

CALIFORNIA BROKER

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MAY 2017

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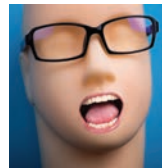
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Health Care Reform Math

WHEN IT COMES TO HEALTH CARE REFORM, IT'S ALL ABOUT THE MATH

by ALAN KATZ

THE FIRST ELEMENT: TRUMP AND WINNING

President Donald Trump hates to lose. He's about winning until we're all sick of winning. (His words, not mine). The American Health Care Act, Republican's attempt to replace the Affordable Care Act, failed. Support was so scarce House Speaker Paul Ryan and the President didn't even bring it to a floor vote in March.

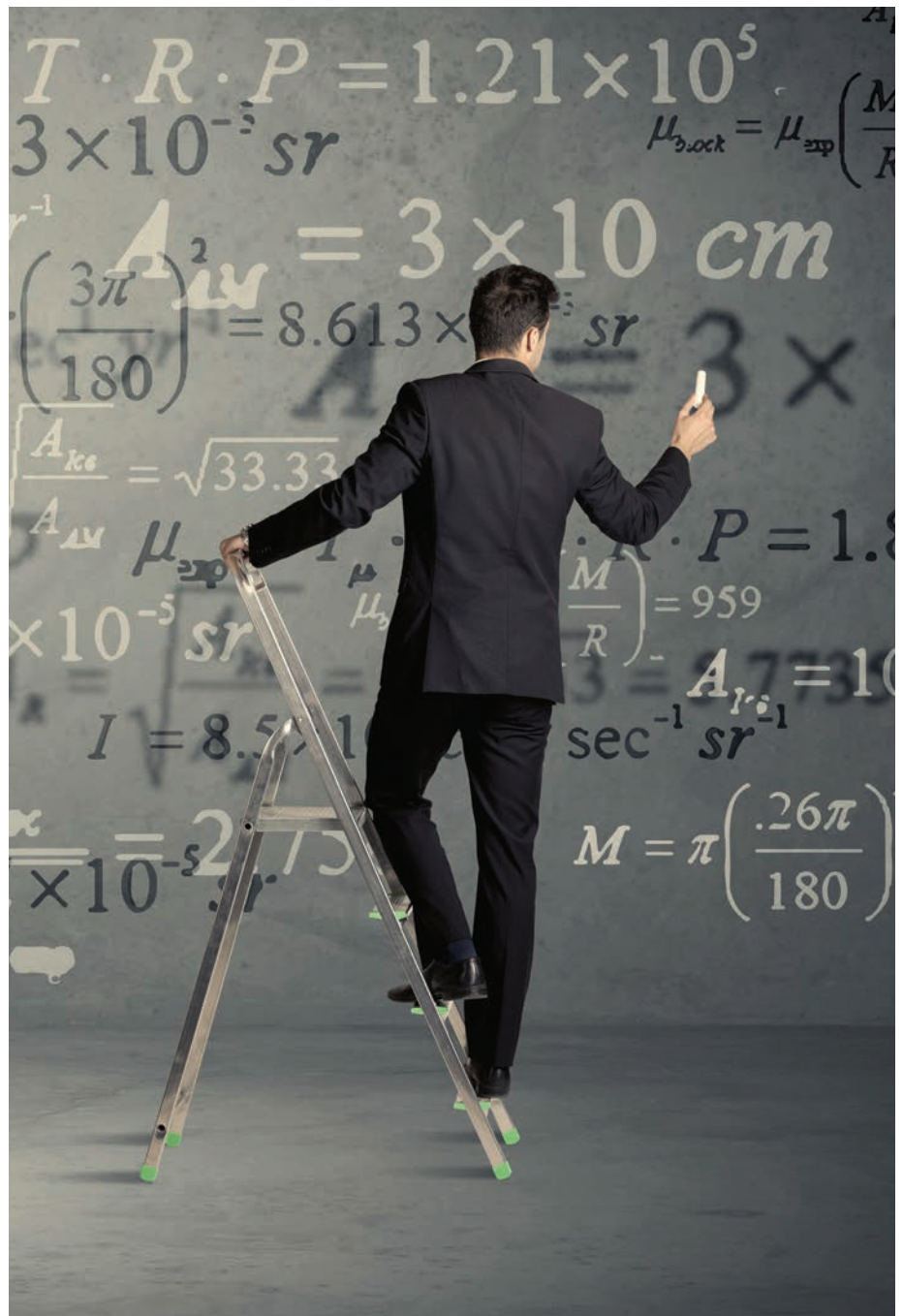
The press said President Trump lost. Given his vocal support and strong lobbying for the bill, this assessment was accurate, but one the President cannot, and, apparently, will not accept. He sent his team to try to salvage the bill before the April recess. They failed. Which was a bit surprising given that President Trump seems more focused on passing a bill – any bill – than on the substance of legislation.

This is the first number in our health care reform equation: President Trump wants to win and doesn't care how.

THE SECOND ELEMENT: DIVIDED REPUBLICANS

It takes a simple majority to pass a bill out of the House. With 434 current members (the elevation of Jim Price to Secretary of Health and Human Services leaves one seat vacant) 218 votes are required to pass legislation. There are currently 246 Republicans in Congress. Having already shut Democrats out of the process, all but 28 members of the GOP caucus are needed to pass a bill; a 29th Republican "No " vote and the bill fails.

There are about 40 members of the House Freedom Caucus, a group of the chamber's most conservative lawmakers
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	Bests	Fitch	S&P									
American Equity	A-	A-	A-	ICC13 MYGA (Guarantee 5) (Q/NQ)	S	2.50%*	5 yr.	None	9%, 8, 7, 6, 5, 0	Yes	\$10,000 (Q) & \$10,000 (NQ)	3.00% age 18-75 & 2.10% age 76-80** 1.50% age 81-85**
				ICC13 MYGA (Guarantee 6) (Q/NQ)	S	2.65%*	6 yr.	None	9%, 8, 7, 6, 5, 4, 0	Yes	\$10,000 (Q) & \$10,000 (NQ)	3.00% age 0-75 & 2.10% age 76-80** 1.50% age 81-85**
				ICC13 MYGA (Guarantee 7) (Q/NQ)	S	2.80%*	7 yr.	None	9%, 8, 7, 6, 5, 4, 3, 0	Yes	\$10,000 (Q) & \$10,000 (NQ)	3.00% age 0-75 & 2.10% age 76-80** 1.50% age 81-85**
*Effective 3/10/17. Current interest rates are subject to change on new issues. **Commission may vary by issue age and state. See Commission Schedule for details												
American General Life Insurance Companies	A	A+	A+	American Pathway Solutions MYG (*Guarantee Return of Premium) (Q/NQ)	S	2.20%** 2.40%**b	5 yr.	None	8%, 8, 8, 7, 6, 5, 4, 3, 2, 1, 0	Yes	\$10,000 (Q&NQ)	1.5% age 0-75 .75% age 76-85
						*CA Rates Effective 4/24/17. First year rate includes 1.50% interest bonus. a (less than \$100K) ; b (100K or more)						
American General Life Insurance Companies	A	A+	A+	American Pathway Fixed 5 Annuity (*Guarantee Return of Premium) (Q/NQ)	S	1.50%** 1.70%**b	5 yr.	None	9%, 8%, 7%, 6%, 5%, 0%	No	\$5,000 (NQ) \$2,000 (Q)	2.00% age 0-85 1.00% age 86-90
						*CA Rates Effective 4/3/17 Includes 2.00% 1st year bonus. 1.00% base rate subsequent years. a (less than \$100K) b (100K or more)						
American General Life Insurance Companies	A	A+	A+	American Pathway Fixed 7 Annuity	S	1.85%** 2.05%**b	7 yrs.	None	9%, 8%, 7%, 6%, 5%, 4%, 2%, 0%	No	\$5,000 (NQ)	3.00% age 0-85 1.50% age 86-90
						*(Guarantee return of premium Q/NQ) *CA Rates Effective 4/3/17. First year rate includes 4.0% bonus 1 st year. a (less than \$100K) b (100K or more)						
Great American Life	A	A+	A+	SecureGain 5 (Q/NQ)	S	2.50%	5 yrs.	N/A	9%, 8, 7, 6, 5	Yes	\$10,000	2.50% 18-80 (Q), 0-80 (NQ) 1.50% 81-89 (Q&NQ)
Effective 1/27/17.. Includes .25% first-year bonus and is for purchase payments over \$100,000. Escalating five-year yield is 2.50%. For under \$100,000 first-year rate is 2.35%. Escalating rate five-year yield 2.35%.												
Great American Life	A	A+	A+	SecureGain 7 (Q/NQ)	S	2.80%	7 yrs.	N/A	9%, 8, 7, 6, 5, 4, 3	Yes	\$10,000	3.50% 18-80 (Q), 0-80 (NQ) 1.50% 81-85 (Q&NQ)
Effective 1/27/17. Includes 1.00% first-year bonus and is for purchase payments over \$100,000. Escalating seven-year yield is 2.69%. For under \$100,000 first-year rate is 2.70%. Escalating rate seven-year yield 2.59%.												
Great American Life	A	A+	A+	Secure American (Q/NQ)	S	1.65%*	1 yr.	N/A	9%, 8, 7, 6, 5, 4, 3	No	\$10,000	5.75% 0-70 4.65% 71-80 4.40% 81-89
						*Effective 1/27/17. Eff. yield is 2.67% based on 1.65% first year rate, 1.00% available portion of 10% annuitization bonus (available starting in contract year two) and 0.02% interest on available portion of bonus at the rate of 1.65%. Surrender value interest rate 1.65%. Accepts additional purchase payments in first three contract years. COM12255						
The Lincoln Insurance Company	A+	AA	AA	MYGuarantee Plus 5	S	1.90%** 2.05%**b	5 yr.	None	7%, 7, 6, 5, 4, 0	Yes	\$10,000 (Q/NQ)	
						*Rates Effective 2/1/17 (a-for premiums less than \$100K, b-for premiums \$100K or more), and are subject to change						
The Lincoln Insurance Company	A+	AA	AA	MYGuarantee Plus 6	S	2.10%** 2.25%**b	6 yr.	None	7%, 7, 6, 5, 4, 0	Yes	\$10,000 (Q/NQ)	
						*Rates Effective 2/1/17 (a-for premiums less than \$100K, b-for premiums \$100K or more), and are subject to change						
The Lincoln Insurance Company	A+	AA	AA	MYGuarantee Plus 7	S	2.20%** 2.35%**b	7 yr.	None	7%, 7, 6, 5, 4, 3, 2, 0	Yes	\$10,000 (Q/NQ)	
						*Rates Effective 2/1/17 (a-for premiums less than \$100K, b-for premiums \$100K or more), and are subject to change						
The Lincoln Insurance Company	A+	AA	AA	MYGuarantee Plus 8	S	2.30%** 2.45%**b	8 yr.	None	7%, 7, 6, 5, 4, 0	Yes	\$10,000 (Q/NQ)	
						*Rates Effective 12/1/17 (a-for premiums less than \$100K, b-for premiums \$100K or more), and are subject to change						
North American Co. for Life and Health	A+	AA-	A+	Guarantee Choice II (Q/NQ)	S	2.45%** 2.70%**b	5 yr.	None	10, 10, 9, 9, 8	Yes	\$2,000 (Q) \$10,000 (NQ)	2.00% (0-80) 1.50% (81-85) 1.00% (86-90)
						*CA rates effective 4/10/17 - a (less than \$200K) b(200K or more)						
Reliance Standard	A+	A	A	Eleos-MVA	S	3.55%*	1 yr.	None	8%, 7, 6, 5, 4	Yes	\$10,000	3.25%**
						*Effective 12/2/16. Includes 1.50% 1st yr. bonus. Min. guarantee is 1.00%. **Reduced 20% ages 76-80, and 40% ages 81-85						
Reliance Standard	A+	A	A	Apollo MVA (Q/NQ)	S	4.45%*	1 yr.	None	9%, 8, 7, 6, 5, 4, 2	Yes	\$5,000	4.00% to age 75**
						Includes 2.00% 1st yr. bonus. Min. guarantee 1.00% **Reduced 20%, ages 76-80, and 40% ages 81-85. Effective 12/2/16						
Symetra Life, Inc.	A	A	A	Custom 7 (Q/NQ)	S	2.80%*	7 yrs.	N/A	8%, 8, 7, 7, 6, 5, 4, 0	No	\$10,000	Varies
						*Effective 4/24/17. 2.30% base rate with no guaranteed return of purchase payments. Plus 0.50% bonus for \$250,000 and above.						



