to three weeks, and usually cost thousands of dollars without any certainty that the policy would price.

Rapid Review

Simplified underwriting differs from traditional underwriting in a few key ways. Instead of relying on costly medical records and third parties, a medical interview is conducted by an underwriter that addresses a number of key health areas to determine life expectancy. Information concerning daily activity, medical issues, types of physicians visited and prescribed medications is all collected during the 20-minute evaluation. The results of the medical interview are entered into an advanced analytics program to determine an extremely accurate mortality evaluation that delivers a pricing decision in less than 24 hours. That allows the client to obtain an offer based on individual medical impairments with no loss in accuracy.



Contracts can be delivered within 48 hours and money confirmed in a third-party escrow account. Over the course of three days, a policy seller can get a fair and timely offer. This is all possible due to advances in simplified underwriting and the confidence from Investors in these proven techniques.

Underwriting without life expectancy: This is not the same as simplified underwriting. While both methods involve purchase of a policy with short turnaround, no-life-expectancy underwriting is primarily used to purchase policies from healthier individuals with guaranteed universal life policies. The only underwriting used is standard mortality tables to access longevity risk. Qualifying for no-life-expectancy buying typically involves clients who are between 77-80 years old and are extremely healthy. Offers can typically be generated in less than 24 hours. Clients who are typically declined due to a longer life expectancy with traditional or simplified underwriting, will often benefit with a no-life-expectancy purchaser. Underwriting without life expectancy serves a valuable niche in today's market and works hand-in-hand with traditional and simplified underwriting.

What's Next?

The National Association of Insurance Commissioners found that \$112 billion dollars of life insurance is forfeited annually. In addition, one study showed 90 percent of seniors with lapsed policies would have considered a life settlement if given the opportunity. Insurance professionals have an obligation to their clients and should be aware if their clients could benefit from a life settlement.

The industry has maintained an exciting trend of growth in recent years due to investor confidence in underwriting stability, cleaner origination, higher levels of transparency, and fair and reasonable regulations. Every indication suggests that trend should continue for many more years as industry insiders continue to develop innovative techniques to deliver value with better service and results. With life settlements becoming more mainstream and awareness being fueled by TV and radio advertising, clients are looking toward their insurance professional for guidance. ★

Scott Kirby is a managing partner at Abacus Settlements in Orlando, Fla., a purchaser of life insurance in the secondary market. <https://abaculifesettlements.com>

How Stop Loss Insurance Can Ease Employers' Fears

by NICK FAVRO



Many employers around the country are all struggling with the same problem: rapidly rising health plan costs while deductibles and out-of-pocket expenses are increasing. Employers are wrestling with how to best control these costs while providing the best health insurance possible. In today's environment,

all companies should take a hard look at how best to manage increasing health insurance costs and weigh fully insured versus self-insured medical plans. With a variety of benefits offered by self-insuring, it's no surprise that this has become an increasingly attractive option among companies.

A fully-insured health plan is the tra-

ditional way to structure an employer-sponsored health plan. The insurance carrier collects the premiums and pays the health care claims based on the group's coverage. Premium amounts are negotiated and set for the plan year. In a self-insured environment, an employer will pay a monthly administration fee to an insurance carrier or third

party administrator and fund a bank account from which claims payments will be deducted. This is the inherent risk in self-insurance: the unknown volatility of what future claims will be. For most small to mid-size business owners, the idea of self-funding insurance costs for employees and their families is a frightening thought. What would happen if suddenly a few employees or their family members had serious health issues? A self-insurer would be responsible for paying these medical costs. Does the business model have the cash flow to sustain the plan during high claim months? What employers may not realize is the risk is minimized and controlled by purchasing stop loss coverage.

What Is Stop Loss?

Stop loss insurance is purchased to insure against high claims and to limit the employer’s risk. There are two main types of stop loss insurance: specific and aggregate. Specific stop loss insurance covers each individual’s claims and insures against large catastrophic expenses incurred by members enrolled in the medical plan. The employer and insurance carrier set a dollar threshold which acts as a maximum limit, after which the insurance carrier is responsible for additional expenses. For example, an employer can decide that they are willing to pay for a member’s claims below \$50,000. The insurance carrier would then be responsible for any amount above that threshold in a plan year. Aggregate stop loss insures the employer’s medical plan to a maximum annual claim amount. The insurance carrier will provide a claim rate that is applied monthly to enrollment and at year end; this is the aggregate stop loss amount. This coverage is often times called “sleep at night” insurance for employers because it limits the annual claim liability.

Advantages to self-insurance include tax savings, and the potential for better-than-expected financial results.

