

CALIFORNIA BROKER

VOLUME 34, NUMBER 8

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Subscriptions and advertising rates, U.S. one year: \$42. Send change of address notification at least 20 days prior to effective date; include old/new address to: McGee Publishers, 217 E. Alameda Ave. #207, Burbank, CA 91502. To subscribe online: calbrokermag.com or call (800) 675-7563.

California Broker (ISSN #0883-6159) is published monthly. Periodicals Postage Rates Paid at Burbank, CA and additional entry offices (USPS #744-450). POSTMASTER: Send address changes to *California Broker*, 217 E. Alameda Ave. #207, Burbank, CA 91502.

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No responsibility will be assumed for unsolicited editorial contributions. Manuscripts or other material to be returned should be accompanied by a self-addressed stamped envelope adequate to return the material.

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TABLE OF CONTENTS

10

HEALTHCARE

Obamacare Exchanges Send Insurers, Consumers Running

by Sally Pipes
The ACA's exchanges now have a three-year record of dysfunction. Consumers and insurers alike are looking for a way out.



12

MEDICARE

How to Choose a Medicare Advantage Plan

by David Milligan
Smart brokers have discovered that adding Medicare Advantage to their portfolio makes a lot of sense



16

Medicare News

- Medicare Supplement Premiums Vary Widely
- Anthem Increases "New to Medicare" Discount on Plan F in California
- CMS Proposes to Test Value-Based Payment Strategies for Part B
- Groups Says that Divestitures Don't Keep Medicare Advantage Competitive
- PhRMA Opposes Part B Reimbursement

18

There's No Such Thing As A Free Lunch: Defining the True Value of \$0-premium Medicare Advantage plans

by Chad Houck
Offering no- or low-premium Medicare Advantage plans is a great way to get your foot in the door, but these plans don't work for everyone.

20

VOLUNTARY BENEFITS

Trumpeting Voluntary Sales: Our Annual View from the Top



How Blowing Your Own Horn Can Make Clients Aware of These Products

by Leila Morris
Executives highlight important trends in the market for voluntary benefits.

28

DOMESTIC PARTNERSHIPS

Domestic Partnerships in California: A Look at the Financial Benefits

by Andrew Vasquez
Many Californians are choosing domestic partnerships over marriage. Here are some of the potential financial benefits.

30

DISABILITY

Helping Clients Assess their Disability Insurance Needs

by Erik Dullenkopf
As a financial professional, I often find that clients overlook disability insurance.

32

Getting Started: A Proven Path to Absence Management Success

by Gene Lanzoni
More effective, efficient, and compliant absence management is no longer restricted to the largest employers.

34

The Value of Disability Insurance: Preparing Employees For The Unexpected

by Stephanie Shield
Brokers and agents need to explain to clients how important it is to have disability insurance.

40

HSA's

Mind the gap: How to Increase HDHP and HSA enrollment

by Rebecca Palm,
How to present a high-deductible plan so that employees are motivated by all of the advantages it offers.

42

LIFE INSURANCE

Flexible Premium Adjustable Life Insurance

by Mark J. Hanna, CLU, ChFC
It has been difficult to manage client expectations in a low-yield environment. But some carriers are making it even more challenging.

44

CRITICAL ILLNESS

Compelling Reasons for Your Clients to Purchase Critical Illness Insurance

by Ken Smith
How do you start selling critical illness? Find a good accident and critical illness plan and start asking your clients important questions.

ALSO IN THIS ISSUE:

Guest Editorial.....	6	New Products	45
Annuity Sampler.....	8	Classified Advertising	46
News.....	36	Ad Index	46

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A LETTER TO A (DEAD) PROCRASTINATOR

Richard Reich

Some of your clients know they need life insurance and “will get around to it someday” while others have started, but never completed the process of getting a policy. The following letter is in response to a very upsetting call I received. It was not a client’s spouse or child calling to get help filing a claim. While those calls are difficult for me, they give me the satisfaction of knowing that I helped the now-deceased person acquire a policy that will provide financial support for a family that is undergoing a rough time.

Dear Jack,

You can’t read this letter since you are no longer living on this material plane. I am writing to gather my thoughts so I can share this experience with others. A few days ago, I got a very troubling call from your mother-in-law on behalf of your newly widowed wife. She was trying to track down a life insurance policy your that widow thought you had purchased. I looked through my files while offering as much comfort as I could muster. These calls are never easy, even after so many years in this business.

When I found your file, I knew that it would offer no comfort to your widow and her mother because you never completed your application. Our records show that our staff sent you many e-mails and called many times requesting information that the underwriter needed to approve your application. It was a simple piece of information we asked you for at least eight times, to which you often replied that you would get to it soon. The insurance company closed your file after several months of trying to get this information from you, which might have taken you all of five minutes to provide. We sent you an e-mail to notify you of this ac-



tion and let you know that we would probably be able to get the underwriter to reopen your file if we could send them the information. But we closed your file too when you didn’t respond to several attempts urging you to send us this information.

When I told your mother-in-law, she was sobbing loudly, and your widow was sobbing in the background. Jack, I have to say that this is the worst call I have ever had in this business, not only because how uncomfortable it was speaking to your mother-in-law (and widow in the background), but also because I couldn’t stop thinking about the fate of your widow and your three children. I’m sure that it’s not going to be easy for them financially without the \$1 million that your policy would have left them. What troubles

me the most is that this could have been avoided if you had taken five minutes to finish what you started, but I’m sure you had more important things to do.

*Sincerely,
Your life insurance agent*

According to a LIMRA study, 85% of consumers agree that people need life insurance, but just 62% have coverage. Many people have misconceptions about the cost of life insurance. The truth is that life insurance is a lot more affordable than consumers think. And, one would argue, much more affordable than a situation like the one I described above. ★

Richard Reich is an insurance broker with Intramark Insurance Services.

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American Equity	A-	A- ICC13 MYGA (Guarantee 5) (Q/NQ)	S	2.70%*	5 yr.	None	9%, 8, 7, 6, 5, 0	Yes	\$10,000 (Q) & \$10,000 (NQ)	3.00%, age 0-75 & 2.10%, age 76-80**
		ICC13 MYGA (Guarantee 6) (Q/NQ)	S	2.90%*	6 yr.	None	9%, 8, 7, 6, 5, 4, 0	Yes	\$10,000 (Q) & \$10,000 (NQ)	3.00%, age 0-75 & 2.10% age 76-80**
		ICC13 MYGA (Guarantee 7) (Q/NQ)	S	3.15%*	7 yr.	None	9%, 8, 7, 6, 5, 4, 3, 0	Yes	\$10,000 (Q) & \$10,000 (NQ)	3.00%, age 0-75 & 2.10%, age 76-80**
*Effective 4/13/16. Current interest rates are subject to change on new issues. **Commission may vary by issue age and state. See Commission Schedule for details										
American General Life Insurance Companies	A	A+ American Pathway Solutions MYG (*Guarantee Return of Premium) (Q/NQ)	S	2.05%** 2.25%** ^b	5 yr.	None	8%, 8, 8, 7, 6, 5, 4, 3, 2, 1, 0	Yes	\$10,000 (Q&NQ)	1.5% age 0-75 .75% age 76-85
American General Life Insurance Companies	A	A+ American Pathway Fixed 5 Annuity (*Guarantee Return of Premium) (Q/NQ)	S	1.20%** 1.40%** ^b	5 yr.	None	9%, 8%, 7%, 6%, 5%, 0%	No	\$5,000 (NQ) \$2,000 (Q)	2.00% age 0-85 1.00% age 86-90
American General Life Insurance Companies	A	A+ American Pathway Fixed 7 Annuity	S	1.85%** 2.05%** ^b	5 yrs.	None	9%, 8%, 7%, 6%, 5%, 4%, 2%, 0%	No	\$5,000 (NQ)	3.00% age 0-85 1.50% age 86-90
*CA Rates Effective 3/14/16. First year rate includes 4.0% bonus 1 st year. a (less than \$100K) b(100K or more)										
American General Life Insurance Companies	A	A+ American Pathway Flex Fixed 8 Annuity (Q/NQ)	F	3.85%*	1 yr.	None	8%, 8%, 8%, 7%, 6%, 5%, 3%, 1% 0%	No	\$5,000 (NQ) \$2,000 (Q)	2.20% age 0-75 1.70% age 76-80 1.20% age 81-85
*CA Rates Effective 3/14/16										
Great American Life	A	A+ SecureGain 5 (Q/NQ)	S	2.10%	5 yrs.	N/A	9%, 8, 7, 6, 5	Yes	\$10,000	2.50% 18-80 (Q), 0-80 (NQ) 1.50% 81-89 (Q&NQ)
Effective 2/15/16. Includes .25% first-year bonus and is for purchase payments over \$100,000. Escalating five-year yield is 2.10%. For under \$100,000 first-year rate is 1.95%. Escalating rate five-year yield 1.95%.										
Great American Life	A	A+ SecureGain 7 (Q/NQ)	S	2.40%	7 yrs.	N/A	9%, 8, 7, 6, 5, 4, 3	Yes	\$10,000	3.50% 18-80 (Q), 0-80 (NQ) 1.50% 81-85 (Q&NQ)
Effective 2/15/16. Includes 1.00% first-year bonus and is for purchase payments over \$100,000. Escalating seven-year yield is 2.29%. For under \$100,000 first-year rate is 2.30%. Escalating rate seven-year yield 2.19%.										
Great American Life	A	A+ Secure American (Q/NQ)	S	1.50%*	1 yr.	N/A	9%, 8, 7, 6, 5, 4, 3	No	\$10,000	5.75% 0-70 4.65% 71-80 4.40% 81-89
*Effective 2/15/16. Eff. yield is 2.52% based on 1.50% first year rate, 1.00% available portion of 10% annuitization bonus (available starting in contract year two) and 0.02% interest on available portion of bonus at the rate of 1.50%. Surrender value interest rate 1.50%. Accepts additional purchase payments in first three contract years. COM12255										
The Lincoln Insurance Company	A+	AA MYGuarantee Plus 5	S	1.30%*	5 yr.	None	7%, 7, 6, 5, 4, 0	Yes	\$10,000 (Q/NQ)	**Rates Effective 3/1/16 for premium less than \$100,000 and are subject to change
The Lincoln Insurance Company	A+	AA MYGuarantee Plus 7	S	1.75%*	7 yr.	None	7%, 7, 6, 5, 4, 3, 2, 0	Yes	\$10,000 (Q/NQ)	**Rates Effective 3/1/16 for premium less than \$100,000 and are subject to change.
North American Co. for Life and Health	A+	AA- Gaurantee Choice (Q/NQ)	S	2.60%** 2.85%** ^b	5 yr.	None	10, 10, 9, 9, 8	Yes	\$2,000 (Q) \$10,000 (NQ)	2.50% (0-80) 1.875% (81-85) 1.25 (86-90)
*CA rates effective 1/5/16 - a (less than \$200K) b(200K or more)										
Reliance Standard	A+	A Eleos-MVA	S	3.25%*	1 yr.	None	8%, 7, 6, 5, 4	Yes	\$10,000	3.25%**
*Effective 2/13/16. Includes 1.50% 1st yr. bonus. Min. guarantee is 1.00%. **Reduced 20% ages 76-80, and 40% ages 81-85										
Reliance Standard	A+	A Apollo MVA (Q/NQ)	S	4.20%*	1 yr.	None	9%, 8, 7, 6, 5, 4, 2	Yes	\$5,000	4.00% to age 75**
Includes 2.00% 1st yr. bonus. Min. guarantee 1.00% **Reduced 20%, ages 76-80, and 40% ages 81-85. Effective 2/13/16										
Symetra Life, Inc.	A	A Custom 7 (Q/NQ)	S	2.80%*	7 yrs.	N/A	8%, 8, 7, 7, 6, 5, 4, 0	No	\$10,000	Varies
*Effective 4/08/16. 2.80% base rate with no guaranteed return of purchase payments. Plus 0.50% bonus for \$250,000 and above.										

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Obamacare Exchanges Send Insurers, Consumers Running

by Sally C. Pipes

President Obama hit the road again to defend his healthcare reform law. Speaking in Milwaukee in March, President Obama bragged about the law's enrollment figures and pointed to those in attendance as "proof the Affordable Care Act works." His proclamation of victory may be premature. There's much more contradictory "proof" that the law's exchanges – one of the chief ways it aims to expand access to coverage – are failing to work at all.

The policies available on the exchange have been nowhere near as popular with consumers as federal officials predicted. Only 12.7 million people signed up during the open enrollment period that ended January 31. That number is expected to fall to 10 million by the end of the year, as Americans drop coverage or fail to pay their premiums.

Last summer, the Congressional Budget Office predicted that roughly 21 million Americans would enroll in exchange plans this year. Younger Americans have been especially reluctant to purchase coverage through the exchanges. This year, less than one-quarter of exchange enrollees are 18 to 34. That's bad news for Obamacare's solvency. According to some analysts, for the exchanges to be financially workable, 40% of enrollees need to come from this younger, healthier population. An insurance pool that's comprised mainly of older, sicker patients will drive up costs for insurers and, in turn, consumers.

These underwhelming enrollment figures have caused insurers to take significant losses on their exchange business. That's prompting many to consider exiting the marketplaces altogether. Consider UnitedHealth Group, the country's biggest health insurer



and provider of some 500,000 exchange policies in 34 states. The company lost \$720 million on its exchange plans in 2015 and expects to lose another \$500 million in 2016. Understandably, the company has signaled its intention to get out of the ACA-exchange business. As the company's chief executive Stephen J. Hemsley put it, "We can't really subsidize a marketplace that doesn't appear at the moment to be sustaining itself."

Other major insurers have expressed similar concerns including Aetna, which lost \$100 million on its exchange plans last year, and Cigna. Aetna CEO Mark Bertolini said, "We continue to have serious concerns about the sustainability of the public exchanges." Of course, Obamacare's architects saw this problem coming. That's why they

created the law's individual mandate, which requires all Americans to purchase coverage or pay a fine.

But for many Americans – especially the young – the mandate is a small price to pay to avoid the considerable cost of an exchange plan. This remains true even in 2016 when the individual mandate will rise to the greater of \$695 per person or 2.5% of income. Compare that one-time penalty to the \$307 average monthly premium for a mid-level silver exchange plan in 2015.

Premiums are even higher this year. And that's made complying with the mandate less attractive for healthier Americans. In Utah and Illinois, for instance, many consumers are facing increases of more than 40%. The rates of the plans offered by the largest insurer on Minnesota's exchange rose by an average of nearly 50%. Deductibles have also been ticking upward. In many states, most exchange plans carry a deductible of more than \$3,000. In some cities – including Miami and Jackson, Mississippi—residents face median deductibles of \$5,000 or more.