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Why Second Opinion Services Will Take Critical Illness Insurance to the Next Level

by SCOTT BOORE

When a critical illness diagnosis is handed to a patient, life takes a turn for the chaotic. In that moment, it's not merely the diagnosis itself that weighs on a patient; every aspect of this person's life, career and daily routine is suddenly thrown into question: What does this mean for my family? Should I continue to work during treatment? How will I pay for time off? What treatment option is best for me? How can I both strive for the best and prepare for the worst?

Critical illness insurance was designed to mitigate some of these anxieties through a lump-sum payment to help defray unexpected costs. But when these patients are swimming in uncertainty, they need more than a simple financial guarantee. They need to know that they're making all the best choices available to them. That security-in-certainty is why second opinion services are rapidly becoming an indispensable complement to critical illness insurance.

Rapid access to expert specialists from around the country translates into peace of mind. This serves the dual function of amplifying the effectiveness of assistance provided by critical illness insurance, while also providing a direct emotional and psychological value-add to patients themselves.

Critical Illness insurance is already one of the fastest growing lines of coverage. Between 2008 and 2015, critical illness insurance posted double-digit annual growth rates of up to 24 percent, with total sales more than tripling to \$490 million. That growth propelled the product past cancer insurance in 2015 sales, and industry surveys now

rank critical illness insurance as the top growth product.

But after that stunning upward growth, critical illness insurance is now in danger of hitting a plateau. Participation rates in critical insurance products are now in the high teens to low twen-

will be key in nudging participation up higher.

KEY TO DIFFERENTIATION

Second opinion services can be the key to that differentiation. Most insurance products offer a simple value proposition to employees: a smoothing of the cost curve for one major and unpredictable expenditure category. By pairing critical illness insurance with a second opinion from recognized medical experts, bundled products offer an entirely different user experience and value proposition for employees; the knowledge that you're doing the right thing, paired with the means to act on that knowledge.

As a relatively recent entrant to voluntary insurance product markets, second opinion services require concise and clear explanations by brokers or human resource managers. Even critical illness insurance, which was first introduced by a South African cardiac surgeon in 1983, requires a strong education component to maintain growth. If bundled together, both second opinion services and critical illness insurance could make a category leap in terms of growth. It's that complementary product offering that cuts through the noise and offers patients what they need most: certainty and security as they face life's most difficult choices. ★



ties, about average for a voluntary insurance offering. As a voluntary product, critical illness insurance requires employees to choose participation out of a crowded field of insurance products, meaning product differentiation

Scott Boore is vice president of sales at More Health in Foster City, California. The company specializes in second opinions when patients are faced with a critical, potentially life-changing illness in areas such as oncology, neurology, cardiology and pediatrics. The website is morehealth.com.

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Increasing competition?
Narrowing networks?
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THE BENEFITS OF TALKING VISION BENEFITS

EMPLOYEE EDUCATION RESOURCES ARE KEY TO ADDED VALUE FOR COMPANIES

By NATHAN WOLLENMAN

In today's job market, it's no secret that offering a competitive health benefits package can go a long way in attracting and retaining top talent—not to mention keeping employees happy, healthy and productive. One benefit in particular that is gaining momentum—and one that should not be ignored—is comprehensive vision coverage.

Employees continue to face increasing visual demands—at work and at home—making access to vision coverage both extremely important and desirable. According to The National Association of Vision Care Plans, enrollment in vision benefits during the last five years increased nearly 20 percent—meaning more than half of all Americans have vision benefits. This is good news for employers, since a comprehensive vision plan is a cost-effective way to ensure employees are seeing, feeling and performing their best. So how can benefit advisors gain from this trend?

HUNGRY FOR INFORMATION

As a benefits broker, it's important to know that employees “see” the value of the vision benefit and want to learn more—craving information both from their employers and directly from their vision care plans.



Brokers can help employers and employees find the information they want and need—after all, 95 percent of employees want their employer to contact them proactively with education on lens technology, new innovations and general eye- and health-related topics, according to the 2017 Transitions Employee Perceptions of Vision Benefits survey. Moreover, employees want to receive this education frequently—not just during the enrollment period—with six in 10 (58 percent) saying they want communication about their vision benefits multiple times throughout the year.

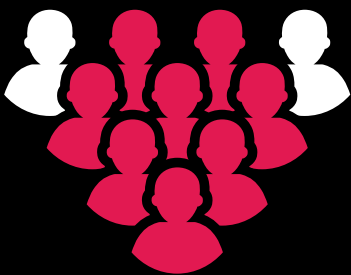
Diving a bit deeper, the survey uncovered that employees are also looking to their vision plans for this type of detailed information—with 83 percent saying they consult the vision care websites and resources provided by their vision plans, and 43 percent saying they do so frequently. For advisors, this means it's important to not only help clients choose a vision plan that is rich in its benefits offerings, but also one that is vigilant in offering education and resources.

What type of vision information do employees want? A little bit of everything. When asked what they were

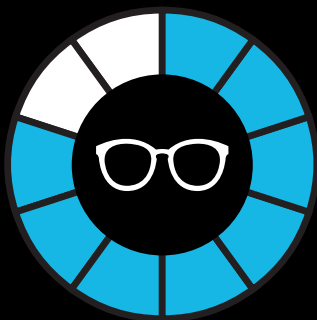
Employees Are
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8 in 10 employees would be more likely to enroll in a vision plan that covers options like *Transitions* lenses.



8 in 10 say they'd pay more if their vision plan fully covered products like *Transitions* lenses...



...and **2 in 3** would pay more than \$3 extra each pay period.

trying to learn from their vision plan's website, not surprisingly the top reasons related to learning the basics about how their coverage works:

- More than two-thirds (69 percent) of employees said they simply wanted to better understand their benefits.
- More than half (57 percent) said they wanted to learn if their eyecare professional is in-network.
- An equal amount (57 percent) said they wanted to learn more about their co-pay.
- More than half (55 percent) of employees said they turn to their vision plan's website to identify an eyecare professional.

Beyond the basics, they want information about premium lens options. In the Transitions Optical survey, more than one-third of employees said they turn to their vision benefits provider's website to learn more about different lens technologies and frame options. And when asked about specifics, the vast majority (93 percent) of employees said it was important that their vision benefits provider help educate on how certain lens options can protect their eyes, and 88 percent said they want more information about how lens technologies work.

EDUCATION ABOUT VISION CAN BOOST ENROLLMENT

Providing vision benefits education goes beyond meeting the needs and expectations of employees who are already enrolled in a vision benefit—it can ultimately result in higher enrollment, thus further improving an employer's bottom line, as well as the broker's commission.

The 2017 Transitions Employee Perceptions of Vision Benefits survey revealed several reasons that would motivate employees who did not already opt for their vision plan to enroll. Nearly six out of 10 employees (59 percent) said they would be more likely to enroll if they knew they could experience better vision.

Other strong motivators include:

- Learning about savings to their overall medical costs (58 percent)
- Learning that an eye exam can provide insights into their overall health (53 percent)
- Learning about the importance of

- eye disease prevention (44 percent)
- Learning that they would be more productive at work (34 percent)

And while productivity may be last on this list for employees, it's sure to be toward the top of the list for employers! Providing educational tools and resources that address these topics can help make the vision benefits enrollment process more efficient and effective. The good news is that many vision benefits providers already offer complimentary resources and education materials that not only review the basics of what each plan covers, but also dig deeper into the topics that matter most to employees.