Employers can expect to receive more robust reporting that details member claim utilization. While many employers do not want to have this data, and they don’t have to access it, your consultant will have the knowledge and ability to effectively man-

age the plan and communicate it to the employer and covered members for better outcomes and cost results. This will ultimately help steer the employer toward providing the type of benefits that make the most sense for their employees. Self-insured plans are subject to the Employee Retirement and Income Security Act but aren’t constrained by state insurance laws and state coverage requirements. The introduction of the Patient Protection and Affordable Care Act as well as premium increases for fully insured plans, contributed to employers’ interest in self-insurance. Any savings that a self-insured employer realizes is captured in real time and can be immediately ap-

plied to the company’s general fund. A fully insured employer must wait until contract renewal to realize any reduction in premiums due to lower costs, fewer claims, and the insurance consultant’s negotiating ability.

ployer should be ready for a three- to five-year commitment to self-funding as there is typically a high claims year in every three-to-five year cycle. Risk is minimized as the number of employees and family members enrolled in the plan increases. Smaller employers are more likely to have unpredictable claim spikes. As the size of a business grows, the rewards begin to outweigh the risks.

Some employers prefer the predictability of a fixed premium payment to insurance carriers, allowing for a set health insurance budget, based on total enrollment that won’t deviate throughout the year. Keep in mind, however, that an employer is not im-



plyed to the company’s general fund. A fully insured employer must wait until contract renewal to realize any reduction in premiums due to lower costs, fewer claims, and the insurance consultant’s negotiating ability.

Look at Risk

Self-insurance is not the right approach for every employer. It’s important to weigh insurance options and risk tolerance before deciding whether self-insurance is a good fit for a company. While there could be substantial cost savings to implement a self-funded plan, there are some additional risks. In any individual year an employer could experience increases in their overall health insurance expense, should they have unusually high claims. The em-

ployer should be ready for a three- to five-year commitment to self-funding as there is typically a high claims year in every three-to-five year cycle. Risk is minimized as the number of employees and family members enrolled in the plan increases. Smaller employers are more likely to have unpredictable claim spikes. As the size of a business grows, the rewards begin to outweigh the risks.

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Nick Favro is a regional underwriter at Epic Insurance Brokers and Consultants in San Francisco.

How to Help Workers' Well Being Through Financial Planning

by TJ GIBB



By taking a broader view of wellness – one of well being – we realize that physical health is only one aspect of creating a balanced lifestyle. Other aspects of well being, such as financial health, are critical, too, and are linked to physical

and emotional health. Employers are starting to take notice of the broader concept of well being and in particular, the impact of financial health on healthcare costs and productivity.

The American Psychological Association reports money issues as

the most common cause of stress in America. That should come as no surprise, as three-quarters of American workers live paycheck to paycheck. The stress of managing personal finances carries over into the workplace. A recent study showed



that 46 percent of employees admit to spending two to three hours per week on personal financial matters while at work.

How do we help employers connect the dots between physical and financial health and well being? An emerging area of focus for employers is to help employees establish financial security now and in the future. These efforts can range from having enough money to pay for daily living expenses to saving for significant future expenditures, such as a home, college tuition for kids and retirement.

Brokers are in an excellent position to share the advantages of voluntary benefits that can help employees relieve financial stressors. Ideally, employers should find one provider that can help with both of these items. This provider should offer solutions that increase engagement in wellness plans, incentivize employees for the proper behaviors and ultimately improve the physical and financial health of the workforce.

Well-Being Strategies

When employers help employees with their personal health, medical claims costs can be positively impacted. A big part of that is providing ways for employees to manage chronic health

conditions, especially since 45 percent of Americans have such a condition. Health care coverage for people with a chronic condition can equate to more than 87 percent of health claims expense.

Through a quality wellness plan, employees are encouraged to participate in health and wellness initiatives and may even be incentivized to take action with health screenings, flu shots or step challenges. Some employers offer discounts on their employees' portion of health insurance premiums or other rewards to incentivize employees to engage in wellness activities. A study on obesity has shown that monetary incentives provide a higher completion rate compared to non-incentivized groups at a success rate of 62 percent versus 26 percent.

The benefits of providing a more comprehensive well-being strategy include improved employee satisfaction and retention, positive culture, increased productivity, fewer absences, lower operating costs and ultimately better financial results for the employer. Healthier and happier employees perform better.

If we look at the typical American worker, many are financially insecure when it comes to daily living expens-

es. A recent survey conducted by the Federal Reserve Board to monitor the financial and economic status of American consumers revealed 47 percent of respondents said they would cover a \$400 emergency expense by borrowing money, selling something or would not be able to come up with the money at all.