The ACA's exchanges now have a three-year record of dysfunction – ever-higher premiums, enrollment numbers consistently below projections, and hundreds of millions of dollars in losses. Consumers and insurers alike are looking for a way out. President Obama won't be around to celebrate the fourth anniversary of the Affordable Care Act's exchanges that opened for enrollment in 2013 for 2014 coverage. The same might be true for the exchanges themselves. ★

Sally C. Pipes is president, CEO, and Thomas W. Smith Fellow in Health Care Policy at the Pacific Research Institute. Her latest book, "The Way Out of Obamacare (Encounter)," was released earlier this year.

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How to Choose A Medicare Advantage Plan

by David Milligan

Smart brokers have discovered that adding Medicare Advantage to their portfolio makes a lot of sense when it comes to building their book-of-business and staying in tune with changing demographics. The senior population is the fastest-growing segment of the market. New seniors (Baby Boomers) are turning 65 at the rate of 10,000 a day. They make up the first generation that has grown up with

managed care as the norm, often having experienced it through workplace benefits or individual plans. These new seniors understand how the system works; enjoy the cost savings; and appreciate the benefits of coordinated care, from preventive health screenings to sensible and effective disease management programs.

For many brokers, the issue has become not whether to sell Medicare Advantage plans, but which Medicare

"The issue has become not whether to sell Medicare Advantage plans, but which Medicare Advantage plans to sell."

Advantage plans to sell. It is a confusing and sometimes intimidating dilemma since the Medicare Advantage space is expanding and contracting at the same time. New Medicare Advantage plans continue to emerge in an attempt to capitalize on this growing market. At the same time, mergers and consolidations are making the big plans even bigger in an attempt to flex their financial muscle. But bigger isn't always better for the broker or

the consumer. Brokers should look for Medicare Advantage plans that focus on offering what they and their clients most want and have a track record of delivering what they promise.

As with selling any insurance product, the Medicare Advantage plan you recommend is a reflection on you. It must be responsive and focused on your clients so they are pleased with your recommendation and you can build ongoing trust in your relationship.

Here are six things to consider when deciding which Medicare Advantage plan to represent:

- 1. Everyone wants a piece of the senior market** – banks, travel agencies, restaurants, housing communities, and more. Health care is no exception with Medicare Advantage plans cropping up to get a slice of the pie. But healthcare is too important to take chances on new plans that don't really understand the needs of seniors and may not be around tomorrow. Even commercial plans with a long history of serving the employer market may not fully understand what makes the senior market different or what it's like to operate in this highly regulated world. Make sure that the plan you represent has a track record of offering Medicare Advantage products; has a deep knowledge of the Medicare space; and has built a strong and trusting reputation in the marketplace with providers, members, brokers, community agencies, and others.
- 2. The plan you advance should offer competitive products, pricing, and benefits to seniors** so that you, as the broker, can feel confident in representing them. Most Medicare Advantage plans offer a wide range of benefits beyond the basics offered by Medicare. These may include transportation to doctors' appointments, dental care, gym memberships, and more. Check these out carefully. Not all plans are alike. It is also important to remember that benefits, as well as out-of-pocket premiums and co-pays vary greatly from plan to plan. Even within a plan, these factors

vary by county. The plan you represent should give your clients the kind of choice and selection they need to feel empowered to find a plan that's right for them.

- 3. Remember that quality matters. A lot.** Healthcare quality has been hard to measure in a way that is universally understood. The Centers for Medicare & Medicaid Services (CMS) established a five-star quality rating system to help educate consumers on quality and make quality data more transparent and comparable among plans. Under the system, CMS ranks health plans on a one- to

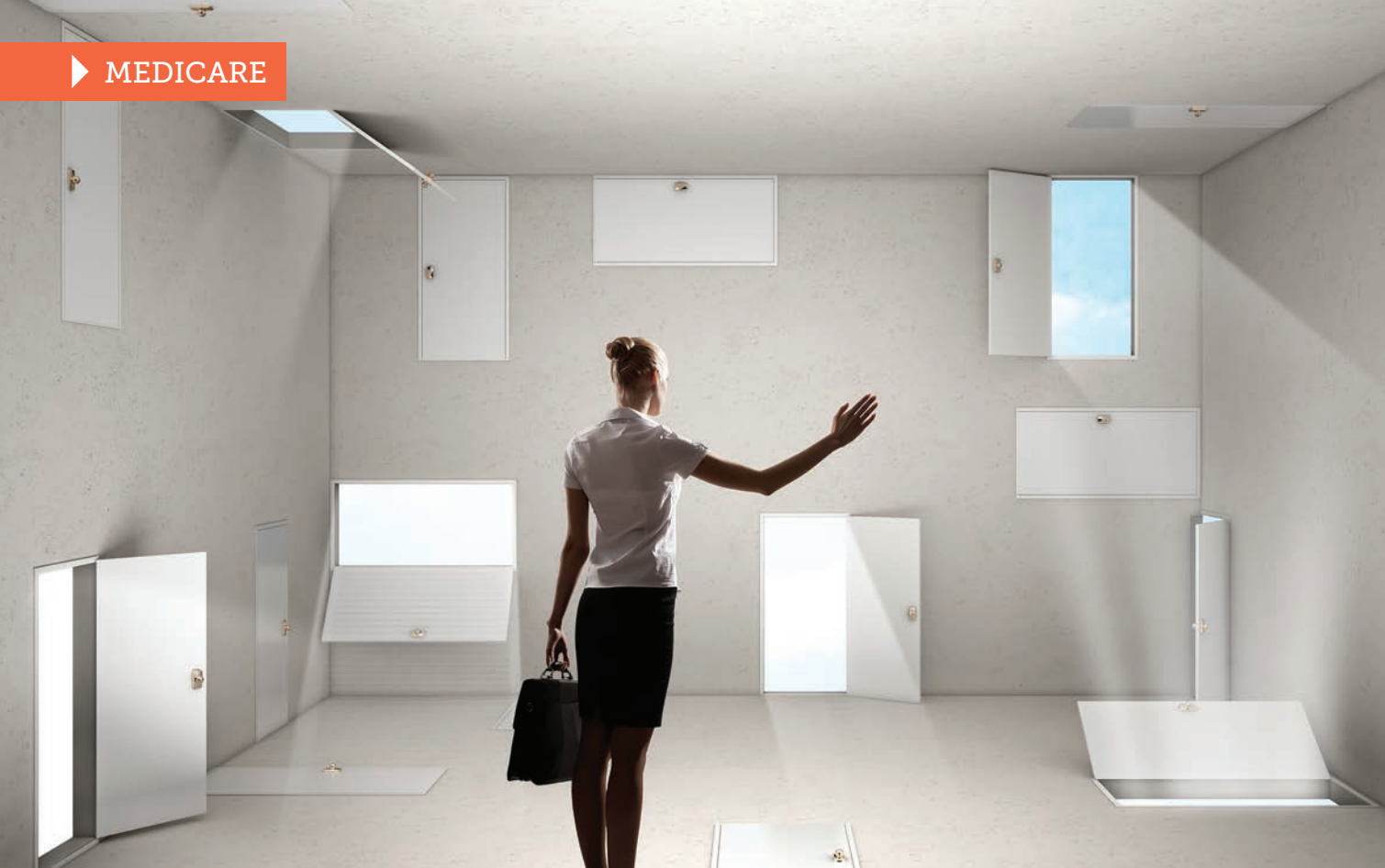
"The Medicare Advantage plan you recommend is a reflection on you. It must be responsive and focused on your clients so they are pleased with your recommendation and you can build ongoing trust in your relationship."

five-star basis. It weighs such factors as clinical outcomes; access to preventive services, such as screenings and vaccines; management of chronic conditions; preventive care; and consumer satisfaction. Star ratings may change from year to year. Be sure to represent a plan that has a current high star rating so you know you are selling a plan that is committed to quality.

- 4. After all of the advertising, face-to-face meetings, and direct mail bombardment, nothing beats word-of-mouth.** Seniors (like all people) talk to each other. More and more are sharing their feelings and experiences through social media. Medi-

care Advantage plans that are successful, over time, put an obsessive emphasis on customer service, responsiveness, and personalization. When considering which Medicare Advantage plan to represent, ask to see their member retention and satisfaction rates. Not only will this be a good guide for you, but it can also serve as a compelling area of differentiation when speaking with your clients

- 5. Work with a plan that does an excellent job in its customer service department.** The better the plan does in providing top-notch service to its members (your clients) the less time you will need to spend performing some of these tasks yourself. Not only will that result in happier clients and an increased likelihood of easy renewal, but it will also give you more time to focus on meeting new clients and growing your business.
- 6. Look for a plan that has a strong, well-respected approach to coordinated care.** With many older adults living longer, it is relatively common for a senior to have six or more chronic conditions and take more than a dozen medications. The complex interactions among these chronic conditions and medications make it imperative that the Medicare Advantage plan has a strong emphasis on health management, disease management, and medication management. While CMS requires all plans to provide care coordination, not all plans are equally proficient in this vitally important area. Repeated studies have shown that, when good care coordination is in effect, seniors have fewer hospital admissions and readmissions, fewer emergency room visits, and lower medical costs. The key to success in all of these areas is emphasizing primary prevention, early intervention, and effective care coordination throughout the spectrum of care. At-risk seniors can be part of geriatric health-management or disease-management programs. They can benefit from a medication-management program that focuses on the correct match between diagnosis and drugs. Having the right



Medicare Advantage plan helps ensure the appropriate utilization of services, improves coordination of care among providers, and improves clinical outcomes.

In addition to looking for a plan that best serves your clients, it is equally important to find a Medicare Advantage plan that best serves you. That means finding a plan that shares your philosophy, is responsive to your needs, and is focused on helping you achieve your business goals in a congenial, positive atmosphere.

Not all Medicare Advantage plans are alike. Consider the following:

1. The plan should make it as easy as possible to sell its products. It should make your learning curve quicker and your business more profitable. That means offering a variety of training classes throughout the year (face-to-face and online) so you can stay abreast of the changing marketplace. This is particularly important for brokers who are selling Medicare Advantage for the first time. It means having a sales support unit that is there to answer

questions and confirm important details, such as member/senior information, low-income subsidies, and member dual-eligible status, etc. It means having an online portal exclusively for brokers that can be accessed 24/7. And it means giving you customized marketing materials, such as flyers and brochures, imprinted with your name and contact information. The less you have to do or worry about these details, the more time you have to sell.

2. Just as a Medicare Advantage plan’s performance history is important to members, it should also be important to brokers. Does the plan have a history of paying brokers on time and with no hassle? Is it well-respected by other brokers in the Medicare Advantage space? Does it have a track record of stability, trustworthiness, promise keeping, and honesty? And does it keep abreast with the changing marketplace and governmental regulations so you can offer the kind of Medicare Advantage plan that seniors want year after year?

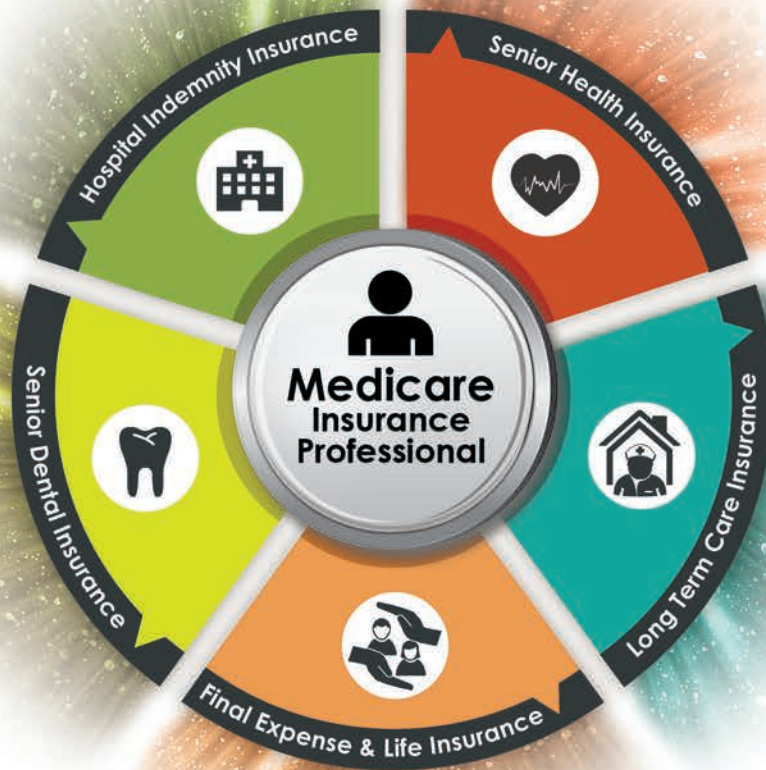
3. Work with a plan that truly views brokers as valued business partners. Actions speak louder than

words. The ideal Medicare Advantage partner gives brokers easy and unencumbered access to company leadership – from ongoing open lines of communication to more formal roundtable sessions where brokers meet with health plan executives to find ways to work better together. The Medicare Advantage plan should be available anytime to assist you with re-certification so your business keeps humming along. And look for a Medicare Advantage plan with a track record of supporting the brokers’ professional associations to stimulate career growth and enhance professional satisfaction.

Whether or not you have ever sold a Medicare Advantage plan, the time has never been better to make it part of your product portfolio. When it comes to which Medicare Advantage plan to represent, choose wisely since it is the first decision to make and the most important in the long run. ★

David Milligan is senior vice president of sales for Long Beach-based SCAN Health Plan, one of the nation’s largest not-for-profit Medicare Advantage plans serving approximately 170,000 members in California.

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Medicare Supplement Premiums Vary Widely

A 65-year old male purchasing Medicare supplement insurance will pay anywhere from a low of \$126 per-month to \$444 per-month, according to the 2016 National Medicare Supplement Price Index. Costs for Medicare supplement insurance, also called “Medigap,” vary significantly for men and women, says Jesse Slome, director of the American Assn. for Medicare Supplement Insurance (AAMSI), which released the first phase of the study.

A 65-year-old woman will pay from \$118-per-month in San Antonio, Texas to \$444 a month in Manhattan. For a 65-year old male, the average difference was 39%. For 65-year-old women, the average difference was 34% but the spread between the lowest and highest costs was as much as 48% in some cities.