VISION RESOURCES SHOULD BE MADE EASY

EyeMed, for example, offers a number of resources that we use regularly to help employers educate their employees, as well as resources that employees can access directly. Available programs and resources include:

- **Enroll.eyemed.com:** EyeMed makes it easy with this enrollment education site for employees to learn before enrolling in vision about the savings of the program and how it will be valuable as part of their overall health and wellness investments. EyeMed also supports many company open enrollment events with on-site representatives and information about the vision program.
- **Eye Site on Wellness:** This easy-to-use consumer-facing website is dedicated to vision health and wellness, and features several vision care guides and checklists, an interactive lens technology guide, video Q&As with an eye doctor, and articles in English and Spanish on maintaining healthy vision, eyewear options, vision care for different age groups, vision technology and more. The idea is to make it easy to help employees stay on the right path to clear vision and eye health.
- **Wellness Calendar:** Created for employers, this content calendar features monthly health themes that make it easy to promote wellness to employees throughout the year.
- **Regular member e-newsletter:** EyeMed's Insights member newsletters regularly provide quick tidbits about

vision and eye health-related issues, linking to the Eye Site on Wellness website for more information.

- **EyeMed Member App:** A handy app allows members to quickly and easily pull important information about their vision benefits, including co-pays and what's covered, an enhanced locator tool to find a nearby eyecare professional plus turn-by-turn directions, digital ID card access, special savings offers and the ability to store optical prescriptions and to set exam and contact lens change reminders.

Additionally, other optical companies and organizations also offer resources that brokers can share with employers, or that employers can pass along to their employees. Transitions Optical, for example, offers a wide range of materials through its Healthy Sight Working for You® initiative. Complimentary resources include a Vision Plan Savings Calculator that employers can use to determine the estimated prevalence of eye health issues within their workforce, as well as money they can save through a comprehensive vision plan. An individual calculator for employees is also available, so that they can learn more about their eye health risks and the benefits possible through their company's vision plan.

By sharing these resources with employers, benefits brokers can be even more valuable as an advisor. They can better communicate the importance of offering a comprehensive vision benefit to employers—while equipping them with the right education and tools for employees. This sets up benefits brokers for a situation where all parties benefit from increased enrollment in vision coverage: employers can help improve the productivity and profitability of their staff; employees will be able to see and perform their best; and benefits brokers will add to their revenue. ★

Nathan Wollenman is an employee benefits advisor with Barkley Insurance & Risk Management, specializing in employee benefits for groups from 30 to 3,000 lives. Barkley Insurance, based in Oxnard, California, provides customized and innovative employee benefits compliance, insurance and risk management solutions for businesses, associations and individuals. For more information about Barkley, visit www.insuranceandriskmanagement.com/

TAKING THE FEAR OUT OF SELLING SELF-INSURED HEALTH PLANS TO MID-SIZE BUSINESSES



By DAVID ZANZE

If you are a broker and not offering self-insured plans to your mid-sized groups, what is the reason why not? Could it be the current volatility of the health insurance industry? Do you offer only fully-insured plans because they seem like the easier sell with a bigger commission? Do you fear that it will take too much of your time to

administer a self-insured plan for your client? Or do you think a self-insured plan might be too risky for your valued clients and if they end up losing money during the year, you will be given the boot along with the self-insured plan?

Yes, as a broker these are legitimate concerns. However, in our experience as a third party administrator (TPA) the past two decades, we have seen time

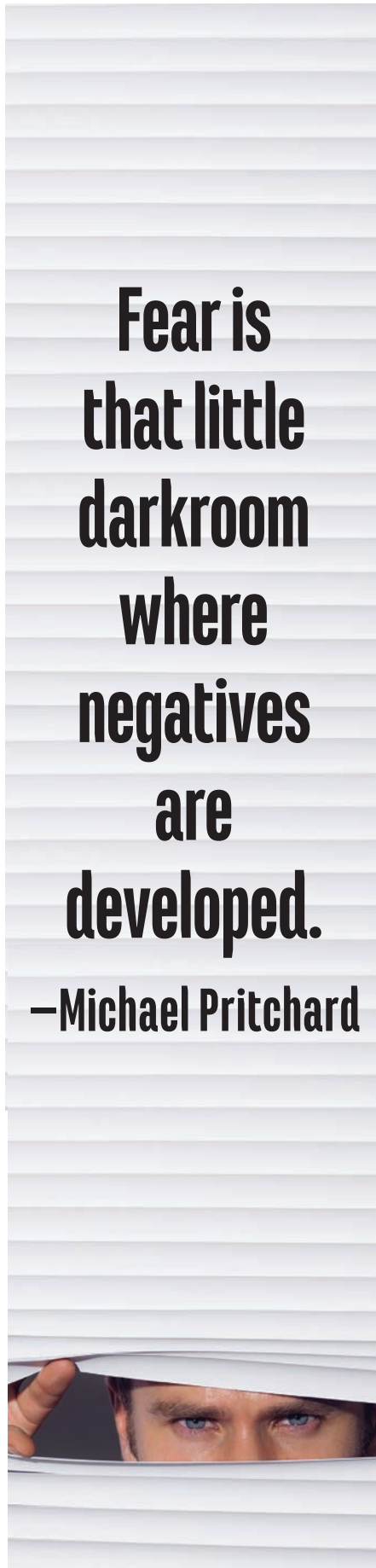
and time again that when an employer moves over to a self-insured plan, they rarely go back to fully-insured. Then why not sell it? It is typically the fear of the unknown and doing what feels "comfortable" that keeps a broker from breaking away from the standard fare they keep offering to clients. However, when you avoid selling self-insurance because it seems too complicat-

ed or the financial incentive not high enough, you are limiting the plans you are presenting to current or prospective clients. With employers looking for every possible solution to save on health insurance, they may decide to go with another broker who will show them the self-insurance option, which can provide more benefits.

What benefits? Benefits such as having the flexibility to design a health plan that meets the specific needs of your client's employee population. An employer can choose the vendors and services that are the right fit for their company's needs and not have to settle for the ones offered by an all-in-one carrier. Another benefit is saving money when the cost of claims come in under what was anticipated for the plan year. With a fully-insured carrier, your client knows for certain their premium will increase if their claims go above expectations. And even if their claims come in under, they will probably get a small premium increase the next year anyway.

Another benefit of going self-insured is the additional savings an employer can receive by offering programs such as care management and wellness to their benefit plan. By reviewing the spending patterns of claims coming in, an employer can target the health conditions that their employees can use additional support with such as type II diabetes, high cholesterol or high blood pressure. Having a program to help employees better manage certain health conditions can not only help them to become healthier, but can reduce health care costs for both the company and for the employee by offering reduced premiums and pharmaceutical costs or other incentives by participating in these programs.

Isn't it time consuming? In spite of the many benefits a self-insured plan can offer employers, some brokers think that having self-insured clients will be too time consuming. This is not an issue when their client hires a good TPA who can do the heavy lifting for you. A TPA will facilitate the claims processing, provide access to a healthcare network, and perform financial reporting along with other services for the employer on an as-needed basis. Moreover, a good TPA



**Fear is
that little
darkroom
where
negatives
are
developed.**

—Michael Pritchard

will keep their broker partners updated on health insurance reform, self-insurance topics and other important information that they can also pass along to their clients.

What about the risk factor? Yes there is some risk involved when a client goes self-insured. You will want to present the self-insurance option to financially stable clients that can endure the highs and lows of paying their own health claims each year. But the good news is that self-insurance is no longer for large employer groups only but for medium-sized employers as well. To reduce the risk, clients can have their TPA coordinate the purchase and management of stop-loss insurance (also called risk insurance), which can help alleviate their fear of getting hit by high health care claims that can take the company under. This insurance limits the annual dollar amount of claims submitted against the employer's self-funded plan and caps a specific limit to any one individual. Annual deductibles are established for both specific and aggregate stop-loss, and once those deductibles are met, the stop loss carrier re-funds monies to the employer's plans for any future claims submitted within the plan year.

Of course, there is still the perception that the only risk when going fully-insured is having to pay the premium each month. But I say the real risk is having your client miss out on the potential savings year after year resulting from being self-insured and leaving it up to the large carriers to determine the cost of their company's health insurance. By helping your clients take the fear out of self-insurance, you are expanding the options available to them, which can pay off positively and be advantageous to both you and your clients. ★

David Zanze has over 30 years of experience as a leader and innovator in the healthcare industry. He is the president of Pinnacle Claims Management, Inc., an all-inclusive third party administrator (TPA), and Pinnacle Rx Solutions, a pharmacy benefit manager. Both companies offer competitive, cost-efficient benefits administration and claims processing in sync with the latest technology in the self-funded market place. Visit www.pinnacletpa.com or call (866) 930-7264 for more information.

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WHAT EVERY SELF-FUNDED GROUP NEEDS:

2 TRENDS + 1 SOLUTION

By JO ANN VERNON



How many of your clients are considering self-insurance? Although the west has been slower to adopt self-funded options, my recent visits with brokers around the Pacific and Mountain time zones show they are feeling the winds of change. The recent House vote of 400-16 in favor of

The Self-Insurance Protection Act overwhelmingly confirms this shift. We'll watch as the bill heads to the Senate.

What does this mean for your client conversations, though? I'm sharing two trends and one critical component for every client considering a move to a self-insurance arrangement.

TREND #1

SELF-FUNDING ISN'T JUST FOR LARGER EMPLOYERS

Perhaps the most notable change in this movement toward self-funding is the number of smaller employers getting in the game. Although most of these are level-funded arrangements, employers see the value in gaining control of their plan with a focus on what's important to their specific employee base. Plus, the tax advantage isn't bad either as state taxes are eliminated on most self-insured plans.

But be sure to help your clients choose the right third party administrator (TPA) for claims adjudication. The right partner makes all the difference and will substantially increase the effectiveness of self-funding.

