

# CALIFORNIA BROKER

VOLUME 36, NUMBER 8

SERVING CALIFORNIA'S LIFE/HEALTH

PROFESSIONALS & FINANCIAL PLANNERS

MAY 2018

## Are You Marketing Medicare and Other Managed Care Plans Blindfolded?

*What No One Is Telling You  
About the CA Department of  
Managed Care Regulations*



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Medicare • 401(k)s  
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Long-Term Care  
Employee Benefits

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Daly City, CA 94015

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### SOUTHERN CA

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Brand New Day Corporate Office  
5455 Garden Grove Blvd., Ste. 600  
Westminster, CA 92683

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#### IMPERIAL COUNTY

**May 11th | 11:00 AM**  
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## AWARDS

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Guardian recently released its Fifth Annual Workplace Benefits Study, Dental Benefits: A Bridge to Oral Health & Wellness.



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*By Naama Pozniak*

I was thrilled to attend the NAHU Capital Conference this year. Here's what I learned and why I was so energized by the experience.

# REAL PEOPLE

*Michael, a member of our Solutions Team, is just one of the many Warner Pacific employees dedicated to supporting our broker partners.*

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# CALIFORNIA BROKER

## MAY 2018

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### LONG-TERM CARE

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By William Upson, CLU, ChFC

Long-term care insurance is an essential product for clients in a society with a growing aging population. It is almost a guarantee that every individual will need some form of long-term care in their life. Advisers must guide clients to obtain coverage while they are still healthy to secure high-quality policies at low premiums.

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Having worked as a 401(k) plan consultant and investment adviser for more than 30 years, I have seen a wide variety of plan designs. Here's what I've learned about plan design.

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By Jeramy Tipton

National Small Business Month is a good time to remember that any small-business clients you might work with are focused on how their companies can control costs and stay competitive, while attracting and retaining a high-quality workforce. Fortunately, brokers can help ease their minds.



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# Meeting Compliance in the Era of “Repeal and Replace”

By COREY VAN HOUTEN

*Editor's note: Views expressed in our guest editorial are those of the author, not Cal Broker magazine. We welcome your opinions on any subject. Tell us at [editor@calbrokeromag.com](mailto:editor@calbrokeromag.com)*

To say that uncertainty surrounding health insurance in the United States currently exists is a lot like saying, “Albert Einstein was smart,” or “Michael Jordan is good at basketball,” – it’s a tremendous understatement. The rules and requirements for offering group health insurance have fundamentally changed, and it appears this trend will continue in the “Repeal and Replace” era that we now find ourselves in. Not surprisingly, many companies have not succeeded in implementing the required changes and even more are uncertain where to begin. Making matters worse, penalties and fines for non-compliance continually increase annually, as does the level of scrutiny and oversight that organizations like the Department of Labor are imposing through their auditing procedures. As a result, health insurance compliance is as important as ever. To help combat these issues, we will explore two specific compliance requirements that companies consistently fail to properly meet: the Form 5500 filing and the ERISA wrap document.

The Form 5500 filing has complexities that many companies miss and the audit risk for companies that fail to file the 5500 properly is increasing. According to studies commissioned by the Department of Labor, nearly 25 percent of all Form 5500 filings have discrepancies within the various

Schedules included with the filing. Under ERISA, Form 5500 must be filed by the plan administrator for every health and welfare plan covering more than 100 participants no later than seven full months following the close of the plan year (July 31 for traditional calendar-year type plans). Often, and as found by the Department of Labor, companies do not fill out the Form 5500 correctly. When this occurs, it guarantees an IRS employee plan compliance check, thereby greatly increasing the chances of a full-blown audit. Most filers do not realize that a separate Form 5500 filing is required for every health/welfare plan unless all the plans are correctly combined under one ERISA wrap document (described below).

Further, even less nuanced filing requirement mistakes are commonly made. For example, failing to accurately detail every benefit that is provided through each insurance contract, not accurately documenting terminated plans or incorrectly stating the number of plan participants can be the first misstep – ultimately leading to an audit from the Department of Labor. Companies and the Certified Public Accountants (CPAs) they often utilize in conjunction with the Form 5500, must correctly adhere to the filing requirements to avoid these types of negative consequences.

The second area where many com-

panies unknowingly risk non-compliance exposure is with regard to the ERISA wrap document. This document provides ERISA required information for group medical, dental, vision, long-term and short-term disability and term life insurance plans, among others (an “employee welfare benefit plan” under ERISA). A properly prepared wrap document generally identifies such items as individual eligibility requirements, plan participation rules and the duration of the offered insurance coverage. This wrap document is needed because the insurance contract issued to the employer does not include all the information required by ERISA. By carefully explaining medical benefit eligibility terms, plan sponsor information, claims procedures and special enrollment rights, the wrap document helps companies avoid “employer shared responsibility” penalties and the penalties for non-compliance can be as much \$110 per employee, per day. For larger companies, this penalty can be terribly punitive.