Some 12.2 million Americans had Medicare Supplement insurance in 2015, which is a significant increase compared to 9.7 million in 2010. With 10,000 Americans turning 65 every day, the number of Medigap policyholders will continue to grow. The Association examined monthly rates for Medicare Supplement Plan F, the most commonly purchased coverage. Sixty-six percent of individual purchasers choose Plan F. No single insurer is consistently the least expensive or most expensive. For more information, visit www.medicare supp.org.

Anthem Increases “New to Medicare” Discount on Plan F in California

Anthem Blue Cross has increased its “New to Medicare” discount in California from \$15 a month to \$20 a month for the first year in which members are enrolled in an Anthem Blue Cross Medicare Supplement Plan F. Total savings are \$240 for the year, making it among the lowest introductory rates for this plan in the state. The discount is available to those who are 65 or older, are within six months of their Part B effective date, and have a coverage effective date starting March 1, 2016, or later. Members can also save each year if they pay their annual premium up front, have another household member on an Anthem Medicare Supplement plan, or

sign up to pay their premiums electronically through bank draft. Other benefits are available for additional costs, such as drug, dental, and vision, benefits. For more information, visit www.facebook.com/AskAnthem.

CMS Proposes to Test Value-Based Payment Strategies for Part B

The Medicare Rights Center sent a letter CMS in support of its proposal to test value-based payment strategies for prescription drugs under Medicare Part B. According to CMS, the Part B prescription drug reimbursement model establishes a perverse incentive to prescribe higher cost medication. The reimbursement is determined by average-sales price plus 6%. CMS wants to test a variety of innovations, many of which are in use in the private insurance market. The new methods are designed to promote the most clinically effective medications, not the most expensive. CMS wants to test multiple strategies that encourage the use of high-value medications, especially those that eliminate or lower cost sharing for beneficiaries and promote evidence-based clinical decision support tools.

Joe Baker, president of Medicare Rights said, “We’re confident that CMS’ proposed payment model will preserve beneficiary access to needed prescription drugs while advancing innovative strategies to ensure that people who need Part B medications receive the highest value care available to them. We believe the proposal can yield results meaningful to today’s beneficiaries through enhanced care quality, and to future generations, through a stronger and more sustainable Medicare program.” For more information, visit medicarerights.org/pdf/040616-ltr-on-proposed-partb-model.pdf.

Groups Says that Divestitures Don’t Keep Medicare Advantage Competitive

Requiring companies to divest does not maintain competition amid health insurance mergers, according to an issue brief by the Center for American Progress. (Competition authorities frequently require merging parties to divest a number of brands or operations

in order to clear a proposed merger.) The Center says that divestitures don’t restore competition with Medicare Advantage plans. Also, seniors pay higher premiums for divested plans. By 2015, acquiring partners exited more than half of the affected counties. Only two of the 15 divested plans are offered, and premiums increased an average of 44% for more than half of the divested plans. Researchers at the Center say that divestitures in the proposed Aetna-Humana merger won’t be successful in maintaining competition and protecting seniors. In fact, the proposed Aetna-Humana merger would greatly reduce market competition for Medicare Advantage beneficiaries. In markets where Medicare Advantage beneficiaries have a choice of insurers, Aetna’s average annual premiums were lowered by as much as \$302 and Humana’s annual premiums were lowered by as much as \$43. Under the merger, premiums could increase beyond these amounts because of the greater market power of the combined company.

PhRMA Opposes Part B Reimbursement

The Centers for Medicare & Medicaid Services (CMS) released a proposed demonstration through the Innovation Center to change how Medicare Part B drugs are reimbursed. The Pharmaceutical Research and Manufacturers of America (PhRMA) has the following objections: Limits would be placed on patient access and provider choice by allowing the government to make one-size-fits-all decisions about health care. Selecting the right treatment depends on a variety of clinical factors, as well as needs, characteristics and preferences specific to an individual patient. Medicare Part B was set up to allow physicians to make the best decisions for their patients, offering a wide range of treatment options for patients suffering from serious illnesses, including cancer, rheumatoid arthritis, autoimmune disorders and more. This proposal would come between providers and patients by allowing the government to make one-size-fits all value judgments about the best care for Medicare patients. As new medicines become available, especially new targeted and personalized medicines, like President Jimmy Cart-

er's recent cancer treatment, Medicare physicians and patients should have those options available to them.

Mandating broad changes for the majority of Medicare beneficiaries is government overreach. The Center for Medicare & Medicaid Innovation (CMMI) has the authority to test alternative payment models and new ways of paying for care. But it is just that: for testing promising new practices in small controlled groups. This proposal is mandatory and nationwide, which marks a dramatic departure from CMMI's usual, voluntary testing approach. Rather, this model flies in the face of testing by making changes to payment for nearly all Part B medicines and mandating participation for three in four Medicare Part B providers in diverse settings, including hospital outpatient departments, physician offices and pharmacies. As a result, this model will affect care for Medicare patients across the country. Physicians treating the sickest patients could have their reimbursement cut dramatically, disproportionately impacting specialists who treat complex diseases. To test this model, CMMI will waive several provisions of Medicare law. Mandating broad changes to laws established by Congress without a thoughtful stakeholder process before and during development is a government overreach – and sets a bad precedent for establishing Medicare coverage and reimbursement policy.

Broad changes that fail to recognize the value of innovative, targeted therapies could hinder future innovation. While policymakers are emphasizing accelerating personalized medicine, cancer cures and more, this proposal has the opposite effect. It could discourage investment in future treatment advances, many of which are expected to be Part B medicines, as well as have a negative impact on the adoption of novel targeted therapies that benefit patients. Medicare Part B already uses an effective, market-based mechanism to pay for medicines, and research shows Part B medicines are a small and stable share of Medicare Part B spending. Mandating nationwide, sweeping changes to this program without thoughtful consideration and process puts Medicare patients at risk. For more information, visit catalyst.phrma.org. ★

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There's No Such Thing As A Free Lunch

DEFINING THE TRUE VALUE OF \$0-PREMIUM MEDICARE ADVANTAGE PLANS

by Chad Houck

You've probably heard your parents say it many times, "Nothing in this life is free. If something's sold at no cost, it may be too good to be true." While that's not always the case with \$0-premium Medicare Advantage plans, agents and consumers need to know that there's a lot more to them. Premiums are the most visible and easy-to-compare factor, but they don't define a plan's value.

Consumers can get caught up in \$0. It's your job, as an agent, not to let them.



STARTING AT ZERO

Let's take a look at some enrollment figures. According to the Centers for

Medicare and Medicaid Services (CMS), Medicare Advantage enrollment continued to grow in 2015. Of the 16.8 million people on Medicare, about one in three were enrolled in a Medicare Advantage plan. Consumers could choose from an average of 48 Medicare Advantage plans just seven years ago, but that selection shrunk to an average of 18 plans in 2015.

In this competitive market, how can an insurer afford to offer \$0-premium plans? In the simplest terms, the government pays private insurance companies to take care of the bills instead of the Medicare program itself, saving the government resources and money. Private insurers can then save costs by establishing networks for their Medicare Advantage plans to keep expenses low. Those savings are put back into mak-

ing the plan cheaper, which is how we get \$0-premium plans. In 2015, about 78% of beneficiaries had at least one \$0-premium plan available in their area. That figure is down from 84% in 2014 and 94% in 2009. Before the most recent annual-election period, 48% of Medicare enrollees were in

"Don't burn a bridge because a client thinks you misled them on a plan's true cost. Offering no-premium or low-premium plans is a great way to get your foot in the door, but these plans don't work for everyone."

a \$0-premium Medicare Advantage plan, a slight drop from 2014.

The average premium of all available Medicare Advantage plans was about \$33 a month in 2015, not including the monthly Part B premium that beneficiaries must continue paying (\$121.80 or higher depending on income), according to CMS. That's about \$396 that a client could save each year being in a \$0-premium plan, but is it worth it? Remember, there's much more to a plan than its premium. Out-of-pocket exposure, such as annual deductibles and copayments, is perhaps the most risky aspect of these super-affordable premiums.

BEWARE OF THE MOOP

No, the MOOP isn't that horrendous monster who lived under your childhood bed, but it can be just as frightening. The maximum-out-of-pocket limit (MOOP) is the point at which beneficiary spending is capped and the insurer begins covering all medical expenses in full. In 2011, CMS be-

gan requiring all Medicare Advantage plans to have an out-of-pocket limit no higher than \$6,700 annually, and a recommended limit of \$3,400 or lower for in-network services. But insurers like to play it closer to the edge. The average MOOP in 2015 was \$5,041. Forty-six percent of Medicare Advantage enrollees had a MOOP of \$5,001 to \$6,700.

In 2015, 9% of Medicare Advantage Part Ds limited out-of-pocket expenses to \$3,400 or less compared to 51% in 2011. That's a huge drop. Keep in mind that these limits don't include expenses for prescription drugs covered under Part D. They have a separate catastrophic cap of \$4,850 in 2016. Also, they won't cover over-the-counter medications or services that aren't part of the plan, such as dental or vision care. The rise in MOOP makes it critical for consumers to get good information so they can understand their range of choices. Low premium, but high exposure can be ideal for some, a nightmare for others.

FACE THE OTHER FACTORS

We know that there's a lot more to a plan than its premium, but how can an agent determine which plans are valuable to which clients? You must know your client and their needs. The first thing an agent should do is find out what doctors their clients will use. Ask them, "If there was something really wrong, what hospital would you go to?" If their hospital of choice isn't in a plan's network, that plan shouldn't be considered an option. Most senior clients want to stay with their doctors. Put simply, their relationship with a doctor means more to them than saving a few bucks.

Additionally, agents should clearly present all of a plan's benefits. Some plans may offer specific values to your client that make a higher premium worth it. Rather than shell out a co-pay each month, it may be cheaper for your clients to pay the premium for a plan that covers a particular cost.

Finally, are you ready for the super combo that could benefit you and your client? Consider pairing a \$0-premium Medicare Advantage plan with a hospital indemnity plan to ease the burden of expensive hospital copays. A low-

premium plan will yield a high MOOP, but clients can spend those savings on an affordable hospital indemnity plan that helps them cover pricey copays on hospital stays.

BE UPFRONT

You know from your CMS training materials that you must be sure that clients understand the exposure of high MOOP. Don't burn a bridge because a client thinks you misled them on a plan's true cost. Offering no-premium or low-premium plans is a great way to get your foot in the door, but these plans don't work for everyone. Savvy

"Savvy agents stick to selling the network and benefits in addition to the premium. They guide their clients to consider copays and deductibles as part of the larger picture."

agents stick to selling the network and benefits in addition to the premium. They guide their clients to consider copays and deductibles as part of the larger picture. Most importantly, they are open and honest with their clients, putting in the work that nets them referrals and business in the long-term. Just remember, like your parents always told you, nothing in this life is free. ★

Chad Houck is editor and lead copywriter at Ritter Insurance Marketing (Ritter). He received his B.A. in Journalism from Duquesne Univ. Ritter is a national Field Marketing Organization that solves the distribution needs of more than 80 insurance companies in the Senior Life and Health Insurance markets. An industry leader in technology, Ritter has developed proprietary services, including a customized CRM and Medicare quoting system, to help their agents serve their clients faster, better, and smarter. For more info visit RitterIM.com.

TRUMPETING VOLUNTARY SALES

OUR ANNUAL VIEW FROM THE TOP

HOW BLOWING YOUR OWN HORN CAN MAKE YOUR CLIENTS AWARE OF THESE PRODUCTS!

by Leila Morris

In this article, experts give their take on trends and opportunities in the voluntary benefit market. Executives tell us that many employers didn't have time to think about voluntary benefits while they were consumed with the changes in healthcare over the past few years. But, now that the dust is settling, it's time to show employers how voluntary plans complement their current benefits.



Many employers, especially in the smaller market, still don't know what voluntary benefits are and how they can help their company. The demand for voluntary benefits will continue to increase along with rising health care costs. Over the past year, there has also been very strong growth in the individual ancillary benefit market. It's a market that's still largely untapped, so there's plenty of opportunity for growth.

1. How has health care reform affected the market for voluntary benefits?

Tom O’Keefe, voluntary benefits regional practice leader, Unum: Employee benefits have rarely been as widely discussed and considered as they have been in this era of reform. As employers balance the requirements of the Affordable Care Act with the needs of employees, they are choosing plans that give employees more choice in benefit decisions. Voluntary benefits, especially critical illness, hospital indemnity, and accident insurance, complement medical offerings, whether it is a PPO, HMO, or HDHP.

Al Tyler, regional vice president, EyeMed: The ACA has ushered in a new era of benefit consumerism. People scrutinize their benefit decisions and transactions more than before. They look for value, convenience, and customization in the same way they do with other purchases. This kind of decision-making leads to increased competition and more innovation in the market.

Art Dammers, director of Voluntary Practices and Business Development, Anthem: Health care reform has increased employer and employee awareness of voluntary benefits, especially around the need for supplemental healthcare products that fill the gaps in high deductible medical plans.

Danielle LaRose, Colonial Life: It’s made communication and benefit education more important than ever. More brokers are entering the voluntary benefit market to diversify their offerings and supplement income they may be losing as a result of health care reform mandates. It’s a great time for brokers to explore voluntary benefits, especially when they partner with a carrier that offers products and services that can help them be successful without having to make considerable investments in their own infrastructure.

Stephanie Shields, vice president of product and marketing for Aflac Group Insurance: Without a doubt, 2015 was a year of big change in the health care industry. We can’t predict what will come in years ahead, but do know that the cost of health care continues to rise. With higher premiums and deductibles, employers are looking for ways to reduce costs. One solution is voluntary benefits since they’re designed to help give employees financial protection beyond traditional major medical insurance. As health care costs continue to rise, we expect the demand for voluntary insurance to continue to increase.

Meredith Ryan-Reid, senior vice president, Group Voluntary and Worksite Benefits, Met-Life: Health care reform has driven significant interest in voluntary benefits. With the rise of high-deductible health plans, there’s a greater need and demand for voluntary benefits to provide supplementary offerings to employees. This is one reason we continue to see sales growth in voluntary benefits. Voluntary sales climbed for a fifth consecutive year, increasing by 6%

in 2015, according to a recent LIMRA report.

Daniel Wray, VP – Sales, Brokerage Segment, National General Insurance Company: From the perspective of individually sold plans, the voluntary benefit market has been on the rise for several years, but the ACA has truly pointed a spotlight on this benefit category to the masses. As brokers/advisors seek to provide truly rounded benefit packages, there is no way to overlook this rapidly growing area of offerings. Voluntary benefits deliver the trinity of wins that are increasingly hard to come by in this health reform market: high-value products, affordable premiums, and fair agent compensation.