TREND #2

PPO AND HDHP PLANS ARE THE MOST POPULAR

According to one study by the Kaiser Family Foundation, most self-funding employers are choosing either a PPO or a high-deductible health insurance plan (HDHP). HDHPs are obvious choices, but the popularity of the PPO option is particularly interesting. Wouldn't an HMO seem to be the more likely choice? Managed care is a common way to control costs, it keeps the network narrow and a tight rein on how benefits are accessed. But when groups are looking to self-insure, they're considering what their employees value most – and it's still about choice and the ability to access care in a manner that works best for them. That's why the PPO ranks high among groups moving to a new self-insurance arrangement.

Tip: include a plan with an advocacy benefit. While employers want to offer choice to their workers, they also want employees to use their health plans in order to avoid unnecessary claims that hit the company's bottom line. Includ-

ing the advocacy benefit is a great solution for both needs. Employees get an expert to help them with things like comparing costs before procedures, locating in-network providers/specialists and negotiating bills. Consumer-Medical published a survey recently that said most employees of large and mid-sized companies aren't making the most of their health insurance coverage because they don't know how to medically advocate for them-



selves. With advocacy, employers see the savings because employees are equipped to make informed buying decisions. The average worker doesn't know the cost of their MRI may vary greatly within a 15-mile radius. However, their health advocate can do the research and provide them with this valuable information. That's a real benefit and a real savings!

CRITICAL COMPONENT

CONSUMER TOOLS

Whether partially funding or fully self-insured, employers need to protect the plan and their employees from high out-of-pocket costs. When consulting

with your clients, it's critical to implement cost-saving tools to help employees access care without driving up the cost of care. These include options like phone, video or email visits with doctors and specialists, additional savings networks outside of the health plan, and expert health advocates to aid employees in using their plans effectively.

And it's not enough to simply offer the consumer tools. Employees must be educated on how these options work to save money on their out-of-pocket costs. Explain how a phone consultation with a board-certified doctor can replace a doctor's office or urgent care visit -- and a prescription can be called in if it's medically necessary. This option delivers value to the employee by saving them time and money. Who doesn't want to skip driving, sitting in a waiting room and paying an expensive bill? Plus, it keeps more costly visits away from the health plan. A win-win.

Rep. Phil Roe (R-Tenn.), who introduced the Self-Insurance Protection Act, said in a statement, "By protecting access to self-insurance, we can help ensure employers have the tools they need to control healthcare costs for working families." I'd add that without implementing the necessary consumerism solutions and educating employees on how they work, the new self-insured plans will fail to meet their original intent.

How are you educating clients on the advantages and disadvantages of self-insuring? What are you suggesting to guide them through their choice? Email me at joann@freshbenies.com. ★



For more than 20 years, Jo Ann Vernon has been helping brokers and employers develop strategies and benefit programs for their clients and employees. She takes a consultative, holistic approach to benefit design by provid-

ing relevant solutions for employees and ultimately cost savings for the employers. She can be reached at joann@freshbenies.com.

Creating a Richer Employee Experience via Innovative Benefits Administration Technologies

By ERIC HELMAN



Samuel Taylor Coleridge famously wrote, "Water, water, everywhere and not a drop to drink." Like a sailor surrounded by salt water, employees are surrounded by web portals and mobile apps designed to help them better understand and use their employee benefits. The general idea was that these vendor-specific resources would increase employees' appreciation of benefits and decrease the number of questions and inquiries addressed to human resources. The strategy hasn't worked. So what innovation can we expect in 2017 to solve the problem?

SIMPLIFYING THE COMPLEX

Insurance providers have invented millions of dollars in self-service portals and mobile applications, but the next wave of innovation will come from benefits administration technology providers. Benefits administration platforms first evolved to bring together disparate benefit products in a unified enrollment experience. The consolidation included plan descriptions, links to provider web sites and helpful information about how to use the benefits. As the number and complexity of these products grew, benefits administration technology providers invested in

sophisticated decision support tools to better equip employees for decision-making during open enrollment. These innovations were typical of the second wave of the benefits administration technology.

Unfortunately, open enrollment only occurs once a year. When it comes time to use the benefits, employees' memories of the tools and resources available to them waned (along with the memory of their user IDs and passwords). According to online password manager Dashlane, the average American has over 130 online accounts registered to a single address. The need



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for aggregation is obvious.

At the same time, employers are investing in a bevy of standalone benefit programs designed to manage costs and increase employee satisfaction, such as telemedicine, wellness, cost transparency and prescription drug optimization. While successful at the microlevel, adoption of these programs remains in the single digits in most cases, thereby limiting their overall effectiveness. Given the competitive nature of these emerging markets for cost reduction programs, employers are often reticent to invest in technology to increase adoption out of fear that the engagement tools are too closely aligned with a vendor who may not continue to be the low-cost, high-quality provider in the future.

DELIVERING A PERSONALIZED, MOBILE EXPERIENCE

Enter the third wave of innovation in benefits administration technology. Leveraging the widespread adoption of smart phones and the experience of mobile application providers, benefits administration technology providers are beginning to deliver mobile applications that truly address the challenges employees face when using their benefits.

Some of these first generation “apps” are merely mobile versions of

the web-based benefits administration systems from where they evolved, but other apps are intelligently designed to consolidate a wide variety of data and resources. Leading providers are emulating the successful techniques of mobile application developers in other industries. To drive high download rates and large numbers of monthly active users (MAUs), consumers demand valuable personalized information that is dynamically updated. The top questions asked by employees are:

- Where do I stand in terms of my deductible and out of pocket maximum;
- What is the balance in my FSA, 401K or other account; and
- Where are my ID cards?

By providing immediate access to the answers to these questions, the best of the new benefits aggregation applications deliver immediate value to employees, encouraging high download rates and active use throughout the year.

AGGREGATING APPS FOR ENHANCED EMPLOYEE ENGAGEMENT

In the same way other successful mobile applications have created value, once you have users you can use the real estate within the application to present other opportunities, which are mutually beneficial to both the employees and the employer. Simpli-

fied access to telemedicine, wellness, cost transparency and prescription drug optimization programs through custom links or single-sign-on integration leads to increased adoption – and more cost savings. Finally, these new benefit aggregation applications often include messaging capabilities that allow human resources executives to break through the email clutter to convey information leading to higher rates of employee engagement.

Why are these attempts at aggregated engagement through benefits administration technology having more success than previous programs? The key differentiator is the value of the information that already exists in the benefit administration system and the value of these platforms as vendor agnostic aggregators. We expect that the capabilities of the smartphones and the creativity of the benefits administration technology firms will lead to the delivery of incremental enhanced functionality for many years to come. ★

Eric Helman is Chief Strategy Officer for Hodges-Mace, where he is responsible for creating, communicating, executing and sustaining strategic initiatives. Eric brings a vast background in innovative employee benefits administration and enrollment processes to the thriving Atlanta-based employee benefits firm. For more information, email Eric at: erichelman@hodgesmace.com





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Three Reasons Your Clients Should Introduce a Health Savings Account



By JIM LYNCH

Between the continued rise in healthcare costs and speculation about anticipated changes to Obamacare, clients are leaning on you to provide insight into the changing landscape of healthcare and consumer-directed benefits (CDBs). How can we help our employees better manage increasing out-of-pocket healthcare costs? How can we encourage

employees to think about savings for healthcare expenses long-term? Are there benefits that are better suited to certain employee demographics and generations? One consumer-directed benefit (CDB) that addresses each of those concerns and is experiencing impressive growth is the health saving account (HSA)—with one study showing 20 percent year-over-year growth in 2016.

Why should your clients consider adding an HSA to their benefits portfolio this year? Here are three good reasons:

1 An HSA stays with the employee—wherever they may go. When money is tight for many employees, contributing to a pre-tax savings account may seem like a risky move due to common misconceptions about how HSAs work. One of the big advantages of HSAs is that they are portable and belong to the account holder, even if they change jobs or healthcare plans. This is critically important for millennials to understand, as this demographic changes jobs more often than any other. While employees need to be enrolled in an HSA-qualified health plan to enroll and contribute to an HSA, they can use the HSA to pay for eligible, out-of-pocket medical costs even if they eventually switch to another health plan, such as a PPO. An HSA is theirs to keep.

2 Many employees are behind with retirement planning. We often hear about mistakes millennials make with their money, but they're not the only ones who are behind the eight ball when it comes to savings. Most people have grossly underestimated—or are in denial about—just how much money is needed to

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cover healthcare costs in retirement. According to HealthView Services: 2016 Retirement Health Care Costs Data Report, the estimated total cost of healthcare for a 65-year-old couple retiring today is \$377,412 (dental, hearing, vision and all other out-of-pocket expenses included). Another common misconception about HSAs is that they are predominantly spending accounts. Yes, HSAs can be used to pay for out-of-pocket medical expenses in the current year, but one of the biggest advantages is that an HSA also serves as a longer-term savings tool. HSA funds accumulate and can be invested to grow a healthcare nest egg to be used for future medical expenses. Your clients' employees will benefit from having both a 401(k) and an HSA to build retirement savings. Unlike a 401(k), an HSA gives employees the flexibility to spend or save funds as they see fit. HSA funds can be used for eligible expenses at any time—without penalty—this year or 20 years from now. In an effort to

encourage HSA contributions and help jumpstart employees' retirement planning, some employers offer HSA "matching" or annual seed contributions similar to the employer contribution model used with 401(k) plans.

3 An HSA is for savers, spenders and those in between. Employees have different financial priorities at different points in their lives. In their 20s, some may be focused on making ends meet and how to best manage new, out-of-pocket healthcare costs. In their 30s, some might start a family and be committed to ramping up



"Help your clients clear up common HSA misconceptions and understand the value HSAs deliver."

As HSA contributions increase and a nest egg starts to build, employees gain the flexibility to spend, save or do a little of both—with the HSA waiting and ready when they are. That's the beauty of an HSA—it's a multi-purpose savings and spending account that is with an employee for life.