Many employees are faced with the reality that they will develop a critical illness. For example, 40 percent of American men and women will be diagnosed with cancer in their lifetime. Living with a cancer diagnosis or suffering a cardiac event can be very costly. Health plan deductibles and out-of-pocket expenses due to an unexpected illness can cripple family finances. Similarly, when an employee experiences an accident, they might not be prepared to deal with the financial implications.

Other Insurance

For decades, products such as disability and life insurance have been available to employees to protect short- and long-term obligations. These are incredibly important products, but, times have changed. Even the gainfully employed have day-to-day budget concerns. Health plan deductibles and out-of-pocket amounts can easily be thousands of dollars. This financial liability has largely become the responsibility of the employee.

To combat this challenge, supplemental health insurance has become very popular and commonly includes accident, critical illness and hospital indemnity plans. These plans help manage an employee's existing living expenses and/or health plan deductibles and out-of-pocket expenses.

Employers are well served to provide employees options to better protect themselves and their families from unexpected financial burdens. To that end, voluntary benefits provide employers with a means to meet these needs at little to no cost to the company.

Don't get left behind. Help your employers to maximize their well being – both physical and financial. ★

TJ Gibb is vice president, Workplace Voluntary Benefits Segment, at Humana Inc. in Louisville, Ky.

Employers Need to Be Prepared for the IRS

Documentation Is Key to Avoiding Penalties Resulting From an Audit of ACA Issues

by JOANNA H. KIM-BRUNETTI

Post election, in December of 2016, the Internal Revenue Service began to issue notices to employers who may have failed to comply with the Affordable Care Act. These notices appear to be the first salvo in the IRS ACA audit process. Failure to successfully defend this audit could mean significant ACA-related penalties. These penalties may be imposed on Applicable Large Employers, namely, those employers with 50 or more full-time or full-time equivalent employees.

There are different types of penalties. Section 4980H penalties are comprised of "A" and "B" penalties. The "A" penalties are for large employers that fail to offer minimum essential coverage to 95 percent of their full-time employees at an annualized rate at about \$2,000, multiplied by the total number of full-time employees. "B" penalties apply if coverage failed to meet criteria, and are at about \$3,100 times the number of full-time subsidized employees.

Section 6721/6722 penalties apply to failure to accurately and completely file returns to the IRS and failure to furnish accurate and complete statements to the applicable employees in the form of the appropriate IRS schedules. These penalties can reach \$260 per return on an employee basis, adding up to more than \$6 million for combined filing and employee statement distribution failures. Moreover, the employer penalties are double for a willful failure. The employer bears the burden of showing that any failure to comply was despite reasonable diligence.

So what must a large employer do to defend against an IRS audit? Here are

some of the key areas to show compliance.

During an IRS audit, the employer has the burden to prove that the company offered minimum essential coverage to 95 percent of its full-time employees. If the employer does not concede that all of its employees are full-time, it can be challenging to prove that some or all of its employees should not be counted. To do so, the employer must be able to prove that the company has correctly identified its full-time employees. This often involves conducting the look-back measurement method sanctioned by the IRS.

The employer will also need to show that it made the offers of coverage to all applicable employees in a timely manner. Unless the employer is going to concede that each applicable employee should have been offered coverage for every month of the reporting year, the employer must prove that, for the months that the applicable employee was not offered coverage, there was an applicable exclusion under the IRS regulations. That could include when the employee was hired and the applicability of various limited non-assessment periods.

How does the employer go about proving the above? Documentation is key. Regardless of whether the monthly measurement method or the look-back measurement method was used to determine full time status of employees, the employer will need to provide documentation of how the chosen method was applied and that it was applied correctly under the IRS regulations, including the timing of the offer of coverage. Moreover, the employer will need to provide documen-



tation justifying the application of any limited non-assessment periods.

Applicable large employers are strongly encouraged to utilize a platform that will document the full-time-employee status tracking and the timing of the offer of coverage along with all of the various human resources data that are relevant to the offer of coverage, including hire and rehire dates, termination dates, leaves of absences and other factors.

In conclusion, employers that are notified by the IRS of an ACA audit will need to get their documentation ready to justify the content of their relevant schedules or face substantial penalties – both for failing to offer the appropriate coverage to applicable employees and for failing to file and furnish employee statements completely and accurately. ★

Joanna H. Kim-Brunetti is vice president of regulatory affairs at First Capitol Consulting, a Los Angeles benefits company that offers a platform providing the tracking needed to document ACA compliance in the face of an IRS ACA audit.