Cameron Bell, Aflac broker sales representative: Health care reform has created ever increasing gaps in the traditional medical plans. As employers shift the financial exposure to their employees, the employees are becoming more and more aware that medical insurance is not enough. As a result, a much higher percentage of employees are enrolling and/or increasing their current coverage. Employers are more open to the idea of providing a stipend to encourage employees to enroll.

2. Which voluntary benefit options are becoming more or less popular?

Danielle LaRose, Colonial Life: There’s a need for all types of voluntary benefits, depending on an employee’s family health history and situation. Nearly everyone needs life and short-term disability insurance, which are basic building blocks of protection. These products, which have been around a long time, help establish a financial foundation to support America’s workers and protect their income and lifestyles. The more recent voluntary products, such as accident, cancer, critical illness, and hospital confinement, have emerged to help fill coverage gaps in major medical insurance. With health care costs increasing, many employers are moving to plans with higher deductibles and co-pays, leaving employees with more financial exposure. We’ve seen an increase in group voluntary products during the past few years for several reasons. They’re typically simpler to enroll and administer, and they can sometimes be more affordable because of the group rate. Insurers can also make more underwriting concessions for group products, such as guaranteed issue, so all employees can take advantage of the offering, regardless of their health condition.

Daniel Wray, National General: Dental insurance was the most popular voluntary benefit in the individual market pre-reform, by a wide margin. But the past two enrollments have seen this focus change as the ACA major medical offering sales mix has shifted heavily into more front-loaded out-of-pocket costs in Bronze and Silver level plans. With this first-dollar exposure, we are seeing trends toward accident and specified disease products, with no loss of interest in dental plans. We have dubbed these non-dental offerings as a

means to “insure your insurance” from those early \$4,000 to \$12,000 out-of-pocket costs that are typical of a Bronze or Silver offering.

Al Tyler, EyeMed: Vision benefits are definitely getting more popular with employees. Key drivers are the demographics as well as the fact that more workers are depending on acute eyesight. Membership in vision plans grew to 184.3 million in 2014, a 13% increase. There was also an 18% increase in the number of glasses purchased with vision benefits, according to a recent analysis of claims data by the National Association of Vision Care Plans.

Art Dammers, Anthem: We are seeing growth in Anthem’s supplemental and optional life while interest in long-term care benefits has decreased.

Stephanie Shields, Aflac: Across the board, voluntary insurance continues to grow in popularity, and has now become an essential part of a well-rounded benefit package. One plan that has been increasing in popularity is critical illness because it helps protect workers from a range of serious illnesses, such as cancer, heart attack, or stroke. Critical illness insurance offers a level of financial protection that simply isn’t available in traditional major medical coverage. If an employee doesn’t have access to the right coverage options, the financial responsibilities that come with a serious illness can make a difficult situation even worse.

Meredith Ryan-Reid, MetLife: Critical illness and accident insurance are becoming increasingly popular as employees look to purchase benefits that provide a wide variety of coverage and value. In fact, critical illness and accident insurance led the voluntary health lines in terms of sales with each increasing by double-digits for a fifth consecutive year, according to LIMRA’s 2015 U.S. Worksite Report.

Cameron Bell, Aflac broker sales representative: Critical illness and accident plans are continuing to grow in popularity. Hospital plans are not as popular due to their limited coverage.

3. Is there a particular argument for voluntary benefits that really resonates with clients?



Danielle LaRose, Colonial Life: Nearly all employers say that controlling costs is job one when it comes to their benefit package. At the same time, they face strong pressure to offer a competitive benefit program to attract and keep top talent. The benefit package is a major factor when employees decide among different employers, and replacing employees can be very costly. Voluntary benefits offer an ideal solution because they can expand

the benefit package, offer more customizable options, and still control costs by allowing employees to choose and pay for the benefits they value most. Employers that are battling rising health insurance costs can reduce costs and protect their workers by adding a voluntary product that helps fill the financial gap of higher-deductible health plans. For example, the employer can increase the deductible or coinsurance to lower their major medical premium and then offer employees a voluntary hospital confinement indemnity plan to help with their increased out-of-pocket expenses. Employees can also use the benefits for non-medical expenses, such as child care, travel, and accommodations for treatment, or even mortgages and car payments. Employers can pay the premium for this new coverage or allow employees to pay the premium. Either way, the total cost for both plans is usually less than the previous health plan alone.

Tom O’Keefe, Unum: Employees tell us over and over that they want coverage options to create an insurance portfolio that meets their needs. They want choices. Voluntary benefits give employees the choices they need to help create a financial safety net straining the employer’s bottom line. Voluntary benefits help boost an employee’s understanding of their total benefit package, including the base of core offerings.



Al Tyler, EyeMed: Vision benefits are unique because they’re designed to deliver value to every person enrolled. Getting an annual eye exam is a simple, non-invasive way to safeguard what most people consider their most important sense – their vision. Eye exams can also reveal hypertension, diabetes, and a host of physical conditions. Once a member has had the annual exam, they generally save as much or more than their total premium for a year. But beyond that rationale,

vision benefit companies need to innovate, anticipate member needs, and respond to client concerns. Vision is a dynamic part of healthcare, and the need for visual acuity is only increasing across the workforce. So, clients should expect something new, something better. Maybe it’s new online in-network providers. Maybe it’s an international solution for members who travel or work abroad. Maybe it’s a self-service tool or cost-savings feature. Vision also lends itself to transparency and ease-of-use in a way few other voluntary benefits can match.

Art Dammers, Anthem: Voluntary plans give employers a way to strengthen the value of their benefits. When communicating with employees about voluntary benefits, we use comparisons that highlight the affordability and importance of the lifestyle/paycheck protection coverage that we offer.



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Stephanie Shields, Aflac: Some clients assume that they don't need to offer voluntary insurance because they already offer major medical insurance, but there are always costs associated with health care that major medical insurance was never intended to cover. Two of the most attractive things about voluntary insurance are that employers can offer financial protection to employees and enhance their benefit cost-savings strategy. In the event of a serious accident or illness, insureds receive cash benefits that can be used to help pay for living expenses, such as rent, mortgage payments, groceries, child care or travel, as well as un-reimbursed medical expenses. By offering voluntary insurance, employers can help protect employees from financial stress, with no direct cost to the company. So, really, the question to clients is, "Why not?"

Meredith Ryan-Reid, MetLife: It's important to show clients how a strong voluntary benefit package can drive employee satisfaction and retention. A recent MetLife study reveals that 55% of employees want their employer to offer a wider array of non-medical benefits that they pay for on their own. Fifty-four percent are willing to pay more for a broader choice of benefits that suit their needs.



Cameron Bell, Aflac broker sales representative: Employers are understanding that accident and short term disability are effective tools to reduce workers' compensation costs. They are also understanding that offering a full benefit package attracts and retains quality employees. Employees understand that medical insurance is limited. The idea of covering gaps is working.

4. What are some of the common objections that clients have to voluntary benefits and what is the best way to answer these objections?



Patrick McClelland, vice president of U.S. Commercial Accounts, VSP Vision Care: Sometimes, clients think that voluntary benefits don't make as much of an impact. But we know that's not the case. They can have a huge benefit to healthcare costs and early detection, especially vision care. We know that people are more likely to get an annual eye exam than they are to get a routine physical. Because of that, an eye doctor is often the first to detect chronic disease and other

health issues. A recent study by HCMS Group reveals that patients whose conditions were detected through an eye exam visited the emergency room less frequently, were less likely to be admitted to a hospital for their condition, and needed fewer medications to control their condition. Vision also provides a great return on investment. HCMS Group also found that employers saw a \$1.45 return-on-investment for every dollar invested in a comprehensive eye exam through lower healthcare costs, improved productivity, and lower turnover.

Danielle LaRose, Colonial Life: A simple lack of awareness is the biggest issue. Many employers, especially in the smaller market, still don't know what voluntary benefits are and how they can help their company. Once they understand that the value these benefits can offer to their business and their employees, they see it's a win-win.



Daniel Wray, National General: Often, the perception on the consumer side, is that voluntary benefits are frivolous compared to their "comprehensive" ACA plan, group benefit plan, or short-term major medical plan. Education and awareness are the bedrock of better decision-making. These products must be framed as a multi-layered solution to a complex healthcare space. Out-of-pocket costs, networks, risk, and other factors contribute to the overall picture. It is incumbent

upon us, as advisors, to position benefits and premiums in package terms and resist the notion that, in a post-ACA era, a health plan is an effective catch-all for all circumstances and situations.

Tom O'Keefe, Unum: Certainly over the past few years, employers have been consumed with the changes in healthcare and have not had the time to invest in understanding voluntary benefits. As the dust is settling, now is the time to show employers how voluntary plans complement their current benefits. Once employers understand the compatibility, coverage, affordable cost, and communications support, they understand the value to their employees.

Al Tyler, EyeMed: Clients don't want to offer any benefit that is a hassle to administer. They don't want to lose hours resolving members' complaints or answering members' questions about the benefit. So, it's important to be honest about your working relationships with clients. You also need to make transparency, communication, self-service tools, and customer service top priorities. Consumers are in the driver's seat even when the benefits are employer-sponsored. And in the exchange environment, consumers are voting directly on the benefits they value and the price they are willing to pay.



Art Dammers, Anthem: Companies are balancing the needs of their employees while dealing with tightening budgets. While face-to-face discussions about enrollment are ideal, on-site enrollment meetings are on the decline. Carriers have had success weaving in multiple enrollment strategies. A surprisingly effective combination of strategies is to offer Intranet process updates, home mailings of enrollment packets, and reinforcement education through webinars.



Stephanie Shields, Aflac: A common objection is that the employer-sponsored benefit package provides ample coverage and protection. Data is a powerful tool to help overcome objections and lend credibility to your perspective. For example, the 2015 Aflac WorkForces Report surveyed more than 5,000 employees, revealing that 88% agree, at least somewhat, that they consider voluntary benefits to be part of a comprehensive benefit package. Sixty-four percent see a growing

need for voluntary benefits. Statistics like these can help turn objections into a broader conversation and encourage employers to take a second look.

Meredith Ryan-Reid, MetLife: A common objection is that voluntary benefits may overwhelm or confuse employees since it's another layer for them to understand. But employees want these options. The key for employers is to communicate these benefits clearly and concisely to help employees understand the value of voluntary benefits and how they can make a difference in employees' lives.

5. How do you present voluntary benefits in a way that doesn't overwhelm employees with confusing options?

Art Dammers, Anthem: We have found it beneficial to answer questions, early in the process, about what it will cost. Enrollments using pre-populated fields on a per-pay period basis generate much higher participation, face amounts, and premium. This approach can use pre-populated personalized forms or online enrollment tools.

Danielle LaRose, Colonial Life: Enrolling in benefits should be simple, modern, and personal. It's important for employees to understand the overall value of the benefits that their employer provides. Pre-enrollment communications, group meetings, and especially one-to-one benefit

counseling sessions help employees fully understand their benefit options, where they're covered, and where they may have some financial risk.

Daniel Wray, National General: Like most effective sales presentations, it is important to speak to the target audience in terms they understand and can relate to. Simply put, it involves telling the story instead speaking insurance-ese with acronyms that make consumers mistrust the insurance industry. Simple, logical plan selections that are tailored to the audience make the decision-making process much more intuitive.

Tom O'Keefe, Unum: Research shows that too many options can cloud our ability to make clear decisions, so the first step is to refrain from offering too many products in one year. Then carefully plan a communication strategy that helps employees understand the benefits. Information should be simple and clear and should be presented in multiple ways like e-mails, intranets, meetings, posters, and home mailings.

Al Tyler, EyeMed: It's not about limiting options; it's actually quite the opposite. People tell us that they want more options – different plans, different types of providers, and different ways to use benefits online. But as you expand choice, you should give members simple, user-friendly tools that help them navigate their options. Members should find it easy to put the benefit to work and feel confident about the choices they make about utilization.

Stephanie Shields, Aflac: Communication and education are key. It is important to have tools and resources that help employers educate employees on available plans, along with the details that make them relevant at various career or life stages. Benefits are personal, so it's important to explain the ways that voluntary benefits help provide protection in a way that is as unique as the employee.

Patrick McClelland, VSP: A good strategy is to propose an alternative effective date that is different from their health insurance. This leaves more time to focus on the offering while not being overwhelmed. This strategy results in higher enrollment and satisfaction.

Meredith Ryan-Reid, MetLife: Along with clear communications, creating optimal enrollment conditions helps employees understand their voluntary benefit options without getting overwhelmed. This entails offering a variety of robust decision support resources and personalized offerings to help employees learn about their benefit options and make informed decisions about the benefits that suit their needs. Employers should provide a variety of communications tools, such as a benefit website, mobile apps, text messages, or one-on-one consultations, allowing employees to choose which resource works best for them. Regardless of age, employees, prefer personalized enrollment, such as a one-on-one enrollment process. Ranging from Millennials to Baby Boomers, data consistently shows

that they value a personalized approach to meet their needs. Another key way to present voluntary benefits is to offer them “on ballot” to integrate them with core benefit offerings. This way, employees’ benefit options are in one place, reducing confusion and eliminating the possibility that employees may see one group of benefits as being more important than the other.

6. Is there an ideal number of voluntary benefits to offer?

Danielle LaRose, Colonial Life: A good start with a new client is to add two or three voluntary options to the benefit package. Research shows having too many choices actually deters purchasing. Life and disability are the basic building blocks of a financial safety net and should be offered first, if they are not already part of the benefit package. Many employers are also looking for an affordable dental product. If the major medical plan has a high deductible, a product that helps cover out-of-pocket costs, such as a hospital confinement indemnity plan, is a good fit. Then you can add additional types of coverage at each year’s annual enrollment, such as accident, critical illness, or cancer.

“Employers should provide a variety of communications tools, such as a benefit website, mobile apps, text messages, or one-on-one consultations, allowing employees to choose which resource works best for them.”

Daniel Wray, National General: The breadth of products available doesn’t support a simple answer to this question. Insurance is a balancing act of trading dollars for risk. Voluntary benefits open up a world of risk mitigation options. We often see voluntary benefit brokers cutting their teeth with one or two offerings; typically dental and accident programs. In our individual segment, it is not uncommon for veteran voluntary benefit advisors to offer three to four products along with a base medical insurance solution.

Tom O’Keefe, Unum: It’s best to start with two products that are the strongest complements to core coverage, followed by additional lines in subsequent years. Although employees want choice, research shows that too many choices can paralyze decision-making. So it’s best to layer offerings over time.