Help your clients clear up common HSA misconceptions and understand the value HSAs deliver. HSAs help employees save money on out-of-pocket medical expenses in the short-term and build a healthcare rainy day fund for the long-term—that stays with them wherever their career may go. HSAs are a critical part of smart financial planning and retirement readiness and we expect adoption to continue to climb. ★

Jim Lynch is the chief sales officer for WageWorks. With more than 20 years of consumer-directed healthcare industry experience, Lynch is responsible for all direct employer sales for the company. He was president/owner of Planned Benefit Systems, Inc. for nine years before it was acquired by WageWorks in 2010. He is a certified employee benefit specialist and a member of the International Society of Certified Employee Benefit Specialists. Jim attended the University of Colorado, Wharton School and University of Pennsylvania. For more information on WageWorks, visit www.wageworks.com.

"An HSA is designed to be there as employees transition to different phases of life and as their spending and savings needs inevitably shift."

savings in case of unexpected, expensive medical events. In their 40s, employees may get more serious about putting money aside for retirement, realizing that next phase of life will be here before they know it.

An HSA is designed to be there as employees transition to different phases of life and as their spending and savings needs inevitably shift. Regardless of how much—or how little—employees contribute to an HSA, the triple tax advantages don't change. Annual contributions go in tax-free; the funds accumulate interest tax-free; and money can be withdrawn tax-free, as long as it's used for eligible expenses.

HSAs are relevant for all employees, regardless of their age or the size of their paycheck. Contributing even a small amount allows employees to see how using pre-tax dollars to pay for medical expenses results in savings.

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IT IS ILLEGAL TO BE A MEDICARE SPECIALIST OR MEDICARE EXPERT



By SUSAN HATCH

Specializing in Medicare Insurance products? Be careful of what you call yourself and what you print on your business cards, brochures and social media. It may be illegal in California.

The titles Medicare Specialist, Medicare Expert, Medi-Cal Broker, Health Insurance Consultant, Certified Health Insurance Agent or Senior Medicare Advisor -- just to name a few -- are not legal in California.

On September 26, 2008, Assembly Bill 2150 (Berg, Chapter 327, Statutes of 2008) was signed into law and became effective on January 1, 2009. This law in the California Insurance Code (CIC) prohibits insurance agents and brokers from using a "senior designation" unless the designation has been approved by the California Department of Insurance (CDI). Don't get too excited, there are almost no approved designations. Even "Certified Senior Advisor" is not approved. I found out the hard way.

MEDICARE SMARTY PANTS IN VIOLATION

I was in violation of this law in 2009. I received a not-so-nice phone call from the California State Department of Insurance. I was in bewildered shock

because I was a "smarty pants." I tested and certified with every carrier in my area. I had passed the AHIP test at 100 percent. I considered myself truly an "expert" when it came to Medicare insurance. I printed out and slept with The Medicare Marketing Rules and Guidelines every year. I couldn't believe the California laws were never mentioned in any testing or certifications.

I felt like an idiot after that phone call. I had to urgently change my business cards as soon as possible. I had to send the new ones to the Department of Insurance, so attorneys there could look over my business card and approve it. I was upset at myself for not protecting my career and license more responsibly. I now study California laws like a Medicare manic madwomen. I believe they may have gone easy on me because the law was only a few months in existence. That doesn't mean they'll go easy on agents now, though. Make sure you are always compliant. If not, be forewarned: you may be getting a call from the California State Department of Insurance or the California Department of Managed Care. Want to avoid a similar problem? Here are my best tips:

DON'T FOOL YOURSELF

Insurance agents test and certify with AHIP and multiple carriers for Medicare Advantage plans and Part D drug plans. Don't think this means

you know everything you need to know about regulations. Medicare Advantage and AHIP testing do not cover California laws. Those certifications and tests are for federal laws only, not state laws. Agents are obliged to comply with all federal and state laws. Many agents think that only relates to paying for their California license and doing California continuing education credits. Not so.

There is virtually no education in the industry about California laws. In the Medicare insurance world, there is no testing or certification for state laws. The majority of carriers, insurance agents, brokers and agencies are still simply unaware of many California laws.

REVIEW SOCIAL MEDIA ACCOUNTS

You should also review all of your social media accounts and phone book listings, etc. Are you listed as a Medicare insurance specialist? A Medicare consultant? Certified Medicare agent? Elder insurance adviser? Health insurance expert? Senior adviser? Those designations and anything sounding like those are illegal. You can't just make up your own designation because you like the way that it sounds.

CONSIDER THE REASON BEHIND THE LAW

There is some sanity and consumer protection to this law. Certain designations could make a senior believe that you are an employee of Medicare, or the government. It might appear that you are working on a salary, not a commission.

Illegal senior designations can confuse, deceive and mislead seniors. No matter how accurate or innocent you believe the designation is, lawmakers say many express or imply that an agent possesses expertise, competence, honesty or reliability with regard to advising seniors.

WATCH YOUR COMPETITION

You might think that no senior will turn you in because they don't know or care about this law. You should still be concerned. It is true that seniors probably don't know this law. But it's your competition and industry peers who turn agents, brokers and agencies into the Department of Insurance, not seniors.

EDUCATION IS KEY

I highly suggest that anyone working in the insurance industry always keep a watchful eye on California laws. You can look at the California state department of Insurance website and the California Legislative Information website at <http://leginfo.legislature.ca.gov/>

Unless you went to law school, you may struggle to comprehend the laws correctly. But reading the laws is far better than not even trying. It is your license after all and only you can protect it. Take it from me, ignorance of the law will serve as no excuse. ★



Susan Hatch is a licensed, independent insurance agent and holds the Professional Health Insurance of Advanced Studies (PHIAS) designation. Hatch is an objective advocate, analyst, speaker and talk radio guest about Medicare

supplements. She's received The NAHU Soaring Eagle Award and The NAIFA Quality Award. She was also awarded the #1 Medicare supplement agent in California. Hatch has worked with Applied General Agency as her preferred general agency for many years. Visit Hatch's website at MedicareToday.net or email her at CaMedicarePlans@sbcglobal.net

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WHAT THE ACTUAL LAW SAYS ABOUT SENIOR DESIGNATIONS

ASSEMBLY BILL 2150 (BERG, CHAPTER 327, STATUTES OF 2008)

A senior designation is defined as any degree, title, credential, certificate, certification, accreditation, or approval, that expresses or implies that a broker or agent possesses expertise, training, competence, honesty, or reliability with regard to advising seniors in particular on finance, insurance, or risk management.

A word, phrase, acronym, or logo constitutes a senior designation if it contains the word "senior," "Medicare," "Medi-Cal," "retire," "mature," "gerontology," or "elder," or any variation or synonym of one of these words within several words of the word "certified," "chartered," "registered," "adviser," "specialist," "consultant," "agent," "broker," "insurance," "planner," "professional," "enrolled," "accredited," "analyst," or "fellow," or any variation or synonym of one of these words.

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The Key is Perseverance

By VANESSA VIZARD



In many industries, only 2 percent of sales occur during the first meeting. Fortunately, for Medicare Advantage sales that number is significantly greater, with closing ratios as high as 30 percent on a first meeting. Yet, many sales professionals lack the perseverance it takes to drastically improve their closing ratios. The problem: they're not following up enough.

The most important and yet the most often missed opportunity by sales professionals is the follow-up. Data suggests that 44 percent of sales professionals give up after one follow-up. While the most successful sales professionals are closing 80 percent of sales because of their commitment to follow-up with their leads and prospects. In fact, they're following up at least five times before they give up on a lead. That's because according to Marketing Donut, 80 percent of sales take up to five follow-ups before the sale closes.

To gain an advantage over your competitors you will need to establish a five attempt follow-up strategy. Utilize multiple channels for your follow-up including phone calls, emails if they pro-

vided you with it, traditional mail and in-person appointments. Of course, don't forget to note what method each prospect prefers. Another important element to remember when converting your leads into sales is your response time. Research suggests that if you don't follow-up within the first hour of a lead contacting your company, the chance of qualifying that lead drops to 10 percent. On the bright side, if you follow up with web leads within five minutes, you're nine times more likely to convert them according to InsideSales.com.

Equally as important as the follow-up is establishing a relationship with your prospect to gain their trust. During your first meeting, take detailed notes about their specific needs for your follow-up calls. When you reach back out to your prospects, show value by referencing what you previously spoke about. At the end of your call, summarize your conversation to reiterate the benefits of your product and the details agreed upon. Repetition is another powerful tool sales professionals have in their tool boxes. The

more someone hears something, the more likely he or she is to retain the information and take action.

With the majority of Medicare sales occurring during the Annual Election Period (AEP), following up with your leads during the "lock-in" period will give you the competitive advantage you need to be successful. Often time, agents collect leads throughout the year at sales events, health fairs and elsewhere, but the potential client isn't eligible to switch health plans until AEP. Most agents only follow-up once or twice before giving up or they forget about the lead altogether. To ensure those prospects become your clients, follow-up with them every two to three months so they remember who you are and want to work with you when AEP hits. If you've done a great job in your follow-up, by September you should already have appointments booked for AEP in October. Remember, the key to success is perseverance. ★

Vanessa Vizard is the marketing director for HRBC Insurance.



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Our Tentative Speaker Line-Up: EmCee: **Linda Rose Koehler**, NAHU Region VIII RVP

- **NAHU UPDATE** **Bob Tretter**, NAHU Medicare Liaison
- **CARRIER CE COURSE** **Top Carrier Rep**, Medicare Sales
- **KEYNOTE (LUNCH)** **Leanne Gassaway**, AHIP State Affairs
- **PANEL DISCUSSION** **“Supplementing Medicare”** Moderator : Bob Trettor

REGISTRATION INFO (AVAILABLE SOON)

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Health Care Reform Math

(Continued from Page 6)

ers. The majority of the caucus were united in opposition to the AHCA. In March, President Trump blamed them for the bill's defeat. In April, he sent his emissaries to get their votes.

The Freedom Caucus demanded elimination of some of the ACA's most popular provisions as the price of their support. These provisions prevent carriers from excluding coverage for pre-existing conditions and requiring health plans include certain essential benefits like maternity coverage. The White House reportedly considered acquiescing to these demands.

The problem, however, was that accepting the Freedom Caucus demands resulted in (relatively) moderate GOP Members abandoning the AHCA. Gaining conservative votes doesn't help if the cost is an equal number of moderate votes. There may be a path to pass the AHCA solely relying on Republican votes, but given the divide between conservative and mainstream Republicans, it's hard to find it.