San Diego Brokers Let the Boom Times Roll

by Steve Silkin



The timing was excellent. The Dow Jones Industrial Average, a leading economic indicator, was flirting with 20,000 – up from 6,600 in 2009. The national unemployment rate, another leading indicator, was at 4.7 percent – down from 9.8 percent in 2010.

The mood at the Sales Expo of the San Diego Association of Health Underwriters in January was in accordance with the climate.

Among the most buoyant of spirits at the expo: Jeff Welty of the Colonial

Life in San Diego, a 42-year industry veteran who has never seen a boom like this.

“We just had our annual meeting, our national sales meeting. Our sales nationally are up double digits,” he said. “That’s five years in a row, 12 percent to 13 percent year-over-year increases. The number of new accounts was up 20 percent. Our numbers are through the roof.”

He thought that the strong economy might play a role in the remarkable re-

sults, but he wasn’t certain.

“I don’t know if I can explain it. But I’m sure enjoying it.” His own office far outperformed the national figures. “Our sales were up 100 percent on new accounts,” he said. His brokerage handles policies for voluntary benefits accidents, cancer care, accidents. “But our big seller now with Obamacare is the gap insurance, and high deductible plans.”

He sells group and individual health care plans to companies with three



employees and up to 1,500 or more.

"I do the largest auto chain in the county; they've got a few dozen dealerships. We do the City of Los Angeles. We have no top end."

How does he expect to follow up on 2016, when new accounts doubled?

"I believe we're going to do better this year," he said. "By a lot."

'Silver Wave'

For Hector Lazaro of Care1st, it's not so much the economy that has him excited, it's the demographics.

With 10,000 people turning 65 each day – the retirement-age onslaught of the baby boomers – the Medicare market is going bonkers.

"That means there's an opportunity," Lazaro said, especially here in California, where the numbers are about 1,000 per day. "That means they're going to be looking for a Medicare supplement or Medicare Advantage plan. And our specialty is the Medicare Advantage plan."

In what's called the "silver wave," Lazaro noted this is the largest-ever segment of the population that's turning 65, so he's looking forward to increased enrollment.

But even if 1,000 Californians turn





Neil Crosby

65 each day, how do you sell policies to them?

"We use field marketing organizations," he said. "They reach them by mail. Or they work with the large groups to educate the human resources person about Medicare, so when the employees come to human resources, the employer can save money by taking the individuals off the group plan. Then they call us and we put them on the individual plan."

How does that help? "It helps the employer because their rates are going to drop. If the employer keeps those individuals on the group plan past 65, there's going to be a rate increase because there's a high risk."

Welty agreed that it's an important move that presents opportunities.

"We have a lot of employees going on Medicare," he said. "We take care of them."

Gail James Clark, executive director of the San Diego underwriters' board, noted that the upbeat mood could also be attributed to optimism over the prospect of political changes.

"It's a good time because there's a new administration coming in and a lot of new things happening here," she

said. "It's going to be a good time for a lot of different changes. We'll see. I'll keep my fingers crossed."

Changing Times

The event took place at the Town and Country Resort and Convention Center on the eve of the inauguration of President Donald Trump. His campaign platform included the repeal of the Affordable Care Act, otherwise known as Obamacare, which put extreme downward pressure on broker commissions.

Fifty-four exhibitors were represented at the event, up slightly from the previous year, with some purchasing double-booths. Tech companies were well-represented.

"We have a lot of new tech groups coming out: They're wanting to show their products and try to market to the health insurance agents," she said. "That's where we are in the world today. That's the No. 1 key of trying to build your business: to be technologically sound and up to date."

She was also happy to see that companies sent brokers who were new to the event.

"We're bringing in a lot of new folks

to the programs," she said. "We have exhibitors that are bringing brokers that haven't been here before. More so than last year."

Amid the optimism, challenges persist.

Neil Crosby, director of sales at Warner Pacific, discussed what a post-Affordable Care Act landscape might look like amid questions over "repeal and replace." Marketing guru Shaun Alger, managing partner at VoloHaus in Carlsbad, warned brokers not to expect miracles: The insurance companies aren't anxious to restore commissions to the pre-Obamacare days. Mark Haskell, association president, noted that insurance companies reported to boards that demand profits. He suspected he would not get a warm welcome from company directors if he were a chief executive who said:

"You know those policies we sold last year and lost money on each one? Let's sell more of them this year and lose even more money."

In fact, he said he'd be thrown out of the company so fast no one would remember him a few minutes later.

Even in boom times, no one's allowed to be stupid. ★

DEPENDENT VERIFICATION DONE RIGHT: Best Practices for a Smooth Review

by MARK HELTON



If an employer is considering completing a dependent verification review, several questions have likely popped into his head. How long will it take? How much does it cost? And is it worth the investment? More than likely, he's concerned about how completing a dependent review will impact your employee morale and the overall employee perception of your organization and its culture. These are all valid questions worth answering. Below are ways to address the top concerns employers face when considering a dependent review project.