Stephanie Shields, Aflac: Workforce size and employee needs vary from business to business. One of the nice things about offering a broad portfolio of voluntary benefits is that employees can select the plans they need. The idea isn’t for employees to apply for every benefit available; it’s for them to have options to select the plans that help best protect them.

Patrick McClelland, VSP: No, as long as there is time to explain the value in the offering. Employees value stand-alone benefits like dental and vision. In fact, the 2016 annual Employee Perceptions of Vision Benefits survey found that eight out of every 10 people choose to enroll in employer-sponsored vision plans.



Meredith Ryan-Reid, MetLife:

The number of voluntary benefits differs based on each organization’s employee needs. It’s important for companies to listen to employees, understand which benefits are highest in demand, and offer the ones that are most applicable to their employees. It is also important to offer a wide variety of benefits to reach different segments of the workforce. Employees need different voluntary benefits based on life situations, such as

marriage, a first child or retirement. In fact, MetLife’s 13th Annual U.S. Employee Benefit Trends Study found a correlation between the number of benefits that an employer offers and the likelihood that an employee would recommend their company as a great place to work. At companies that offer 11 benefits or more, 66% of employees would recommend their employer as a great place to work, compared to 53% at companies that offer one and five benefits, and 46% at companies that offer no benefits.

7. What is the market like for individual voluntary benefit sales?

Danielle LaRose, Colonial Life: We’ve seen very strong growth, over the past year, especially in the public sector and smaller employer markets. The market is still largely untapped, so there’s plenty of opportunity for growth.



Tom O’Keefe, Unum:

We do very well with individual short term disability and individual whole life. Whole life is a great complement to the employer-paid term base plan and voluntary buy-up term. Although term can be inexpensive, the premiums grow over time. Many people end up getting rid of it when it becomes price prohibitive. With whole life, the price is fixed from the time of purchase. It’s something that employees can take into retirement.

Voluntary short term disability coverage is a nice addition to California’s short-term disability insurance or to other states where employees don’t have access to an employer paid plan.

Stephanie Shields, Aflac: Voluntary benefit options have become more popular over the past several years. They have really become a fundamental part of an employer's benefit package. We do not see that trend slowing down any time soon with the increase in high deductible health plans (HDHPs) and a larger shift in employee cost-sharing. We also have seen a large increase in value-added services sold along with traditional voluntary policies that provide value to the insured every day, starting on the first day the coverage is in force, compared to just being there at the point of claim.

"Although term can be inexpensive, the premiums grow over time. Many people end up getting rid of it when it becomes price prohibitive. With whole life, the price is fixed from the time of purchase. It's something that employees can take into retirement."

8. Are they any common mistakes you see when it comes to presenting voluntary benefits?

Tom O'Keefe, Unum: Two mistakes come to mind. First is the failure to complete a due-diligence review of voluntary offerings given the current and proposed core offerings. This includes selecting appropriate coverages and price points while considering the needs of the employee base. The second mistake is a lack of communication. Employees want and need information to evaluate the offerings with enough time to review it before making final decisions. Given diverse learning styles, communications tools should be varied and easy to understand. Not having a clear communication program and getting all parties dialed in well ahead of time can lead to frustration and poor results.

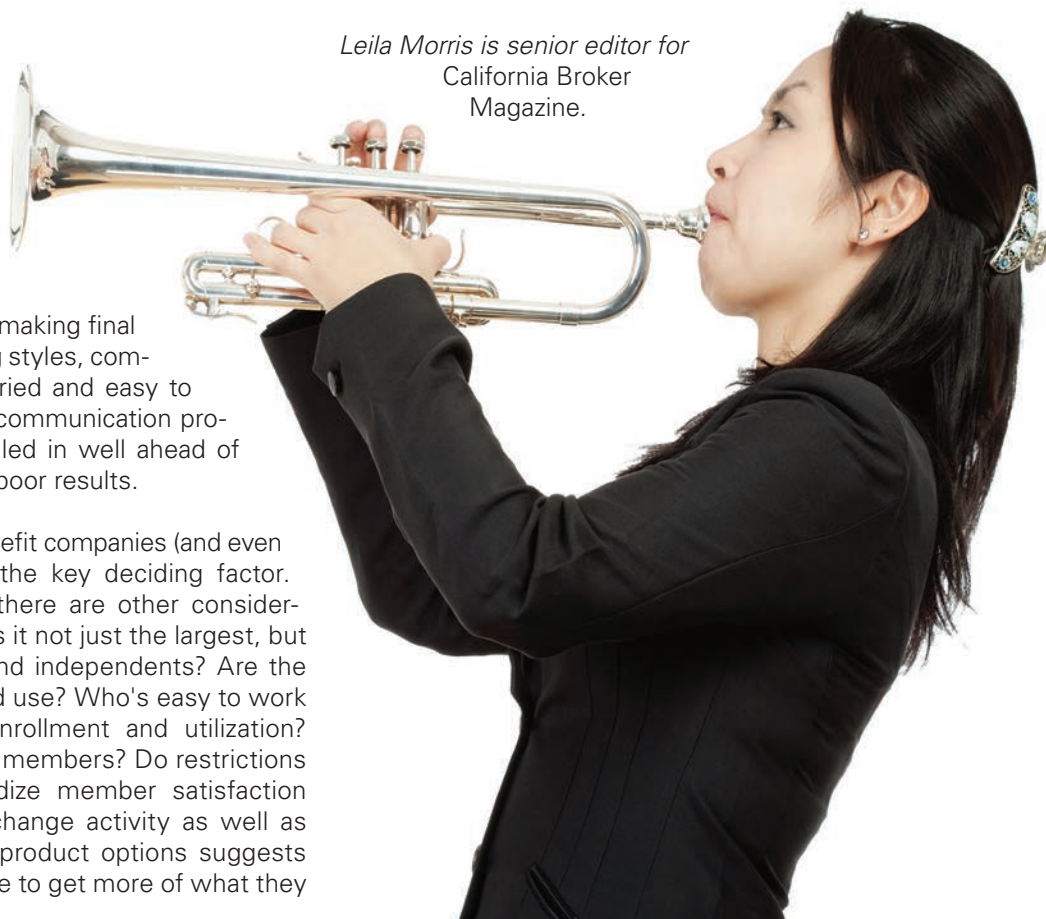
Al Tyler, EyeMed: Voluntary benefit companies (and even some clients) make premium the key deciding factor. Price matters, of course, but there are other considerations. Is it the right network? Is it not just the largest, but the right mix of retail, online and independents? Are the benefits easy to understand and use? Who's easy to work with? Which benefits drive enrollment and utilization? Which are more appreciated by members? Do restrictions on frames and lenses jeopardize member satisfaction with a vision plan? Private exchange activity as well as our experience with multi-tier product options suggests that members will pay a bit more to get more of what they want from a vision benefit.

Stephanie Shields, Aflac: Voluntary policies are often brought in at the tail-end of a benefit conversation as an add-on or something that is nice to have. But these benefits are actually very essential in today's health care landscape. Not only do they help employers offer more robust benefit offerings at little to no cost, but they also help employers lower costs as part of a benefit redesign strategy. For employees who bear increasing financial responsibility for health care expenses, voluntary benefits may provide the financial protection that offers peace-of-mind and helps sustain their desired lifestyle through serious illness or injury.

Patrick McClelland, VSP: A common mistake is not engaging employees and explaining the value of vision care. To achieve high enrollment, the employee must really understand "what's in it for me."

Meredith Ryan-Reid, MetLife: Lack of communication about the value of voluntary products is a common mistake. As benefit companies and brokers are immersed in the industry, it can be easy to forget that there is significant confusion about benefits. MetLife's 14th Annual U.S. Employee Benefit Trends Study found that only 47% of employees agree that non-medical benefits can help them limit their out-of-pocket medical expenses. This illustrates the need for benefit managers and brokers to clearly explain the practical and financial value of voluntary products to help employees to see how these benefits can reduce financial concerns and make a difference in their lives. ★

Leila Morris is senior editor for California Broker Magazine.



Domestic Partnerships in California

A LOOK AT THE FINANCIAL BENEFITS

by Andrew Vasquez

Federal legalization of same-sex marriage went into effect in July 2015, allowing any two individuals to legally wed in the United States. However, some couples are opting to avoid getting married for financial reasons, especially in California.

Across the country, the number of unmarried couples living together is rising just as the rate of remarriage is declining. The national divorce rate is about 50%, but in California it's 60%. This has led California's unmarried couples and larger-than-average population of divorcees to take a close look at the benefits of commingling their financial situations in a domestic partnership instead of getting married. Why are so many Californians choosing domestic partnerships over marriage? Here are some of the potential financial benefits they've found that they can take advantage of.

TAXES

Unmarried couples can use tax planning to improve their combined financial profile. For example, the higher-earning partner might receive a bigger tax benefit by taking mortgage deductions and credit exemptions for children by filing alone instead of filing jointly. At the same time, the lower-paid partner may benefit from child-

care and education credits or itemized medical expenses that a married couple might not qualify for. Similarly, there are many programs for special needs children that provide assistance based on income. If a couple is married, their combined income is more likely to disqualify them from these significant benefits as well.

DEBT

Remaining unmarried may be beneficial for couples in which one partner has significant student loan debts. Marriage laws allow creditors to hold a debtor's spouse accountable for a loan even though their name may not be on it, and if a married couple begins making debt payments from a joint checking account, the loan is considered commingled. Creditors can then target both partners and employ scare tactics to coerce them into paying off the debt before it actually makes financial sense for the couple to do so. In addition, if a married couple cannot pay off a debt and needs to begin making late payments, they can be forced to file for bankruptcy together, causing both of their credit histories to suffer.

BENEFITS

Since employers can't discriminate against same-sex couples, marriage

is generally not a requirement in order for both partners to take advantage of company-sponsored benefits. Many employer benefit plans allow enrollment for medical, dental, and life insurance by all domestic partner couples. The low-earning partner may be able to qualify for subsidized health insurance under the Affordable Care Act as well.

Defined benefit plans and pensions also typically recognize non-spouses as qualifying joint annuitants. Additionally, couples can invest an IRA annuity with a provider that recognizes domestic partnerships and provides eligibility for the same lifetime income benefits afforded to married couples.

The one area where domestic partners lose in retirement is with Social Security. Only a legally married couple is entitled to spousal and survivor benefits, but unmarried couples can still take advantage of this benefit by simply planning to marry later in life. The same strategy can be applied to pensions, in order to retain the surviving spouse's lifetime benefit.

ESTATE PLANNING

Legal rights are not automatic in domestic partnerships as they are with marriage, but any potential issues can



be addressed with proper estate planning:

- An updated will ensures that assets are transferred to the surviving partner upon death.
- A trust can be put in place to protect real estate assets from probate and facilitate transfer of ownership.
- By completing beneficiary and transfer on death (TOD) forms correctly, unmarried couples can ensure that assets within insurance policies, bank accounts and retirement accounts are distributed appropriately.
- Power of attorney documentation and health care proxies enable an individual to select a trusted partner to make legal, financial and medical decisions in an emergency.

It's worth noting that married couples can transfer any assets at death with an unlimited marital credit exemption allowing all assets to transfer tax-free at the death of the first spouse. For unmarried partners, the maximum

"Regardless of which route a couple chooses to go, they should take the time to understand how their financial situation will be affected. Entering into their new union with a full understanding of its financial implications will help ensure their relationship is a lasting one."

tax-free gift transfer during life or at death is just over \$5 million.

The choice to become married or

enter into a domestic partnership is a personal one for couples, and financial considerations are certainly not the only ones to take into account. Regardless of which route a couple chooses to go, they should take the time to understand how their financial situation will be affected. Entering into their new union with a full understanding of its financial implications will help ensure their relationship is a lasting one. ★

Andrew Vasquez, ChFC, is a financial professional for the MetLife Premier Client Group, which helps clients grow and safeguard their assets by designing wealth management, retirement planning, estate planning and small business planning solutions tailored to their needs. Based in Walnut Creek, Vasquez is dedicated to developing advanced planning strategies for families and businesses. As a special needs planner, he also works to help families with special needs dependents protect their children's financial futures through proper planning.

HELPING YOUR CLIENTS ASSESS THEIR DISABILITY INSURANCE NEEDS

by Erik Dullenkopf

As a financial professional, I'm constantly working with clients to help them prepare for the unexpected. I often find that disability insurance is one area of financial planning that clients overlook. Many clients dismiss the possibility of becoming disabled as highly unlikely, but the statistics tell a different story. Almost 25% of 20-year-olds will become disabled before 67. The average 20-year-old is twice as likely to become disabled than to die before age 67, according to the Social Security Admin. Disability insurance is something all clients should consider, given the devastating effect that a disability can have on their livelihood.

It can be tricky to understand how much disability coverage you should have. Here are several areas that California clients and their financial professionals should examine together.

CALIFORNIA'S STATE DISABILITY INSURANCE PROGRAM

In California, disabled individuals may be eligible for short-term disability benefits under the state disability insurance program. The program is state-mandated and funded through employee payroll deductions. According to the program's website, "Workers who suffer a loss of wages when they are unable to work due to a non-work-related illness or injury, pregnancy, or childbirth, may be eligible for disability insurance benefits." The benefit is equal to roughly half of the individual's regular earnings and capped at 52 weeks.

In my experience, the application process for state benefits has been relatively easy. I encourage clients to take advantage if they qualify. However, given the amount they will receive and the limited duration, it's generally

necessary to have additional sources of income in place, if their disability spans more than a year.

EMPLOYER-SPONSORED DISABILITY INSURANCE

Many employers offer group disability insurance. This is another critical benefit I encourage my clients to take advantage of if they have the opportunity to, especially since the cost may be subsidized by the employer. Group disability insurance can provide important short- and long-term benefits, but it's essential for the employee to understand what they will be eligible to receive. For example, group long-term disability insurance is typically capped at a certain dollar amount, and may not fully replace an individual's income. Also, group disability plans don't apply to income from bonuses. Furthermore, the benefit is considered fully taxable as income to the disabled person since employers normally pay the group plan's premium and receive a tax deduction for doing so. Once again, depending on an individual's personal financial situation, additional funds may be required.

SOCIAL SECURITY DISABILITY INSURANCE

Depending on a client's disability, they may also qualify for benefits from Social Security. Here too, it's important to understand how that benefit works. Social Security does not offer benefits for partial disability or short-term disability. Instead, it pays only for total disability, which it defines as the inability to do work that one did before, the inability to adjust to other work because of one's disability, and a disability that has lasted or is expected to last for at least one year or result in death. As the Social Security Administration notes,

"This is a strict definition of disability. Social Security program rules assume that working families have access to other resources to provide support during periods of short-term disabilities, including workers' compensation, insurance, savings, and investments." To that end, it can be challenging to qualify for Social Security disability insurance benefits. In 2015, the program provided awards to 32% of the applications, and the average monthly benefit was less than \$1,300.