Which provides the second number for our equation: Republicans can't pass health care reform on their own.

THE THIRD ELEMENT: DEMOCRATS WANT REPAIR

Democrats believe the ACA has been good for America – especially for those who but for the ACA would have no health care coverage. Most liberal Democrats think the ACA doesn't go far enough. They won't be satisfied with anything less than a single-payer system.

Many Democrats, however, think the ACA is generally fine, but in need of critical tweaking to keep it working. Some liberals will hold out for their dream of "Medicare for All," but even many in their ranks will take a repaired ACA over a broken system or what Republicans are offering.

Which is why Democrats united against the Republican plan. Not that it mattered. Republicans never sought Democratic votes for the ACA.

Democrats want to fix the ACA.

That's the third number and final number in our health care reform equation.

THE MATH OF HEALTH CARE REFORM COMPROMISE

If President Trump wants to win he needs to move beyond a purely Republican formulation. Otherwise, as shown above, the math doesn't work. Republicans need the larger numbers Democrats provide to pass health care reform legislation.

How does this math work? Let's say a health care reform package reaches the floor of the House that attracts 164

"There are ACA taxes neither Republicans and Democrats like. Eliminate them. The Shared Responsibility Payments that penalize Americans for going without coverage is universally acknowledged to be ineffective. Fix it."

Republicans – just two-thirds of their caucus. However, it gains support from 54 Democrats – only one-third of their caucus. The bill moves on to the Senate. In short, it's easier to find 218 votes among 434 Members than from among 246.

This path makes the challenge before the President straightforward, if difficult: find a legislative package that attracts enough Democratic votes to offset the Republican votes it loses. In the old days (before Washington became hyper-partisan) pragmatists from both parties would meet and hammer out a compromise. That's what's needed now. Significantly, there's plenty of common ground to be found.

There are ACA taxes neither Republicans and Democrats like. Eliminate them. The Shared Responsibility Pay-

ments that penalize Americans for going without coverage are universally acknowledged to be ineffective. Fix it. Both Democrats and many Republican swant to keep the ACA's Medicaid expansion. Preserve it.

The path to a compromise won't be easy, but the equation is simple addition: President Trump wants to win and doesn't care how PLUS Republicans can't pass health care reform on their own PLUS Democrats want to fix the ACA. The result: compromise.

POLITICAL COVER

The biggest obstacle to achieving health care reform is not the math, it's the politics. Incumbents in both parties dread being "primaried" – Republicans fear being challenged from the right; Democrats from the left.

This is not paranoia. The extremes of both parties will seek vengeance on their less pure teammates. Party leaders and the Administration will need to give these members extensive cover in terms of messaging, campaign money and resources to beat back these attacks. Or, they will need to convince the public that failing to achieve health care reform is a worse outcome than the compromise.

This is where President Trump proves he deserves to win. He must demonstrate his self-proclaimed negotiating prowess and his proven marketing acumen can create a political environment where compromise on health care reform doesn't doom incumbents.

In other words, for President Trump to win he needs to make sure that members of Congress win, too. Otherwise, he loses. That's politics—and math. ★

Alan Katz is a past president of the National Association of Health Underwriters. He is a principal in Take 44, the company behind the NextAgency agency management and employee management systems. His award winning blog on health care reform can be found at www.AlanKatzBlog.com and his health care reform magazine can be found on Flipboard.

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HOW INSURANCE TECHNOLOGY CAN AND WILL UNCOMPLICATE THINGS FOR BROKERS

By DAVID REID

When President Donald Trump recently commented that “nobody knew that healthcare could be so complicated,” there were many who were taken aback. But, in truth, many of those who enjoy both good benefits and good health – and who have people to take care of the details for them – may be blissfully unaware of the complexities of the healthcare system. There are many others who know all too well that healthcare is complicated, and counted among them are the brokers who help individuals and businesses make their way through the challenging health insurance and employee benefits environment. Navigating the benefits landscape has never been easy – that’s why there are brokers – but a number of accelerating trends have added to the challenge. To put it mildly, yep, it’s complicated.

WHY SO COMPLICATED, THOUGH?

Perhaps the most significant trend is the pressure to keep insurance costs down (for themselves and their employees) and efficiencies up, which leads to exploring (and offering) a wider range of options. Compliance requirements are more exacting, and may not be letting up any time soon. Plans in themselves have become more detailed, and the nuances among plans – different provider networks, different

formularies – may be difficult to identify and interpret without close study. And there are a lot of plans out there.

In a recent article that appeared in BenefitsPRO, Vericred CEO Michael Levin noted that, in New York City, eight carriers offer over 700 small group plans. That’s New York City, but

“Brokers can uncomplicate things by adopting a benefits administration and enrollment system that can make their lives – and the lives of their customers – simple”

even in a far smaller city, there will be many different offerings. Take Portland, Oregon, where 10 carriers offer more than 300 small group plans.

Technology trends are a factor, as well. The digitization of just about every aspect of life means that people expect everything – information, analysis, sign ups and transactions – to be online and at their fingertips. This is especially true for the millennial “digital natives,” now the largest cohort in the U.S. workforce and stepping into management positions in HR. Yet much in the healthcare insurance world – despite what is heard about all those instantaneous quoting apps – remains manual: paper first.

GOOD NEWS: A LOT OF PLAN ENROLLMENT INFO IS ONLINE

Brokers don’t need to rely on outmoded manual approaches because much of the needed plan enrollment information is available online. The bad news, however, is that these capabilities are mostly contained in systems that are proprietary to each carrier. While this information is accessible online, it presents a couple of difficulties. For one, while technology is pervasive, at the end of the day insurance carriers are just that – insurance carriers, not software developers. Their efforts should be more appropriately focused on insurance, not coding. More importantly, having each carrier come up with its own unique system, with its own unique interface, puts the burden on brokers and the companies they work with to learn and manage multiple ways of retrieving information and forms, and enrolling employees. Even companies that provide only one plan, and are dealing with only one carrier, may switch carriers with some frequency. This puts the pressure on them to learn a new system. Multiply this by the fact that many companies offer a myriad of benefits in addition to

AMPLIFY

just medical insurance, such as dental and vision plans, as well as myriad other benefits, and that's a lot of user interfaces for brokers to contend with.

BETTER NEWS: BENEFITS ADMINISTRATION AND ONLINE ENROLLMENT SYSTEMS

While carriers have been cobbling together their proprietary systems, a new type of insurance technology application has emerged: benefits administration and online enrollment systems. Benefits administration systems, which are typically incorporated within a larger suite of HR-related applications such as payroll and PTO tracking, have at their core provided online enrollment for employees (both empowering employees and relieving the paperwork burden on HR), better benefits management for HR, and compliance with the ACA (or its replacement, in that eventuality). Increasingly, the vendors developing these applications are partnering with carriers to integrate with their proprietary systems so that they're both able to include plan information, forms and enrollment capabilities – all under one umbrella.

The benefits for brokers are clear: a single environment where they can access the information they need, all in one place, streamlining their day-to-day activities and letting them focus on more high value tasks. Many brokers are now offering these systems to their customers, making life easier for HR administrators and, in the process, solidifying their relationships. Brokers are increasingly using these systems to branch out their offerings, helping their customers define and put in place richer benefits plans.

So, while it is complicated, brokers can uncomplicate things by adopting a benefits administration and enrollment system that can make their lives – and the lives of their customers – simpler, and the solutions they offer better able to keep up with today's ever-more-complex environment. ★

David Reid is the founder and CEO of San Francisco-based Ease Central. EaseCentral is the broker's paperless solution for complete, paperless onboarding of HR, payroll and benefits. EaseCentral currently hosts over 12,000 employers nationwide, providing online benefit communication, enrollment and ACA compliance tools. The platform provides a working, 'real world' solution for agents to migrate away from paper-based enrollment for groups of any size, including small groups between 2 and 99 employees. More information can be found at www.easecentral.com.

LIFE INSURANCE SETTLEMENTS

AN ATTRACTIVE ASSET CLASS THAT CAN GENERATE STABLE RETURNS

by LINGKE WANG

Life insurance policies are financial assets for many people. They represent important investments in a diversified portfolio. However, people with grown children who are financially secure may not need the life insurance during retirement that they wanted when



they were younger. Others may realize that their nest egg is not as large as they'd like, and want to learn more about getting cash out of their life insurance policy.

In many cases, a policy simply becomes too expensive to keep in force. Over \$100 Billion in face value of life insurance is either voluntarily surrendered or lapsed each year by Americans over the age of 65. Nine out of 10 seniors surveyed by the Insurance Studies Institute indicated that they would have considered selling their policy instead of letting it lapse if they understood the life settlement option.

LIFE SETTLEMENT BASICS

Selling a life insurance policy through the life settlement process provides clients with a host of potential advantages. They can use the cash to meet their most immediate needs while eliminating the high cost of premium payments.

In a life settlement, an investor offers a cash payment to a life insurance policy holder in exchange for the policy itself. For people who want to get the most amount of money possible out of their whole life or permanent insurance policy before they die, a life settlement offers a well-regulated, safe, and reliable way to do so relatively quickly.

Investors see life settlements as an attractive asset class because they offer the ability to generate a stable return. Typically, investors are insurance companies, hedge funds, banks and pension funds. This type of investment is often included as part of a well-diversified portfolio allocation.

In most cases, the cash offer for a whole life or permanent life insurance policy is about 20 percent of the policy's face value. This figure varies depending on many factors, of course. While this amount is obviously a lot less than the death benefit, it's also usually more than the cash surrender value, which is an average of 10 percent of the life insurance policy's face value.

More than 90 percent of Americans live in an area where life settlements are regulated. The LISA (Life Insurance Settlement Association) website is an excellent resource for state-specific information on life settlement laws.

Life settlement funds may be taxable, depending on the individual's situation. IRS Revenue Ruling 2009-13 covers life settlement taxation in depth. It's important that the insured person check with their accountant to fully understand the tax consequences of participating in a life settlement before making a final decision.