Is annual enrollment the right time of year to conduct a dependent review? The best practice for timing a dependent review is the first quarter after your annual enrollment season. While it may seem like conducting a review while you're completing enrollment could cut down on workload and reduce the amount of ineligible dependents on plans, it can actually cause confusion for employees and more

work for HR in the long run. Because dependent reviews do not typically run on the same timeline as annual enrollment, there is often confusion around deadlines, which results in missed enrollments or verifications.

If the quarter following your dependent review is not the ideal time for your organization, the second and third quarters following are still acceptable time periods.

Cost and Savings

Is a dependent review worth the expense? Some employers find that between 5 percent to 12 percent of their insured dependent population is actually not eligible to be on the plan they've selected. At an average healthcare cost of \$3,940 per person annually, that is an expense that adds up quickly for an employer.

In addition to the upfront cost of ineligible dependents, if a claim were to be declined, 100 percent of that healthcare expense could become the responsibility of the employer or the employee.

How will employees react to a dependent verification review? The reaction from your employees is highly dependent on how you approach and communicate about the dependent verification review process. The more effectively you communicate the reasons that a dependent review is being conducted and the protection it provides to employees who otherwise run legal and financial risk, the more successful the dependent review will be. When a review is supported by effective communications, employees come away appreciating their employer for taking steps to protect them and

their finances.

How will executives feel about completing a dependent verification review? Most executives understand the need for mitigating the costs and risks associated with keeping ineligible dependents on an employer-funded healthcare plan. Their biggest concern will likely be around the communication with their employee population. Communicate with your executives early and often, and ensure they have answers to the most frequently asked questions before their employees come to them for answers.

Document Submission

How should employees submit verification documents? It's important to make sure employees are able to submit documents in a way that works for them. This helps decrease the friction around completing a dependent verification review. Many employers find that having a submission portal, mail-in options, fax and scan availability, and even accepting photographed documents can help increase the speed and efficiency of document submission.

When you begin a dependent verification project, it is easy to feel overwhelmed by the impact it may have on your organization. But it is important to remember that communication is the most critical aspect of a review. Ultimately, you are helping protect your employees and their dependents from unplanned financial and legal burdens. ★

Mark Helton is responsible for dependent verification strategic initiatives for Hodges-Mace clients and brokers, with 25 years human resources management experience. Hodges-Mace is an employee benefits administration company in Atlanta.

Two Mega-Mergers Blocked

Plus: Chaos Reigns Over Future of Obamacare
New Products...Philanthropy...People

MERGERS

Anthem-Cigna and Aetna-Humana Deals Blocked

A federal judge in Washington, D.C., blocked the proposed mega-merger of health insurance heavyweights Anthem and Cigna. The \$54 billion deal — Anthem was trying to acquire Cigna — would have created the largest health insurance company in the nation. The decision follows a similar ruling that halted Aetna's bid for Humana Inc.

The judge's ruling came in a lawsuit brought against Anthem and Cigna by the U.S. Justice Department and the attorneys general in 11 states. The lawsuit argued that the merger would violate antitrust laws — basically, Anthem and Cigna are so huge that, when combined together, they would smother competition in the health insurance marketplace. And that would be bad for consumers because it would reduce the incentive to keep costs low and would likely instead drive up the prices of insurance plans.

U.S. District Judge Amy Berman Jackson noted that Cigna and Anthem are two of only four insurers currently that offer a nationwide network capable of serving the country's largest employers. That alone was reason to block the merger, she wrote, although she suggested that Anthem's and Cigna's combined might in other areas of the insurance industry also concerned her.

Earlier this year, a judge blocked the \$37 billion merger of Aetna and Humana, upholding the Justice Department's decision that the deal would hurt competition and raise prices for consumers.

"The Court is unpersuaded that the efficiencies generated by the merger will be sufficient to mitigate the anti-competitive effects for consumers in the challenged markets," U.S. District Judge John D. Bates wrote.



Jason Chaffetz

HEALTH CARE REFORM

ACA Focus of Angst at Raucous Town Hall Meetings

More than seven years after angry anti-Obamacare town halls erupted across the country, raw emotions are boiling over again — this time, as the Republican Party under President Donald Trump gears up to dismantle Barack Obama's legacy.