INDIVIDUAL DISABILITY INSURANCE

California's disability insurance program, group disability insurance policies, and Social Security disability insurance benefits can all provide much-needed resources if a client becomes disabled, but an individual disability insurance policy can offer additional support. I help my clients examine which benefits they would receive from the first three sources if they became disabled. If it looks like more coverage may be necessary, we look at how an individual disability insurance policy could help fill in the gaps. Regardless of what a client decides, the most important thing is that they understand what their financial picture would look like if they were to become disabled. Armed with that knowledge, they can then make a decision about what's best for them. ★

Erik Dullenkopf, CFP, is a financial professional for the MetLife Premier Client Group (metlife.com/individual/planning/premier-client-group), which helps clients grow and safeguard their assets by designing wealth management, retirement planning, estate planning and small business planning solutions tailored to their needs. Based in Ventura, Calif., Erik is dedicated to providing the right balance of stewardship, advice, and solutions to help all clients achieve their families' financial goals.



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GETTING STARTED: A Proven Path to Absence Management Success

by Gene Lanzoni



For many employers, the path to a successful absence management strategy begins with using external expertise to ensure compliance and efficiency. About eight in 10 U.S. employers are making efforts to manage leaves and improve productivity, according to Guardian's Workplace

Benefits Study in 2015. However, most companies say their efforts have yet to make a significant impact on achieving their goals, such as increasing return-to-work rates, reducing lost time, or decreasing absenteeism.

Certainly, employers have an easier time getting started on the path to

more effective absence management practices with the wider availability of third-party expertise and technology to support in-house activities, as well as increased outsourcing. Yet, challenges remain for many employers, including the following:

- Keeping track of intermittent Fam-

ily and Medical Leave Act (FMLA) leaves and interpreting federal and state leave laws.

- Ensuring fitness-for-duty before returning employees to work.
- Applying the American with Disabilities Act (ADA) and the ADA Amendments Act.

Firms with 100 to 1,000 employees are more likely to be in the early stages of their absence management journey. Their biggest struggle is self-administering their family-medical leave programs. In addition, they are more likely than are other employers to handle most or all of the administration with in-house resources, according to the latest Guardian Absence Management study.

Employers that outsource at least their FMLA and short-term disability tend to report more positive outcomes. Forty-six percent of employers that outsource short-term disability and FMLA administration achieve five to six positive outcomes compared to 16% of those not outsourcing or outsourcing only short-term disability and not family-medical leave.

A vast majority of U.S. employers are still in the early stages of their absence management journey, especially those with fewer than 1,000 employees. So here are some tips that employers can follow to establish their programs and improve them continually over time.

SET A PHILOSOPHY

An employer's underlying philosophy is often associated with early decisions. Therefore, when mapping out a leave-management strategy, setting clear and measurable objectives can be critical to success. Employers tell us that returning employees to safe and productive work is a high priority in an absence management program. This goal serves as a beacon for the employer's absence-management philosophy and can guide subsequent activities. Encouraging employee health and wellness should be a second priority since workforce health is highly correlated with productivity and successful leave management.

Of course, a top priority for many companies is ensuring that they handle family-medical leave in compliance with state and federal laws. This can

be even more important among firms with employees located in multiple states, smaller firms, and firms with limited in-house HR/benefit resources that have a harder time keeping up with changing state and local leave laws.

TAKE FOUNDATIONAL STEPS

Also key to success is getting senior management buy-in and adhering to a clear communication strategy, according to employers surveyed. For example, large employers may prefer to implement their program in phases and conduct pilots to demonstrate the return-on-investment potential and gain broader support among senior leadership. Other employers make

"Looking at the best practices of employers with successful absence-management strategies offers a proven path for employers to get started on their own absence management journey."

a compelling business case for outsourcing by focusing re-allocating internal resources or mitigating the risk of non-compliance. They underscore the benefits of leveraging an external partner's expertise, processes, and technology to manage their leaves more efficiently and effectively.

Making sure that everyone is clear on their roles is critical for first-time outsourcers. Assumptions that are based on how things were handled in the past no longer apply. Getting all parties on the same page, from the outset, greatly increases chances of success.

DEVELOP A MODEL

Our research shows that outsourcing family-medical leave administration produces more positive outcomes than does managing the process in-house.

Outsourcing both short-term disability and family-medical leave brings even greater success. In addition, using the same short-term disability resource for FMLA (whether internal or external) is a key predictor of achieving positive outcomes.

MEASURE SUCCESS

For the best chance of success, it is essential to establish clear and practical metrics early on, which tie back program objectives. Setting targets for improvement in traditional areas, such as return-to-work rates, lost time, and absenteeism can help quantify a leave-management program's return-on-investment. But according to Guardian research, employers say that one of the most critical measures of absence management success is employee engagement, given its linkage to productivity and positive outcomes. Engaged employees miss fewer work days and have stronger performance.

Employers with the most advanced absence management activity tend to receive higher employee engagement and productivity scores. They also tend to achieve greater progress on the following:

- Consistent administration.
- Better tracking or reporting.
- Reduced costs.
- Easier administration for the organization.
- Improved compliance.

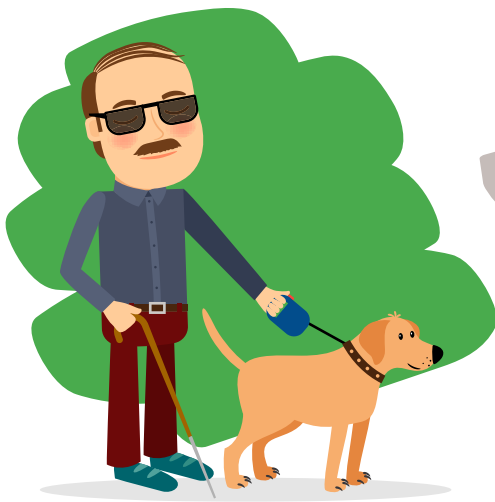
The ability to achieve more effective, efficient, and compliant absence management practices is no longer restricted to the largest U.S. employers. Smaller firms – with fewer than 1,000 or even 500 employees – increasingly recognize the importance of improving their leave management efforts. They can now outsource administration to external partners that have the necessary expertise and technology. Looking at the best practices of employers with successful absence-management strategies offers a proven path for employers to get started on their own absence management journey. ★

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The Value of Disability Insurance

PREPARING EMPLOYEES FOR THE UNEXPECTED

by Stephanie Shield



There are more than 40 million injury-related emergency room visits in the U.S. each year, according to the Centers for Disease Control and Prevention. In spite of the frequency of accidents occurring in our day-to-day lives, Americans don't have the financial resources to fall back on when they need medical help. Fifty-two percent of American workers have less than \$1,000 set aside to cover the costs of an unexpected medical expense, according to a recent Aflac study. More than 37 million Americans are classified as disabled. That translates to about 12% of the population. More than

50% of disabled Americans are age 18 to 64, according to the Council for Disability Awareness.

One thing is for sure – being prepared can help employees avoid the expenses of a disability. Disability insurance can be a tough sell when employees don't have this preparedness mindset. Brokers need to explain to clients how important disability insurance is. Employees who are unable to work and earn a paycheck risk losing their savings, their retirement funds, or even their homes. Below are a few ways to educate your clients and their employees about why disability insurance is essential.

WHO NEEDS DISABILITY INSURANCE?

Disability insurance is a low-cost solution that pays off in the long run because it helps safeguard employees' finances. A policy pays a monthly percentage of an employee's gross income for a set period while they're disabled. Cash benefits can help pay for daily living expenses that can't be put on pause, such as rent or mortgage, groceries, or other day-to-day expenses. Employees have peace-of-mind knowing that they have a source of income to help pay for bills while they're recovering.

Any employee should seriously con-

sider purchasing disability insurance to protect their income in the event they become disabled and can't earn a paycheck regardless of age or whether they are single or have dependents.

WHY IS BEING COVERED SO IMPORTANT?

"It won't happen to me," is the most common response among Americans when asked about the possibility of being disabled. An accident that is serious enough to prevent an employee from working may seem unlikely, but accidents aren't the primary cause of disability insurance claims. Back injuries, cancer, heart disease, and a host of other illnesses are often the culprit, according to the Council for Disability

"Arming clients with information is the most productive way to educate them about how essential disability coverage really is."

Awareness. Being covered in every type of circumstance will help put clients' minds at ease whether it's an accident or an illness.

Another serious factor for employees to consider is that most disability claims last about 34 months. This means that the typical worker needs almost three years of emergency savings to cover daily living expenses. More than half of personal bankruptcies and foreclosures are a direct consequence of a disability, according to a Harvard study. For employees who are living paycheck to paycheck, even a small medical expense can send them into debt.

These numbers are staggering, but there is good news – the debt that companies lack of disability insurance is preventable. For brokers, the challenge lies in educating employees and

employers about just how serious the possibility of this scenario is. Proactive planning can lead to a stress-free recovery in the event of debilitating injury or illness.

WHAT DO WORKERS NEED TO KNOW ABOUT DISABILITY INSURANCE?

Learning how disability insurance works is the first step to avoiding long-term risk. There are two main ways to get covered:

1. Short-term disability insurance typically replaces 60% to 70% of the employee's base salary to help ease the financial stress associated with serious accidents or illnesses. Major medical was never intended to cover these costs. In the event of a physician-documented disability, participants can receive benefits to help pay for daily living expenses, such as the mortgage or rent, gas, groceries, utilities, and other necessities.
2. Long-term disability insurance helps ensure that employees get a portion of their income when they are absent from work for an extended period due to a covered disability. This benefit can help employees pay the bills when they cannot work due to a covered illness or injury.

An important aspect to note is that California offers a disability insurance and paid family leave benefits wage replacement program, which covers 55% of earnings shown in the highest quarter of an employee's base period. However, this program only covers workers who experience a loss of wages because they are unable to work. Plus, the plan has an eight-day waiting period. Employees without enough savings to cover expenses simply can't afford to wait.

For these reasons, voluntary disability insurance is a great option for California employers who want to offer workers protection that can provide fast claims payment. Voluntary plans tend to have fewer limitations and more streamlined claims review and payment. Fast cash is usually the preferred route with so many Americans struggling to make ends meet.

It's important to help clients and their employees understand the difference between short- and long-term

disability coverage. As trusted benefit advisors, you are in the perfect position to act as disability insurance advocates to those in doubt.

THE BOTTOM LINE

The best aspect of providing voluntary coverage is that it doesn't have to cost employers a dime since premiums can be paid fully by workers who elect to apply for coverage. By making supplemental policies available, your clients can offer employees the protection they may need with no direct effect to their bottom lines.

"Any employee should seriously consider purchasing disability insurance to protect their income in the event they become disabled and can't earn a paycheck regardless of age or whether they are single or have dependents."

Offering disability insurance is a cost-efficient way for employers to show they care about their employees' physical and financial health. Arming clients with information is the most productive way to educate them about how essential disability coverage really is. Brokers, employers, and employees can work together to ensure more adequate financial protection in the event of an accident or illness. ★

Stephanie Shields is the vice president of Marketing, Product Development and Strategic Planning at Aflac Group Insurance. She is responsible for setting Aflac's business strategy, developing and positioning Aflac Group products, and overseeing the overall strategic marketing plan for the broker channel.

IN CALIFORNIA

COVERED CALIFORNIA ANNOUNCES CONTRACT CHANGES WITH CARRIERS

Covered California adopted significant changes to its contracts with health insurers. The contract provisions were developed over the past year with consumer advocates, health plans, clinicians, other stakeholders, and subject matter experts. Plans must do the following for years 2017 to 2019:

- Ensure that all consumers select or are provisionally assigned a primary care clinician within 30 days of when their plan goes into effect.
- Exchange data with providers. This will enable physicians to be notified if their patients are hospitalized and track trends and improve performance on chronic conditions, such as hypertension or diabetes.
- Identify hospitals and providers that deliver poor-quality care or unwarranted high-cost care. Health plans will be expected to work with them to improve their care or lower their costs. Hospitals that don't improve and don't provide justification will be excluded from Covered California networks as early as 2019. Covered California will adopt a payment system for hospitals, such as the one employed by the Centers for Medicare and Medicaid Services (CMS). Over time, it will put at least 6% of reimbursement at risk or subject to a bonus payment based on quality performance.
- Manage high-cost pharmaceuticals and help consumers understand the effectiveness and costs of their drug treatments as well as any alternatives.
- Track health disparities, identify trends in disparities, and reduce disparities, beginning with four major conditions: diabetes, hypertension, asthma, and depression.
- Develop programs to identify and manage at-risk enrollees with requirements to improve in targeted areas.
- Provide tools to help consumers understand their diagnosis and treatment options and understand their share of costs based on the contracted costs of their plan.

Covered California will encourage

plans to promote advanced models of primary care including patient-centered medical homes and integrated health care models, such as accountable care organizations. Also, Covered California is improving its patient-centered benefit design for 2017 plans. Outpatient care in Silver, Gold, and Platinum plans will not be subject to a deductible. Bronze plan consumers would get three outpatient visits that are not subject to the deductible, in addition to the free preventive visits. For 2017, Covered California is proposing to lower out-of-pocket costs for primary care and urgent care. For more information, visit board.coveredca.com.

ANTHEM & DIGNITY HEALTH INTRODUCE AN EPO/PPO PLAN

Anthem Blue Cross and Dignity Health, one of the largest hospital systems in the country, introduced a tiered EPO/PPO plan designed to improve employee health and lower costs through integrated care management. The Premier Tiered EPO/PPO product is designed for self-insured large groups or employers with more than 101 employees. It will launch on May 1, 2016 in Ventura County. Product expansion is planned across select California regions over the next 18 months. Members can choose the exclusive provider organization (EPO), which provides the best price with a pre-determined network of Dignity Health providers. Another option is the PPO, which provides access to a wider range of providers at varying copay- and cost-sharing levels. In 2014, Anthem launched Vivity, a partnership with seven hospital systems in Los Angeles and Orange counties. Anthem has joined with 19 medical groups to create accountable-care organizations across the state. For more information, visit facebook.com/AskAnthem or dignityhealth.org.