Selling a life insurance policy to investors through a life settlement may be a good option for this type of client:

- **Over age 65**
- **Owner of a convertible, permanent, or whole life policy with a death benefit over \$100k**
- **Doesn't need the death benefit**
- **Can't afford high premium payments**
- **Policy issued by a highly-rated company**
- **Insured is a U.S. citizen and resident of the U.S.**

In a survey prepared for The Lifeline Program, nearly 80 percent of clients thought their financial advisors should inform them about the life settlement option. Over half of seniors in the survey let their policies lapse because they saw it as a financial liability.

Seniors may consider selling their life insurance policy to investors for the following reasons:

- **They need the financial resources provided by the sale to pay for rising health care costs**
- **Premium payments are prohibitively expensive**
- **Cash to improve quality of life in retirement is a priority**
- **Replacing the income of the insured in the event of their death is no longer a concern**

A life settlement may not be ideal for every client. The beneficiaries of the life insurance policy will no longer

be able to collect when the insured dies, and this may cause interpersonal problems.

Individuals involved in a bankruptcy or other debt situation should move forward with a life settlement with the full knowledge that the funds from the settlement may be subject to claims from creditors.

It's also important to understand that the life settlement process may take four to five months to complete. Policy holders who need cash fast may not be able to get the relief they need promptly. Ovid can speed up the life settlement process by matching the insured and their advisor directly with institutional buyers who are interested in their policy.

"In a survey prepared for The Lifeline Program, nearly 80% of clients thought their financial advisors should inform them about the life settlement option. Over half of seniors in the survey let their policies lapse because they saw it as a financial liability."

Learning about the life settlement process and getting offers from life settlement companies doesn't obligate the insured person to move forward in the process. There are other options for paying high premiums, such as taking out a loan against the policy to pay the premium or reducing the death benefit for a lower premium.

Participating in a life settlement is a process that should be approached carefully, and with as much information as possible. Consider consulting a tax professional, attorney, and financial advisor to help the policy holder make the best decision for their specific situation. ★

Lingke Wang is the co-founder of Ovid Life, a life settlement exchange that instantly matches policyholders with institutional buyers. Aside from his duties at Ovid, Lingke is also starting a second life insurance startup, Ethos. Ethos is still in stealth stage, but its goal is to make life insurance easier to buy and more affordable for the average American.

THE FUTURE OF EMPLOYEE BENEFITS AND DRIVERLESS CARS

By MONICA HIRNING

Healthcare cost continues to climb and consumers are increasingly shouldering the burden. In today's tight labor markets, where competition for skilled workers is reaching new peaks, employers recognize that passing on the cost of healthcare to employees is not a sustainable strategy – no more so than absorbing the cost into the company budget. Still, only a minority of California employers target the root causes of cost increases through proactive and innovative tactics, such as consumer-directed health plans (CDHPs), cost transparency solutions and reference-based pricing. Instead, according to the 2016 Benefits Strategy & Benchmarking Survey by Arthur J. Gallagher & Co., more than half continue to cost-shift.

As benefits consultants, we understand the hurdles to innovation. Launching new benefit programs takes time and effort from HR and staff – and there is also fear of an

employee backlash if benefits delivery is disrupted. Yet, we also see evidence that when employers wholeheartedly embrace strategic cost containment, coupled with strong execution and communication, good things happen. Company management feels more in control of this major area of expense, HR feels more empowered to drive strategic initiatives and employees reap the real benefits of having access to better, more affordable healthcare. So how do we convince more employers of the value of innovation?

In its essence, the conversation about whether benefits innovation pays is similar to the discussion about whether driverless cars are safe. Data in support of both arguments may abound, but overcoming the fear of fundamental change is tough. Inevitably, such conversations turn to the stand-out examples of when a self-driving vehicle was involved in an accident – or a rollout of a full-replacement HSA plan went haywire



The power players in the self-driving car space will, no doubt, continue to put forward evidence that supports their cause. In the healthcare benefits space, we too need more ammunition to present a cogent case to employers focused on retaining talent and achieving growth and profitability goals. With this objective in mind, Arthur J. Gallagher & Co. conducted a best-in-class employer analysis based on data from our 2016 national benchmarking survey, which includes a large California component. The analysis studied the behavior of organizations that rank in the top 20 percent in healthcare cost management (in their size group). We controlled the cost-control metrics for a variety of factors, such as evidence of plan affordability and employee turnover, to ensure that the expense reductions were net-positive and did not result from benefit cuts.

The results showed clearly that the best-in-class companies were far more likely than the norm to adopt proactive, innovative tactics. Knowing that objective data alone does not motivate change, we also interviewed some of the top performers to get to the core of what they are doing. During a recent series of seminars held across the state before a live audience of more than 500 employer representatives, we invited a number of local HR leaders to tell their stories. Just as the data itself showed, common patterns emerged.

UNCOVERING THE VALUE OF CDHPS

Best-in-class organizations are not only more likely than the norm to offer CDHPS, but also to drive high enrollment in these plans. They accomplish this objective by truly leveraging the consumerism aspects of the plans, rather than viewing them as a cost-shifting vehicle. Funding HSAs and HRAs at higher levels, and focusing on education by integrating decision-support and cost/quality transparency tools help these employers meet their mark.

In our interviews, one HR leader from a Northern California company highlighted how the introduction of a CDHP has been transforming the level of employee engagement in their healthcare choices. Positive outcomes measured through employee satisfaction surveys are providing proof.

MANAGING THE SUPPLY SIDE OF BENEFITS

Large best-in-class employers (1,000 or more employees) are almost twice as likely as the norm to feature plans with high-value narrow networks. They are also three times more likely to apply reference-based pricing, an approach that sets a cap on how much a plan sponsor will pay for specific healthcare services, thus incenting employees to choose a lower-cost option. While such measures may be viewed as draconian by benefit traditionalists, best-in-class employers reveal they are adopting them for the right reasons. Faced with today's healthcare market reality, where the price of the same procedure performed at different facilities can vary by 500 percent, guiding employees to the centers of excellence where they will receive affordable care of equal or better quality is a win-win. Of course, introducing these concepts to employees requires diligent communication and ongoing support, so best-in-class companies take employee education seriously, for example, adding support from high-touch benefit call centers.

Telemedicine is another tool that savvy employers are introducing to increase cost-effective access to care. In our interviews, several HR leaders related personal experiences with doctor video chats they used to evangelize the service with their employees.

SELF-FUNDING AND WELLBEING 2.0

Given their propensity for innovation, it is not surprising that the best-in-class are more likely than other employers to self-fund their medical plan, thus gaining greater flexibility in program design. The levels of self-funding in California are still lower than nationwide, given the strong presence of cost-effective HMO products, but they are growing. A Central Valley public sector employer with a self-insured plan shared an experience of "shopping" for a new PBM vendor – a process that involved a committee of employees in vendor interviews and the selection process. The organization ended up reaping savings that were substantial enough to keep the employee contribution flat at the following renewal, while not taking away anything from the benefits.

In the wellness arena, the best-in-class are not only



more likely to offer a program, but also tend to go beyond traditional wellness and develop a culturally-relevant wellbeing strategy. One financial sector HR executive described his company's shift away from health risk assessments, enforced through the penalty of higher health premiums, toward a health-centric culture. This "upgrade" includes fresh fruit deliveries, special events and a friendly competition where employees work in teams and self-report on their accomplishments.

While only a distinct minority leverages proactive benefit solutions, as healthcare costs continue to grow and the evidence of positive outcomes mounts, the scale is going to tip in favor of innovation. It is an exciting time to be in "benefits business." In contrast to self-driving car inventors, it is our role as consultants to encourage employers to not let go of the wheel, but rather to take firm control and exercise the many different levers to manage cost, improve benefits delivery and, ultimately, help protect the health of employees and their families. ★

Monica Himing, ASA, MAAA (monica.himing@ajg.com) is a strategic technical lead with Arthur J. Gallagher & Co.'s Benefits and HR Consulting division in Glendale, California.



Dearborn Introduces Dearborn Cares

Dearborn National Life Insurance introduced a new service called Dearborn Cares, which allows eligible life insurance beneficiaries to receive immediate, advanced payment of up to \$10,000 of their claim check – within 48 hours of confirmation – to help cover imminent expenses like funerals or medical bills. “We developed Dearborn Cares because we know that losing a loved one can be emotionally and financially overwhelming,” said Mike Witwer, chief operating officer at Dearborn National. Highlights of the service include: pays up to \$10k of employer-paid basic life insurance claims, check is mailed within 48 hours, available for covered employees and retirees, applies to claims with one or two named beneficiaries, no death certificate required. More information: contactus@dearbornnational.com.

Aflac's New Group Accident Plan Offers Customized Lifestyle Protection

Aflac announced the launch of its new Group Accident plan with innovative benefits, higher payout amounts and lower premium rates. The new insurance offering allows brokers to provide clients with a customized plan that fits most budgets and directly targets the out-of-pocket costs that impact employees' financial freedom. One out of every eight people seek medical

attention for an injury each year, according to Aflac. "Creating this new Group Accident plan demonstrates Aflac's commitment to meeting the needs of brokers and their clients by providing more choice, tailored coverage options and Day One value with bundled services," said Stephanie Shields, Aflac vice president of product innovation and marketing. New benefits include an organized athletic activity rider, which covers accidents that result from participating in team sports, as well as pain management, chiropractic treatment and alternative therapies needed as a result of a

covered accident. By offering Aflac's new group accident plan, brokers can provide clients with a robust benefits package bundled with services that deliver day one value at little or no cost. For example, Aflac's health advocate program helps customers navigate the complex health care landscape by offering support for a variety of issues, including finding doctors, understanding a diagnosis, negotiating medical bills and helping reduce out-of-pocket costs. With four flexible benefit categories, the updated group accident plan allows clients to fully tailor their coverage by choosing which categories to offer their employees and at what benefit level. With more specialty benefits offerings, this mix-and-match plan gives clients more control over benefits spending without sacrificing employee coverage. The four modules include: initial accident treatment, hospitalization, after care and life-changing events with benefits such as prosthesis repair, vehicle modification and more. All four categories in the expanded group accident plan can be paired with optional riders. For more information, visit <https://aflac-groupinsurance.com/>.