And the fury is flaring up in some of most conservative corners of the country. Two Republican members of Congress — Reps. Jason Chaffetz of Utah and Diane Black of Tennessee — were each confronted with impassioned constituents during simultaneous events. The shouted questions, emotional pleas and raucous protesters of the evening crystalized the GOP's tough political road as it forges ahead with rolling back Obama's accomplishments, including the Affordable Care Act.

In suburban Salt Lake City, local police estimated that some 1,000 people packed into a high school auditorium to see Chaffetz as hundreds more



Diane Black

waited outside. For 75 minutes, the congressman confronted a crowd that fumed with resentment of Trump and accused Chaffetz of coddling the President. And some 1,700 miles away in the town of Murfreesboro, Tenn., Black was met with roughly 100 protesters at an "Ask Your Reps" event hosted by the Middle Tennessee State University's College Republicans. The complaints about the pending repeal of Obamacare without a substitute in place were similar.

* * *

Hospital Execs Say 'Show Me the Money'

Hospital executives have met with lawmakers in Washington, D.C., and expressed concerns over losing insured patients and revenue under an Affordable Care Act replacement plan, according to a report in the Wall Street Journal.

The executives have said they do not want Americans to lose insurance under any Republican ACA replacement plan, according to the article. But

if that happens, the report states, they want Congress to restore billions of dollars in federal funding they lost with the ACA.

This federal funding includes disproportionate share payments for some hospitals to help them care for uninsured and low-income patients. It also includes annual raises the federal government paid hospitals for treating Medicare patients.

The report notes hospitals lost this federal funding with the belief the ACA would make up for the cuts by providing hospitals with more insured patients.

"If you're going to repeal the Affordable Care Act, we need to have the cuts repealed as well," William Carpenter, chief executive at LifePoint Health in Brentwood, Tenn., said during a San Francisco healthcare conference in January.

CALIFORNIA NEWS

Zenefits Lays Off 430, Moves to Arizona

Beleaguered San Francisco human resources startup Zenefits, known for an HR memo asking employees to stop having sex in the stairwells, is laying off 430 employees, or almost half its workforce, the company said, and will centralize its operations in Arizona.

The cuts and restructuring come as the company continues to grapple with continued fallout from a year of high-profile setbacks.

"This isn't how any CEO would choose to spend his first week on the job," Chief Executive Jay Fulcher said in the email to staff first reported by BuzzFeed. "But I strongly believe these difficult decisions are essential in setting Zenefits up for success."

The cuts are the third round of layoffs at the San Francisco based company in a year, and come just a week after Fulcher was named chief executive — the company's third in under a year.

About 430 workers will be cut, including 250 in Zenefits' San Francisco headquarters and 150 in its office in Tempe, Ariz., leaving the company with about 500 employees.

The once-hyped company was beset by scandals for most of 2016. First



Jay Fulcher

it was put under scrutiny by regulators in multiple states on suspicion of selling insurance through unlicensed brokers; that news forced the resignation of founder and CEO Parker Conrad.

That led to a revelation that the company had access to a software tool that let them avoid California regulatory requirements for obtaining a license to sell insurance. Just weeks after that, the San Francisco Business Times reported that Zenefits had a hard-partying office culture that forced its HR director to request employees last summer stop having sex in the stairwells.

* * *

Covered California Enrollment Falls 3 Percent

The number of Californians newly signed up for health insurance through Covered California, the state's insurance marketplace created under the Affordable Care Act, dropped 3 percent compared with last year, according to enrollment figures released by Covered California.

About 412,000 people signed up for health plans through the exchange

during the open enrollment period for 2017, compared with 425,000 who signed up during open enrollment last year.

The falloff comes amid a national decline in enrollment in health plans through Healthcare.gov, the federal insurance marketplace used in several dozen states but not California, which fell for the first time, according to figures released by the Centers for Medicare and Medicaid Services.

The number of people signed up for Healthcare.gov plans fell by 500,000, or about 5 percent, to 9.2 million people. The drop coincides with continued promises by President Trump and Republicans in Congress to repeal and replace the Affordable Care Act, President Barack Obama's signature health care law.

* * *

Uninsured Rates Could Climb Under Repeal

While the GOP-led Congress promises to 'repeal and replace,' new studies show repealing parts of the ACA could result in the number of uninsured Californians increasing above pre-ACA levels.

After the ACA was passed, California saw the largest decline in the uninsured rate in the nation, dropping from 6.5 million in 2013 to 3.3 million in 2015. A study out of UC Berkeley and UCLA shows how that could shift in the other direction.

Low income workers, young adults, part-time workers, and Latinos were least likely to have health insurance before the ACA. If repealed, these groups stand to lose coverage gained under the ACA.

While increased coverage can also be attributed to an improving economy and more employers offering coverage, most Californians were able to gain coverage under the expansion of Medi-Cal and through Covered California.