HEALTHCARE HOW BENEFIT STRUCTURES AFFECT UTILIZATION AND SPENDING

Health insurance benefit structures, particularly cost-sharing, can encourage or discourage patients from seeking care, according to a recent study by the National Institute for Health Care Reform (NIHCR). NIHCR

looked at contracts between the International Union, UAW, and Fiat Chrysler, Ford, and General Motors in 2011, which significantly changed autoworker health benefits. There was expanded coverage of outpatient physician visits and additional cost sharing for emergency department visits unless the patient was admitted to the hospital. The changes contributed to higher spending in these areas:

- Advanced imaging
- Diagnostic tests
- Minor procedures
- Prescription drugs

Lower patient cost sharing for physician visits resulted in substantially higher spending as a result of more physician visits and increased diagnostic services and procedures. However, higher cost sharing did not significantly decrease emergency department visits or expenditures. For more information, visit nihcr.org.

DOL EXPANDS FIDUCIARY RULE TO HSAS

The Dept. of Labor issued a final rule with a fiduciary standard that covers all financial professionals offering investment advice for retirement accounts—including 401(k)s, IRAs, health savings accounts (HSAs), and others. The National Assn. of Health Underwriters (NAHU) is concerned that expanding the fiduciary standard will limit employee access to HSAs. Janet Trautwein, NAHU CEO said, "Employees who participate in employer-sponsored health plans don't bear the same type of financial risk as people investing in retirement plans. It is a mistake to apply the same requirements to types of plans. The new rule also creates unprecedented new compliance responsibilities and liabilities for employers and licensed health insurance agents and brokers. NAHU is apprehensive that employers and health insurance agents and brokers will be unable to accept this new liability and will be unable to assist employers with HSAs through employer-sponsored health plans. This may reduce access to the benefits of HSAs for their employees, resulting in fewer health plan choices and more limited benefit options." For

more information, visit nahu.org.

FREE WHITE PAPER ON HSA PROGRAM STRATEGIES

HSA Bank released a white paper that reveals best practices for a successful health savings account (HSA) program. To download a free copy, visit www.hsabank.com.

HEALTH INSURANCE STOCKS IMPROVE

The stock price performance of health insurance companies increased 11% in 2015, according to a report by A.M. Best. However, A.M. Best's outlook for the health insurance industry was recently revised from stable to negative, largely because of the Affordable Care Act's (ACA) pressure on earnings and capitalization. There is growing concern about compressed margins. UnitedHealth has said that it may stop offering insurance plans to individuals through the public exchanges established by the ACA. It will be interesting to see if there is a domino effect if UnitedHealth exits the health insurance exchanges, according to AM Best. A.M. Best has a favorable view of the industry's emphasis on diversifying, implementing technology, and reducing expenses. These strategies should continue to improve revenue and earnings growth. For more information, visit www3.ambest.com.

HEALTH PLAN COSTS & OPTIONS BY STATE AND INDUSTRY

Health insurance premium renewal rates climbed 6% in 2015 and 5.6% in 2014, according to a survey by United Benefit Advisors (UBA). Businesses with fewer than 25 employees were hit the hardest, says Les McPhearson, CEO of UBA, "In 2014, employers overwhelmingly used early renewal strategies to delay moving to higher cost ACA-compliant plans and keep increases in check. These delay tactics ran out in 2015. As a result, these small businesses were forced into higher-cost, community-rated ACA plans. Without the negotiating power of bigger groups or the protection from grandmothing, many small employers were left with no cost containment strategies other than reducing coverage."

UBA finds significant regional dif-

ferences in health plan costs. Alaska has the highest average annual cost of \$12,822 per employee. Alaska's average annual cost per employee is 51% higher than Hawaii, which is 25% below the national average at \$7,610. More than 40 years ago, Hawaii adopted an integrated care model to address cost, quality, and access. Alaska has resisted most forms of care management including the carrier's ability to contract with physicians. Lon Wilson of the Wilson Agency, a UBA Partner Firm in Alaska said, "We are...beginning to see collaboration among payers, providers, and hospitals, but we are way behind the rest of the country." In Alaska, there is a perfect storm of high cost of care with large variations in quality, limited access to care, a small population, the geography, the cultural diversity, and a transportation infrastructure that's lacking.

The five best states for health plan costs include Arkansas at \$7,704, New Mexico at \$7,793, Virginia at \$7,858, and Oklahoma at \$7,915. Premiums increased the most for singles in Louisiana (23.5%) and California (17%). Families saw the biggest premium increase (7.6%) in South Carolina. Connecticut was the only state to see a modest decrease in single premiums (5%).

Total costs, per employee, for the retail, construction, and hospitality sectors are 8.6% to 21% lower than average. Surprisingly, the finance industry eclipsed the government sector in total costs at \$11,842 per employee, a 16% increase from 2014. Government plans still have the third highest average cost per employee at \$11,817, yet employee contributions are 45% (\$2,105) less than the average employee contribution of \$3,333.

Fifty-four percent of employers offer one health plan to employees while 29% offer two plan options, and 18% offer three or more. Compared to the previous five years, 28% more employers offer three or more plans. More employers are offering expanded choices by offering private exchanges with high-cost, medium-cost, and low-cost options, a trend that UBA expects to continue to increase. Not only do employees get more options, but also employers can introduce lower-cost

plans that may attract enrollment and lower their costs, according to UBA. For more information, visit UBAbenefits.com.

EMPLOYEE BENEFITS EMPLOYEES WANT FINANCIAL GUIDANCE AND BENEFITS

Forty-six percent of employees expect their financial situation to get better in the next year, and they're turning to the workplace for financial education, according to a recent MetLife study. These financial concerns may be making employees more loyal, with 45% of employees planning to work for their current employer 12 months from now, compared to 41% last year. The study finds the following:

- 47% of employees say that non-medical benefits can help limit their out-of-pocket medical expenses.
- 52% of Millennials understand life insurance compared to 69% of Baby Boomers.
- 38% of Millennials understand long term disability insurance compared to 57% of Baby Boomers.
- 68% of Millennials prefer one-on-one consultations with a benefit expert, compared to 62% of Gen Xers and 57% of Baby Boomers.
- 44% of Millennials want their employer to help them solve their financial concerns compared to 20% of Baby Boomers
- 75% of Millennials say employers have a responsibility for the financial well-being of employees.
- 62% of employees are looking to their employer for more help in achieving financial security through employee benefits, compared to 49% in 2011.
- 44% of employees feel in control of their finances.
- 65% of Millennial employees don't have a savings cushion of three months of salary.

The study finds that strong communication is a key driver of employee confidence when selecting benefits. The most effective resources are one-on-one consultation. Todd Katz, executive vice president, Group, Voluntary & Worksite Benefits, at MetLife said, "Employers looking to harness the power of one-on-one consultations can turn to outside experts such as

brokers, consultants, and enrollment communications firms. For employers, this is an opportunity to evolve into a more consultative role and provide meaningful education and training for employees, while engendering loyalty. Helping employees understand the value of their benefits through engaging communications is critical for employee and for the workplace. If employees fully understand their benefit options, they'll make better purchasing decisions and decrease their financial stress. To alleviate confusion about benefits, it's critical that employers...enable their employees to make informed decisions about which benefits best suit their needs. This includes providing a variety of decision-support resources and offerings to help them make educated benefit decisions." For more information, visit benefittrends.metlife.com/us-perspectives/opportunity-is-knocking.

MORE COMPANIES ARE OFFERING FINANCIAL & EMOTIONAL WELL-NESS PROGRAMS

More companies are investing in total well-being programs to address financial and emotional health of their employees, according to a report by Fidelity Investments and the National Business Group on Health. Employers are adding programs that help employees manage stress, improve their resiliency, and meet financial challenges. In 2016, 87% of employers offer emotional or mental well-being programs, and 76% provide financial health programs. Sixty-seven percent plan to expand their efforts while 17% plan to maintain offerings at the current level. Adam Stavisky, senior vice president, Fidelity Benefits Consulting, said that employers are focusing on things that affect well-being, such as emotional stress and financial challenges.

Mollie O'Brien is director of Total Rewards at BASF, which has more than 15,000 employees in the United States. She said that BASF has seen strong employee participation and engagement since launching its wellness program a few years ago. O'Brien said that the company is looking at strengthening financial wellness offerings to meet the needs of a

diverse workforce. By far, stress management is the most popular emotional well-being program. Fifty-four percent of employers offer this program and 12% plan to do so in 2017. Also popular is resiliency training, which helps employees manage setbacks in the workplace or outside of work. Twenty-seven percent of employers offer this program, with another 20% planning to do so in 2017.

Seventy-three percent of companies offer on-site financial seminars, and 59% make a financial coach available to employees. In 2016, 13% of employers offer student loan repayment assistance – a benefit that's typically been offered only in the public sector. Another 21% are considering adding this benefit.

In 2015, 81% of employees received incentives, up from 73% in 2014. The percentage of employees receiving incentives increased steadily as employers expanded well-being programs. The number of employers using outcomes-based incentives is expected to drop from 44% in 2015 to 24% in 2016. Brian Marcotte, CEO and president of National Business Group on Health said that social factors and the work environment play an important role in employee engagement and their view of their well-being. Companies are integrating initiatives that focus on financial and emotional well-being, social connectedness, and job satisfaction with more traditional offerings. For more information, visit www.businessgrouphealth.org.

LIFE INSURANCE STUDY SHOWS AN IMPROVING CLIMATE FOR LIFE INSURANCE

A growing number of consumers say they would recommend life insurance to others, which contributes to a more positive climate for the product, according to a report by LIMRA and Life Happens. Sixty-six percent of consumers are at least somewhat likely to recommend life insurance, an increase of 11% over last year. Eighty-six percent agree that most people need life insurance. "We're encouraged by Americans' understanding of the need for life insurance and their openness to...

purchasing it. While not everyone who shows interest in life insurance buys it, increased awareness...is a promising development," said Marvin Feldman, CLU, ChFC, RFC, president and CEO of Life Happens.

Seventy-seven percent of Millennials are likely to recommend having life insurance. Fifty-one percent of Millennials and 30% of people overall are very or extremely likely to consider wearing an activity tracker and sharing the results with a life insurance company to get financial rewards. Sixty-five percent of consumers who already use an activity tracker would consider sharing the results for financial rewards.

For 66% of American consumers, having enough money for a comfortable retirement is the top financial concern. Next on the list are paying for long-term care and medical expenses at 58%. Twenty-five percent of all consumers and 40% of Millennials said they'd be very or extremely likely to choose life insurance and long-term care combination products when purchasing life insurance. While two out of three Americans agree that most people need long-term care insurance, fewer than one in five have a policy, signaling a great opportunity for the life insurance industry to engage with more consumers.

Sixty percent of Americans say they have life insurance (individual and/or group), and 34% are at least somewhat likely to purchase it in the next year. These intentions are more positive than they have been over the past few years, thanks to more favorable attitudes about life insurance among Generation X and Millennial consumers. Even as people accomplish many day-to-day activities online, 51% still prefer to purchase life insurance in person. Three out of four say that a major reason to meet with a financial advisor or agent is to get immediate answers to their questions. Feldman said, "The findings show that consumers recognize the need for insurance products to protect their financial security. Even in this digital age, speaking to an advisor and getting their guidance is still very important to consumers." For more information, visit limra.com. ★

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MIND THE GAP:



How Brokers Can Help Employers Increase HDHP and HSA Enrollment

by Rebecca Palm

The healthcare industry is undergoing a cost revolution. More than one sixth of the U.S. economy or about \$2.9 trillion—is devoted to healthcare spending, and that percentage continues to rise, according to the Centers for Disease Control. As healthcare costs grow, insurance companies and employers are shifting more of the cost onto consumers, mostly in the form of high-deductible health plans. For businesses large—and especially small—the cost of administering employer-sponsored health plans is becoming more burdensome by the year, making benefit packages an increasingly expensive proposition and possibly making those employers less competitive in

the hiring market.

To offset some of these costs, more employers than ever are offering high-deductible health plans (HDHPs). These plans have lower premiums for employers and employees, but larger deductibles for employees. By offering these plans, employers hope to increase consumer awareness of what healthcare actually costs, and shift some of that cost increase to employees. To date, those efforts are proving successful. Enrollment in this type of plan, which was introduced in 2004, has been growing about 15% year-over-year. In January 2014, there were nearly 17.4 million people enrolled, according to the AHP Center for Policy and Research.

But there's growing evidence that employees are not taking full advantage of their health benefits. Thirty-six percent of Americans under 65 who have private health plans have taken advantage of HDHPs, but only one third of those are enrolled in health savings accounts (HSAs), according to the National Center for Health Statistics. Health insurance brokers are poised to help employers close the gap and meet their objectives by presenting all parts of a high-deductible plan—HSAs included—in such a way that employees are motivated by all of the advantages of the benefits offered. Here are some points brokers should be sure to convey to employers when it comes to HDHPs and HSAs:

HDHPs ARE THE RIGHT CHOICE FOR SOME EMPLOYEES AND SOME EMPLOYERS

Offering high-deductible health plans may mean that employees can pay lower premiums, but their out-of-pocket costs are higher. These plans are great for employees who don't have predictable, large healthcare expenses or chronic conditions. And they're great for employers who are looking to reduce the cost burden of healthcare. Consumer-directed health plans cost up to 20% less per employee than do traditional health plans, according to a Mercer survey released in late 2014.

HSAs GREATLY REDUCE THE FINANCIAL RISK OF HDHPs, MAKING THEM GOOD INVESTMENTS

High-deductible health plans shift the consumer cost of health insurance from the premiums paid out of every paycheck to larger, one-time payments when employees actually go to the doctor. If an employee is otherwise healthy, it could amount to less money spent in the long run, but unexpected illnesses could result in hefty payments. HSAs help employees plan for those higher out-of-pocket expenses with a savings account that employers and employees

can contribute to. HSAs greatly reduce the risk of being hit with unexpected, high medical costs because they ensure that employees have some money put away just for medical expenses—money that's theirs to keep even if they go to a different employer. Also, it rolls over from year to year. HSA money isn't limited to traditional healthcare expenses like medical procedures and doctor visits. HSAs can be used to pay for any qualified health expense including things not traditionally covered by health insurance, such as over-the-counter medications and contact lenses.

HSAs COME WITH BIG TAX BENEFITS FOR EVERYONE INVOLVED

Any dollars contributed to an HSA are tax exempt, no matter who contributes them including employers. This is a great way for employers to contribute to their employees' benefit plans in a tangible, transparent way that raises employee awareness of costs while still getting a tax break.

HSAs CAN COME WITH AN EXTRA ADMINISTRATIVE BURDEN, BUT IT'S NOT AS MUCH AS YOU THINK

Some companies with more limited

benefit resources have been hesitant to encourage reluctant employees to sign on because of the increased administrative burden on the employer. It's another account, another contribution, and another service that an already-strapped HR department needs to administer. However, newer tools as well as private exchanges and services have made it easier to register for and administer these accounts. Many employees can enroll on online exchanges, rather than by paper.