MetLife Releases U.S. Employee Benefit Trends Study
MetLife's 15th Annual U.S. Employee



Benefits Study confirmed that the gig economy and demographic shifts are disrupting the workplace and redefining employees' workplace expectations. MetLife's study found that the gig economy is posing a real threat to employers, with over half (51 percent) of employees saying they are interested in contract or freelance work for more flexible hours, the ability to work from home and project variety, as opposed to a full-time salaried job which may not offer such perks. Freelance work appeals to millennials most, with nearly two-thirds (64 percent) of the generation interested, followed by gen X (52 percent) and boomers (41 percent). Employers agree that the gig economy is affecting the workplace: nearly two-thirds (59 percent) say the increase of temporary jobs will impact the workplace in the next three to five years. When asked to rank their top benefits priorities, more employers (83 percent) chose retaining employees as an important benefits objective than increasing employee productivity (80 percent) and controlling health and welfare benefit costs (79 percent). More so, over half of employers (51 percent) say that retaining employees through benefits will become even more important in the next three to five years. "Not only is the gig economy disrupting the traditional workplace, but the workforce itself is transforming. There are four generations working side by side. Employees' definitions of family are changing, and certain demographics, like single women, are on the rise. Employees have very distinct wants and needs and expect their employers to meet them," said Todd Katz, MetLife executive vice president, group benefits. "To attract and retain top talent in this new era, especially during a time of decreasing unemployment rates, employers have an opportunity to adapt their workplaces to address the unique needs of their employees. This is especially critical when it comes to benefits." The full MetLife study can be accessed at www.benefitstrends.metlife.com/

Limelight Health Selected for Silicon Valley Plug and Play

Limelight Health announced it was selected by Plug and Play Tech Center to



join their Insurtech Innovation Platform. Plug and Play connects startups with a number of the largest insurance corporations, including Admiral Group, Aon, American National, Aviva, Farmers, Markel, Munich Re, Nissay, Pronto Insurance, SOMPO Digital Lab, State Farm, Sun Life Financial, Talanx, The Hartford, Thrivent Financial, Torchmark, Travelers, USAA and Westfield Insurance. "Participating in the Plug and Play insurance program is a tremendous opportunity for us," said Jason T. Andrew, co-founder and CEO of Limelight Health. "Plug and Play has accelerated many of the top companies that have transformed their industries." Limelight Health's enterprise technology helps streamline the employee benefits 'quote-to-enrollment' process for insurance professionals and their clients. Limelight offers a real-time, mobile, all-in-one platform so brokers have instant access to data and decision support technology for health insurance. With integrations to many HR, payroll, and CRM systems, Limelight says insurance and employee benefits professionals have a seamless end-to-end solution to manage multiple previously fragmented and manual processes. As part of the program, Limelight Health will attend Plug and Play's Insurance EXPO, with the chance to pitch to Silicon Valley's biggest investors. Limelight Health has offices in San Francisco and Redding, California. For more information, visit <http://www.limehealth.com>.

Hodges-Mace Launches SmartBen NOW Centralized Benefits Dashboard and Mobile App

Hodges-Mace LLC announced the release of SmartBen NOW, a mobile app and centralized benefits dashboard solving one of the top frustrations in employee benefits – how to gather and present critical information securely from multiple locations. For the first time, employees can access up-to-date information and account balances for all of their benefit plans in one convenient location. SmartBen NOW also includes single sign-on and one-touch launch into employer-provided benefit portals, which will help employers execute their benefits strategy and lead to improved benefit utilization and cost-per-claim. With SmartBen NOW, employees enjoy simplified access to personalized benefit information on their smartphones or tablets. In addition to enhancing the employee experience, SmartBen NOW also provides employers with an easy and effective way to send messages and reminders to employees, straight to their mobile devices. "The world of healthcare and benefits has become so complex that employees tend to disengage from the conversation," says Greg Hodges, Hodges-Mace co-CEO. "Our clients tell us that one of their major pain points is keeping the value of benefits top-of-mind during

the plan year. By making benefits information more intuitive and easier to access, employers will be able to interact with their employees in a more meaningful way than ever before." With the power of SmartBen NOW, employers connect employees to the value of their benefits throughout the year, not just during annual enrollment. Employees will now access their benefit elections and account balances related to 401(k), health plan deductibles and out-of-pocket maximums, flexible spending accounts, paid time off, and more, through a centralized dashboard. The portal also provides a one-touch launch to important resources, such as telemedicine, provider transparency tools, and health engagement programs. All employee information is stored securely in a cloud-based platform. SmartBen NOW will be available on Apple and Android for new and existing SmartBen Essentials clients. For additional information visit <http://www.hodgesmace.com>.

The Standard Launches New Health Advocacy Select Service with Short Term Disability Plans

Standard Insurance Company launched the Health Advocacy Select service, offered along with the com-

pany's Short Term Disability insurance coverage. The new Health Advocacy Select service, offered through an arrangement with Health Advocate™, a leading health assistance and support company, can help employees navigate the health care system while on a short-term disability claim and ease the administrative burden on HR professionals. "When a disability strikes, navigating the complexity of today's health care system can be a challenge for both employers and employees," said Daniel Tkebuchava, marketing product manager at The Standard. "We believe that providing Health Advocacy Select to employees experiencing a short-term disability is an additional way to assist them in moving forward with their lives when a disability occurs." Health Advocacy Select provides employees on a short-term disability claim with access to Personal Health Advocates, who are typically registered nurses. Personal Health Advocates can assist employees with common health care challenges such as finding the right health care provider and resolving medical insurance claims. "Backed by medical directors and benefits experts, Personal Health Advocates handle each case confidentially and in compliance with all state and federal privacy laws," said Tke-

buchava. "Employers often share the burden when frustrated employees consume valuable work hours trying to manage their health care needs or turn to their HR departments for help. Personal Health Advocates can help an employee obtain the assistance and care needed, alleviating the burden on an HR team." For more information visit <https://www.standard.com/employer/insurance/group-services/health>.

Decisely Receives \$60 Million Commitment to Expand HR and Employee Benefits Platform for Small Business and Benefits Brokers

Decisely, an HR and benefits platform for small businesses, announced today a \$60 million funding commitment from Two Sigma Private Investments and EPIC Insurance Brokers and Consultants, a portfolio company of The Carlyle Group. According to Decisely, the funding will be used to make HR, benefits insurance and employee administration simple and painless for small businesses in the U.S. Created by benefits technology and brokerage experts, Decisely combines the benefits of a technology platform with the personalized guidance traditionally provided by a benefits broker. "Decisely





is the only dedicated small business and broker-collaborative solution. We deliver a unique, complete service to both small businesses and the brokers who have traditionally served them," said Kevin Dunn, CEO of Decisely. "We combine dedicated, licensed trusted advisors and a complementary technology platform as a full-service broker-friendly solution for small business." For more information, visit <http://www.decisely.com>.

NFCC® Annual Survey Reveals Return to Higher Household Credit Card Debt; Consumers Still Want Professional Advice

The National Foundation for Credit Counseling® (NFCC®) released the results of the 2017 Financial Literacy Survey. Sponsored by Washington-based credit union BECU, the survey found an increase in Americans' credit card debt, decreases in the number of people with non-retirement savings and higher levels of concern about long-term financial stability, including retirement savings. "It is concerning that so many Americans remain in such a fragile financial position after the Great Recession," said Susan C. Keating, NFCC president and CEO. Compared to last year, significantly more U.S. adults indicate their household carries credit card debt from month to month (39 percent vs. 35 percent in 2016), with nearly two in 10 adults saying they roll

over \$2,500 or more in credit card debt each month, up from 2016 (16 percent vs. 14 percent in 2016). Interest rate increases related to the recent Federal Reserve announcement will likely add to the cost of carrying credit card debt, which could increase financial pressures on families who are unable to find extra room in their budget to offset the impact of these changes. Reversing a trend that has been consistent since 2009, more U.S. adults are spending less than they were last year (26 percent vs. 23 percent in 2016). As more households carry costly credit card debt from month to month, spending could become a greater challenge as Americans try to pay off balances while working against a rising tide of interest and fees. A little over half of adults (54 percent) say they are saving the same as last year, slightly down by 4 percentage points from 2016. Those who say they are saving "more" remains unchanged since 2016 (26 percent). The proportion that has non-retirement savings has decreased slightly in the past year (68 percent vs. 69 percent in 2016). Additionally, more than 1 in 4 U.S. adults (27 percent) do not save any portion of their household's annual income for retirement, which holds steady compared to 2016 (26 percent). When asked what areas of personal finance are most worrisome, retiring without having enough money set aside was

the top response, up significantly more than the previous two years (18 percent vs. 15 percent in both 2016 and 2015). Although the percentage who said they would not recommend student loans as a way to finance college education remains the same as last year (11 percent), the percentage who said their student loan was a good investment has actually increased since 2015 and 2016 (now 9 percent vs. 6 percent in 2016 and 2015). A person's confidence in their ability to repay a student loan is one possible factor in determining if borrowing is a good investment. More options for affordable repayment of student loan debt and the availability of nonprofit student loan counseling services may be among the factors influencing this positive trend. It remains encouraging that a majority of U.S. adults (80 percent) agree that, considering what they already know about personal finance, they could still benefit from advice and answers to everyday financial questions from a professional. Additionally, if they were having financial problems related to debt, nearly one-quarter of adults, or almost 59 million people, indicated they would reach out to professional for assistance. The complete 2017 Consumer Financial Literacy Survey can be viewed at <https://www.nfcc.org/data/>. ★





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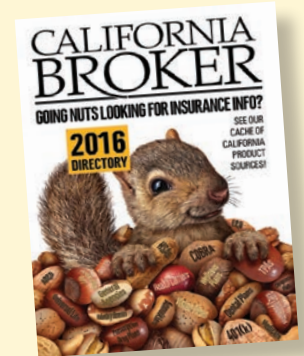
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