Medi-Cal enrollment went up by 5 million under the ACA; 3.7 million were newly eligible enrollees under the expansion. But if Medi-Cal is replaced with block grants or the government applies a per capita cap on federal funding, 9.8 million enrollees could lose eligibility or benefits.

NATIONAL NEWS

Blackstone Funds Buy Aon HR Platform

Blackstone in New York today announced that affiliated private equity funds have entered into a definitive agreement to acquire Aon technology-enabled benefits and human resources platform, currently part of Aon Hewitt, for cash consideration of up to \$4.8 billion, including \$4.3 billion at closing and additional consideration of up to \$500 million based on future performance.

The business is the largest benefits administration platform in the United States, and a leading services provider for cloud-based HR management systems. It serves approximately 15 percent of the U.S. working population across more than 1,400 companies. Aon and the new, stand-alone company will continue to work together on behalf of shared clients and prospects.

"We are excited to acquire a world-class leader of scale in health, retirement, and HR services, providing critical human resources and benefits administration services to millions of employees and their families throughout the United States and Canada," said Peter Wallace, a senior managing director at Blackstone. "Blackstone sees tremendous opportunity for investing in leading businesses within the technology-enabled services sector, where we believe there is a significant opportunity to accelerate future growth."

* * *

National General Buys Quotit, HealthCompare

National General Holdings Corp. in New York will acquire Quotit Corp. and HealthCompare from Word & Brown Cos. Quotit is an application service provider for the health insurance and employee benefits industry that directly connects insurance companies, brokers and retail consumers with insurance rates and benefits online. HealthCompare is a call center operation as well as a consumer facing website that connects individuals, families and seniors with major medical or Medicare related coverage.

National General Chief Executive Barry Karfunkel stated: "Quotit is one of the largest comparative raters that exist in the market today and we look forward to leveraging their platform to enhance our offering within the A&H marketplace. HealthCompare enhances the scale of our A&H segment by broadening the scope of customers that we are able to connect with health policies through a direct to consumer platform, while allowing more seamless sales of Medicare and other health insurance product lines by leveraging the same platform as Velapoint. We are able to expand the Medicare platform by bringing those products to our independent agents currently selling our health insurance products."

NEW PRODUCTS

Shepler & Fear Introduces Excess Loss Insurance

Shepler & Fear General Agency of Rosville, Calif., has introduced a new product in the group health marketplace – Employer Excess Loss Insurance.

Employer Excess Loss Insurance can be written to provide a coverage layer that protects the employer from overall high medical claim risk exposure.

Excess Loss was developed for two specific applications: First, for employers who are offering a Health Reimbursement Arrangement to their employees and desire to have their total risk exposure limited to a predetermined level. Second, for smaller employers who are self-funding their medical benefits by using an aggregate stop loss policy in a state that imposes a minimum annual aggregate attachment point.

In either case, Employer Excess Loss Insurance can be written to provide a coverage layer that protects the employer from overall high medical claim risk exposure. The cost of cov-

erage varies by the overall amount of risk protection purchased at the time of initial application.

For more information call Shepler & Fear, 877-361-7342 and ask for Jennifer Mason-Zoeller or David Fear Sr.

* * *

Annuity Indexes Unveiled

Great American Life in Cincinnati is expanding its annuity offerings with two new indexed strategies that earn interest based on the performance of the iShares U.S. Real Estate ETF and the S&P U.S. Retiree Spending Index.

The iShares U.S. Real Estate ETF provides exposure to domestic real estate companies and real estate investment trusts. Allocating money to the iShares U.S. Real Estate point-to-point indexed strategy offers a convenient way for contract owners to obtain exposure to potential upside in the real estate sector.

According to John Burhoe of Great American, the iShares U.S. Real Estate indexed strategy provides an opportunity for diversification.

"The real estate market tends to perform well when interest rates are low, which provides contract owners the opportunity to diversify their funds," he said. "Since returns on real estate typically vary from those on other asset classes, allocating to the iShares U.S. Real Estate indexed strategy may allow contract owners to earn interest even when other Indexes are performing poorly."

The S&P U.S. Retiree Spending Index provides exposure to economic sectors expected to be impacted by retiree spending.

PHILANTHROPY

Anthem Donates to USA Warfighter Sports

Anthem Blue Cross is supporting the Disabled Sports USA Warfighter Sports program to help severely injured service men and women rebuild their lives through sports. The Woodland Hills insurer is giving \$25,000 in support to this year's winter ski event.