Employers are considering all these factors as they decide which plans to offer employees, but they're also trying to anticipate how to keep costs down while keeping employees happy. Everyone wins when brokers can give employers the facts and tools they need to educate employees on the benefits of HDHPs and HSAs: employees have a better chance of being satisfied with their health plans; employers have a better chance of controlling benefit spending; and brokers have a better chance of meeting enrollment quotas. ★

Rebecca Palm is co-founder and chief strategy officer for Copatient. For more information, visit copatient.com



Managing Expectations On Flexible Premium Adjustable Life Insurance

by Mark J. Hanna, CLU, ChFC



When I talk about life insurance, I always differentiate between the insurance industry and the insurance profession. Those of us who provide guidance and advice to the insurance-purchasing public are in the insurance profession. Whether we refer to ourselves as agents, brokers, or advisors, our duty is to fully understand our clients' needs and abilities. We must apply our knowledge and training appropriately. We must recommend the same

course of action that we would take if we were in our client's situation. Licensing, professional credentialing, and experience give us the insight and understanding to see things that others may not see, or at least we hope this is the case.

Conversely, the insurance industry is comprised of companies and their employees who are involved in the design and service of insurance products. In other words, those who draw a paycheck as opposed to a commission are

likely to be employed within the insurance industry. The distinction is important because the industry isn't charged with looking after a policy owner's interest beyond fulfilling the contract terms. Nor is it required to evaluate the adequacy of coverage or plan design, or even ascertain the suitability of coverage except in limited instances. The professional advisor evaluates suitability, coverage, premium adequacy, plan design, ownership, and beneficiary language. That's why we are required

to be licensed, and why we seek ongoing education to refine our skills.

Flexible premium adjustable life insurance was introduced four decades ago. Those of us who were accustomed to selling fully guaranteed whole life marveled at the design flexibility, premium cost differential, and high yielding returns available on policy cash values in current assumption UL. But astute advisors realized that much of the flexibility and lower cost was achieved by shifting risk from the insurer to the policy owner. While the increased risk allowed for design flexibility and benefited consumers, the advisor also assumed more responsibility. The advisor has a duty of full disclosure along with the knowledge and training to set reasonable parameters for the client on plan performance and premium variability.

For three decades, we have been dealing with decreasing interest crediting rates and the impact on policies that we sold. It has been difficult to manage client expectations in a low-yield environment. But it has gotten much more challenging as carriers move to change a variable that we thought was sacrosanct.

According to recent *Wall Street Journal* article (December 4, 2015), several major life insurance companies decided to raise the internal cost-of-insurance charges assessed on blocks of life insurance policies issued when interest rates were higher. So what is a guarantee really worth? I can imagine a client conversation going something like this, "Mr. and Ms. Client, your policy from ABC Life Insurance Company guarantees a minimum interest rate of X percent. Even though the policy guaranteed a floor rate-of-interest, the company is shifting the interest rate risk to you by raising the cost-of-insurance. ABC Life is going to raise the cost of insurance charged against your policy value, every month, since prevailing interest rates are now at the contract minimum and are not expected to increase in the near term. It will be necessary to increase your scheduled premium in order for the projected policy duration to remain unchanged. The company is no longer profitable or as profitable on this policy block as it needs to be."

The heart of the question is a legal loophole, which is certain to be further tested in the courts. This loophole allows an insurer to shift interest spread revenue loss (occasioned by interest rate compression) to the policy owner by increasing cost-of-insurance even when actual mortality is stable or improving. More recent current assumption UL policies include language that defines the cost-of-insurance as more than just mortality costs, but also as carrier margin and other expense factors.

"It has been difficult to manage client expectations in a low-yield environment. But it has gotten much more challenging as carriers move to change a variable that we thought was sacrosanct."

Agents and advisors are experienced in presenting current assumption UL policies with current and guaranteed interest assumptions. Until recently, we felt confident discussing the two variables and explaining to our clients that it is reasonable to expect interest crediting to remain a moving target. Prudent plan design dictates that scheduled premium payments should, at least, be calculated and agreed upon in advance based on the guaranteed minimum interest rate specified in the contract. In advance, we agreed on the approximate premium funding required to sustain the policy if interest rates decline.

For decades, mortality risk has been trending lower and is likely to continue to improve with health and technological advances. Life insurers that market current assumption UL routinely allow the advisor to illustrate lower assumed interest rates in their product illustra-

tion system, but not a variable (higher) assumption cost-of-insurance. Cost-of-insurance rates for permanent life insurance are generally reinsured for decades. No one anticipates a scenario in which the actual mortality risk increases. Therefore, the cost-of-insurance should remain stable throughout the contract term.

For example, agents sold policies with an abbreviated premium contribution schedule based on much higher interest rates. Scheduled premiums were intended to disappear. Advisors are accustomed to explaining why scheduled premiums have not disappeared and still require funding, often for many years beyond the original illustration. This presents a difficult discussion, to be sure. But at least the consumer understands the macro forces at play and realizes that lower interest rates affect all financial institutions. The next conversation will be much harder for the professional advisor. We need to diligently counsel clients to understand raised internal costs. We need to explain how it is possible that an interest rate guarantee can be circumvented by shifting the carrier interest-rate spread into the cost-of-insurance deduction.

It won't be an easy conversation for many of us. It will force us to question the assumed covenant that guaranteed interest is guaranteed. The era of current assumption UL, as we know it, may be coming to an end. Until life insurance companies allow their illustration software to illustrate a higher cost-of-insurance for future clients, the solution will be to select only fixed premium, fully guaranteed contracts or current assumption UL with a lifetime secondary guarantee. Without these two options, advisors should consider maintaining a heavily documented and fully disclosed client file, which reveals that the new risks of current assumption UL is discussed and understood by the client. ★

Mark J. Hanna, CLU, ChFC, of Concord, Calif., is a 37-year veteran of the financial services industry, and is recognized internationally for professional and industry accomplishments. He is the first vice president of the Million Dollar Round Table (MDRT), and a 27-year MDRT member with three Court of the Table and 16 Top of the Table honors.

Compelling Reasons for Your Clients to Purchase Critical Illness Insurance

by Ken Smith

The railroad was the principal form of transportation in the 1930s. But the railroads were bankrupt by the 1970s. The owners were so busy running a railroad that they forgot they were really in the business of moving passenger from one place to another. What can we learn from the railroads? We need to stop selling insurance. Instead we need to start solving problems.

Last year, millions of quarter-inch drill bits were sold in the United States. No one really wants to buy a drill bit. Customers buy drill bits because they have a problem; they need a hole. The same is true with health insurance. No one wants to buy health insurance; they want to solve a financial problem that would arise if they needed medical care. The purpose of health insurance is to pay the bills and help reduce financial stress when an illness or accident occurs. Would your client or prospect rather work with an agent who sells just products or one who solves problems?

With higher deductibles and out-of-pocket-costs, health insurance, alone, no longer solves the problem. I believe that we should include an accident and critical illness plan with health insurance. How many of your clients can write a check for \$10,000? Even if your client has \$10,000, it's probably earmarked for something else. If you are not familiar with critical illness protection, it pays a lump sum on the diagnosis of cancer, heart attack, stroke, and a number of other conditions. It helps with deductibles and out-of-pocket costs as well other costs, such as medications that are not covered by health insurance, travel, time, off from work, and comforts during treatment.

To really understand the need for critical illness protection, answer the following questions:

- Whom do you know who has been diagnosed with cancer or had a heart attack or stroke?
- Was it expected?
- Was there unplanned emotional or financial stress on the family?
- Would cash have helped?

What do a good lawyer and a good sales person have in common? They only ask questions when they know how the witness or prospect will answer. Asking questions is the most effective way to help prospects see that they have a problem. Then show them the solution. Try these questions next time you meet with a client or prospect:

- If your expenses exceeded the large out-of-pocket costs on your health coverage, what do you think would likely be the reason? (The most common response? Accident, cancer, accident, and heart attack.)
- If you reached the out-of-pocket maximum because of an unforeseen accident or critical illness, would you cover that huge bill through your savings account, or do you want an option that would give you access to \$15,000 in a direct payment to you?
- If you had an unforeseen accident or critical illness, would you be able to cover out-of-pocket expenses of \$10,000 or more?
- Would you like to learn a way to cover bills and other expenses if you had a break in pay because of critical illness or accident?

The question that I always ask is, "Would you rather limit your spending on going out to buy coffee or snacks or face writing a check for \$10,000 or \$15,000? I believe that every small business owner should own at least

enough critical illness to cover three months of income. Ask your small business clients the following: Suppose you wake up tomorrow morning and decide you are going to Hawaii for three months. You don't tell anyone you are leaving or what you are working on. You just leave. What would

your business look like when you came back? The business owner will laugh and say it would be a mess if it was still there. The follow up question is would it be any different if it was a three-month leave of absence because of cancer, heart attack, or stroke?

How do you start? Find a good accident and critical

illness plan and start asking the questions. It works! ★



Ken Smith has more than 35 years experience in field and home office positions. Before starting Ken Smith Sales Training & Consulting, he was director of Health Product Sales with Assurity Life for over 12 years. Before that, he was with Mutual of Omaha over 10 years as first vice president. Smith wrote "Sales Lessons from the Masters." Ken's field-tested approach to training incorporates principles from the masters of insurance sales -- Frank Bettger, W. Clement Stone, Ben Feldman, and Joe Gandolfo. Ken has written numerous articles for insurance industry trade publications, and has conducted many presentations at insurance industry conferences.

Ken also produces videos that include sales ideas and sales concepts. These blogs were highlighted at the LIMRA Marketing Conference. Ken has written numerous articles for insurance industry trade publications, and has conducted many presentations industry events for NAHU, NAIFA, the International Disability Insurance Society, and National Association of Fraternal Insurance. He was a presenter at World Critical Illness Conference.

SMALL BUSINESS RETIREMENT PLAN

Lincoln Financial enhanced its Lincoln Director employer-sponsored retirement plan for small business clients. It includes a broad investment universe of revenue-neutral funds and a flexible, simple, and transparent pricing structure. The program now offers a deeper, non-proprietary investment universe, made up of more than 250 revenue neutral investment options in nearly 60 different asset categories, represented by 40 popular fund families. It also includes a broad range of qualified default investment alternative options. These enhancements will allow sponsors and their advisors to choose from one of the largest investment options universes in the industry. For more information, visit: www.LincolnFinancial.com/Director.

ADVERTISING COMPLIANCE MANUAL

The Professional Insurance Marketing Association (PIMA) released its 2016 Advertising Compliance Manual. The manual covers best practices for print and electronic media advertising, state advertising filing requirements, and more. It assists in ensuring that advertising copy and marketing materials meet statutory and regulatory requirements. The manual is published in a searchable CD format. It is free to PIMA members and \$695 to non-members. For more information, visit pima-assn.org.

GROUP ACCIDENT PRODUCT

Boston Mutual launched a group accident insurance plan. This competitively priced product is the company's first group accident plan. Employers can customize their voluntary benefits and offer employees the same accident plan and rate across multiple states. It offers eight flexible modules, providing many personalized options. Each benefit category can be customized including hospital care, emergency care, emergency room care, diagnostic imaging, continuing care, specific loss, major injury, fractures, and dislocations. Three shelf plans are available (Silver, Gold, and Platinum), or the plan can be tailored to offer additional versatility for employers. Currently available in 41 states, enrollment will begin in April 2016, with issue dates effective starting in June 2016. For more information, visit bostonmutual.com.

**ONLINE DENTAL PLAN TOOLS**

Cigna is offering online comparison tools to make it easier for DPPO members to select a dentist and budget for dental expenses. The enhancements include personalized out-of-pocket costs by service and by dental office as well as detailed profiles about each dentist, often including photos and videos. The tools are now available on myCigna.com, Cigna's personalized customer website, and the myCigna mobile app.

LEGAL INSURANCE PRODUCTS FOR INDIVIDUALS

ARAG, launched consumer-direct legal insurance products in the United States. Previously available through employee benefit programs alone, ARAG's new products are designed to offer access to affordable, broad-based legal representation for all consumers. Consumers pay a monthly premium that is generally \$15 to \$30. They can meet with an attorney when they experience a legal event, such as purchasing a home, creating a will, or handling a traffic ticket. Depending on their legal plan, consumers may pay a deductible, receive services at reduced rates or may have attorney fees paid in full by the insurer. For more information, visit ARAGlegal.com.

LIFE INSURER TO REWARD CONSUMERS FOR HEALTHY EATING

John Hancock Insurance added the HealthyFood program to its John Hancock Vitality solution. Now policyholders can earn rewards for the healthy food choices. They get real-time discounts and/or cash-back up to \$600 a year on their grocery bills and program points that lead to savings on their annual premiums—as much as

15%. The Vitality program, which was introduced a year ago, provides savings and rewards to policyholders who complete health-related activities like exercising, getting an annual health screening, or getting a flu shot. People have the option of tracking their physical activity with smartphone apps and devices like the Apple. The Vitality HealthyFood component takes the program a step further by rewarding policyholders for purchasing healthy food at any of the 16,000 participating stores nationwide. For more information, visit nutrisavings.com/all-retailer.

PPO NETWORK ADDED TO SHORT TERM MEDICAL PLAN

Petersen International Underwriters of Valencia, Calif. launched an enhanced short term medical plan. It now offers a preferred provider network from First Health, removing the requirement for claims reimbursements. Client out-of-pocket expenses will be limited to standard policy deductibles. An insured person does not need to worry about paying up-front for medical services nor having to submit claims for reimbursement of expenses incurred. Petersen says that the addition of a well-known and reliable PPO network will be a key marketing advancement for the agents. Petersen International is providing the First Health PPO network at no additional cost to applicants of the short term medical plan. For more information, call 800-345-8816 or email piu@piu.org.

SMALL GROUP RATE QUOTE & PREMIUM CALCULATOR

Landmark Health plans has updated its rate quote and premium calculator, allowing brokers to quote our small group plans through June 1, 2017 effective dates. Rates remain low and unchanged since July 2015. Landmark is about to launch a multi media marketing ad campaign in Sacramento County to help support to support landmark individual & family plan membership. Recently, Landmark Healthcare changed its name to eviCore healthcare. Launched earlier this year, Landmark's group voluntary chiropractic plan is for groups with two or more enrolled subscribers/employees. For more information, visit www.LHP-CA.com or call 800-298-4875, Option 5.

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