The 2017 Ability Celebration and Winter Ski Festival served about 28 wounded warfighters and their families free of cost. They received instruc-

tion in adaptive alpine skiing, snowboarding and snowmobiling through Achieve Tahoe at four ski resorts in the north Lake Tahoe region of California Jan. 24-29. Through a combination of grants and corporate sponsorships, Anthem has given the group more than \$800,000 since 2009 in support of the Warfighter Sports program and other winter and summer activities.

"At Anthem, we are very proud to once again be the lead sponsor for this ski event," said Mike Wozny, president of Anthem Life. "This event is one way we can support those who have served our country."

Warfighter Sports offers sports rehabilitation for severely wounded warfighters in major military hospitals and communities across the U.S. through a nationwide network of more than 120 community-based chapters. Disabled Sports USA has served wounded warfighters, including those injured in the Iraq and Afghanistan wars, since 1967.

PEOPLE

David Taaffe to Head BenefitMall's California Sales

BenefitMall in Dallas, a provider of employee benefits, human resources and payroll products and services, announced the appointment of David Taaffe as regional vice president of California benefits sales, and national head of the account services division.

In this role, Taaffe will be based in California and will be responsible for leading the California benefits sales team. Additionally, as the national head of the account services division, Taaffe will provide resources to agencies that seek additional customer support beyond traditional general agency model.

"David brings a combination of financial acumen, sales experience and impactful relationships to our California market," said Bernard DiFiore, chief executive of BenefitMall. "This combination will best serve our California broker and carrier partners in successfully navigating the next generation of the benefits industry."

BenefitMall has partnerships with a network of 20,000 brokers and CPAs to



David Taaffe

deliver employee benefits and payroll services to more than 200,000 small and medium-sized businesses. By combining payroll and benefits, BenefitMall allows advisers to develop the best employee programs while maintaining compliance with government regulations and Health Care Reform.

* * *

Epic Names Adam Frugoli as Vice President

Epic Insurance Brokers & Consultants, a retail property and casualty brokerage and employee benefits consultant in Stamford, Conn., announced that Adam Frugoli has joined the firm as a vice president of Epic's Health Care Strategy Group.

Frugoli will be responsible for new business development, program design and management, marketing and coverage placement, and will oversee Epic's delivery of products and services to clients in the healthcare, consumer finance and banking industries. He will divide his time between Epic's new presence in Idaho Falls, Ida., and Epic's offices in Sacramento, Calif. Frugoli will report to Tom McCready, managing principal, Sacramento Property & Casualty Operations.

Frugoli brings more than 16 years of experience serving health care and financial services clients to Epic. He started his career in 2001 at US Bank N.A. where he was a vice president of branch investment advisory services, providing investment counseling, business planning and advisory services to physicians and other

medical industry professionals.

Frugoli spent eight years as vice president and insurance broker with the Leavitt Group where he focused on creating risk transfer strategies for accountable care organizations, hospitals, physician groups, individual doctors and long-term care centers. He has extensive experience working with complex health care clients.

* * *

Zachry Named to Fellowship

The Sedgwick Institute in Memphis, Tenn., has awarded a senior fellowship to risk management expert William Zachry. Sedgwick established the institute in 2016 as an interdisciplinary community of experts dedicated to elevating the dialogue around issues affecting the risk and benefits industry. As a senior fellow of the Sedgwick Institute, Zachry will work with Director Chris Mandel and Senior Fellow Dr. Rick Victor to pursue research and provide thought leadership on industry issues. He will also serve as a senior adviser to Sedgwick's workers' compensation practice group.

Zachry is known as a champion of workers' compensation reform. He serves on the board of the State Compensation Insurance Fund, California's largest provider of workers' compensation insurance; Zachry was appointed to the board by Gov. Arnold Schwarzenegger in 2010 and reappointed by Gov. Jerry Brown in 2014. He also participated in the design and implementation of regulations to bring greater equity to the California workers' compensation system.

"With so much regulatory uncertainty on the horizon, Bill Zachry's experience, expertise, passion and long-standing industry relationships will be invaluable assets to the Sedgwick Institute," said Dave North, Sedgwick president and chief executive. "This new role will allow Bill to share his tremendous knowledge and benefit the claims industry at large. We're thrilled to have him on board." □

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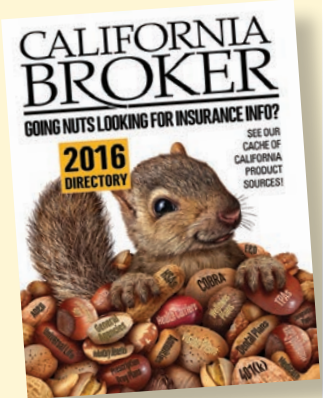
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