To help address compliance hurdles, organizations should turn to trusted partners who can help them with a compliance assessment – uniquely tailored to their size, business type, plan offering and funding arrangement. The purpose of the assessment is to diagnose compliance issues that may exist, or that could exist for a company. Specifically, it evaluates compliance



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- Subscriber count (i.e. enrolled employee count) is determined at time of initial enrollment as counted in CCSB systems and is based on medical subscribers only. No retroactive additions will be eligible for incentive payment. Dependents of enrolled employees are not counted.
- Groups must satisfy standard CCSB binder payment requirements for enrolled employees to count towards incentive program payments.
- Business written through partnering General Agencies qualifies.
- CCSB intends to issue incentive payments 90 days following the effective month of a qualifying group. CCSB may modify its payment schedule at any time.

For a complete list of the program rules go to: [bit.ly/AgentBonusProgram2018](http://bit.ly/AgentBonusProgram2018)

with the ACA, ERISA, group health plan mandates, COBRA and state continuation, HIPAA privacy and security, nondiscrimination rules, wellness rules, tax-advantaged plan rules, documentation requirements and reporting requirements. Compliance assessments also help companies identify areas where their individual processes and systems may not align with best practices and highlight the areas that need further improvement.

It's important that industry professionals stay up-to-date on the latest compliance regulations in order to provide the best guidance and support to clients. For example, OneDigital places a tremendous importance on compliance education for its consultants.

Each week a compliance roundtable is led by our national compliance team that focuses on specific, wide-ranging compliance topics. Designed to provide real-time updates on proposed/enacted legislative changes and rulings, these roundtables offer each consultant the ability to provide high-level expertise to their individual clients.

In an ever-changing health insurance and benefits world, it is paramount that companies are continuously and proactively working to achieve compliance. The Form 5500 filing and the ERISA wrap document are two on a long list of compliance requirements that present companies across the country with a consistent struggle. However, with regular assessments

and education, and by utilizing tools like checklists and compliance calendars, a company can ensure it's staying on track with various deadlines and can plan compliance initiatives in conjunction with annual individual planning. There isn't a magic formula to meet compliance in today's volatile regulatory environment, but the right combination of tools and processes can significantly reduce the burden. ★

*Corey Van Houten, Esq. is a client executive at One-Digital, a national team of experienced, local employee benefits advisers. He provides clients with strategic solutions to help reduce both their health-care costs and enhance their employee's perception of benefits value and negotiates insurance contracts on behalf of mid-size and large companies.*

ANNUITY SAMPLER

APRIL 1, 2018

Company Name	Ratings			Product	Type SPDA FPDA	Initial Interest	Guar. Period	Bailout Rate	Surrender Charges	Mkt. Val. (y/N)	Min. Contrib.	Comm. Street (May Vary)
	Bests	Fitch	S&P									
American Equity	A-	A-		ICC13 MYGA (Guarantee 5) (Q/NQ)	S	2.30%*	5 yr.	None	9%, 8, 7, 6, 5, 0	Yes	\$10,000 (Q) & \$10,000 (NQ)	3.00%, age 18-75 & 2.10%, age 76-80** 1.50% age 81-85**
				ICC13 MYGA (Guarantee 6) (Q/NQ)	S	2.45%*	6 yr.	None	9%, 8, 7, 6, 5, 4, 0	Yes	\$10,000 (Q) & \$10,000 (NQ)	3.00%, age 0-75 & 2.10% age 76-80** 1.50% age 81-85**
				ICC13 MYGA (Guarantee 7) (Q/NQ)	S	2.60%*	7 yr.	None	9%, 8, 7, 6, 5, 4, 3, 0	Yes	\$10,000 (Q) & \$10,000 (NQ)	3.00%, age 0-75 & 2.10%, age 76-80** 1.50% age 81-85**
*Effective 11/9/17. Current interest rates are subject to change on new issues. **Commission may vary by issue age and state. See Commission Schedule for details												
American General Life Insurance Companies	A	A+	A+	American Pathway Solutions MYG (*Guarantee Return of Premium) (Q/NQ)	S	2.75%** <sup>a</sup> 3.05%** <sup>b</sup>	5 yr.	None	8%, 8, 8, 7, 6, 5, 4, 3, 2, 1, 0	Yes	\$10,000 (Q&NQ)	1.5% age 0-75 .75% age 76-85
*CA Rates Effective 6/2/17. First year rate includes 1.50% interest bonus. a (less than \$100K) ; b (100K or more)												
American General Life Insurance Companies	A	A+	A+	American Pathway Fixed 5 Annuity	S	2.10%** <sup>a</sup> 3.10%** <sup>b</sup>	5 yr.	None	9%, 8%, 7%, 6%, 5%, 0%	No	\$5,000 (NQ) \$2,000 (Q)	2.00% age 0-85 1.00% age 86-90
*CA Rates Effective 8/7/17 Includes 1.15% 1st year bonus, 1.00% base rate subsequent years. a (less than \$100K) b (100K or more) (*Guarantee Return of Premium) (Q/NQ)												
American General Life Insurance Companies	A	A+	A+	American Pathway Fixed 7 Annuity	S	3.00%** <sup>a</sup> 4.00%** <sup>b</sup>	7 yrs.	None	9%, 8%, 7%, 6%, 5%, 4%, 2%, 0%	No	\$5,000 (NQ) 1.50% age 86-90	3.00% age 0-85
*(Guarantee return of premium Q/NQ) *CA Rates Effective 6/2/17. First year rate includes 4.0% bonus 1 <sup>st</sup> year. a (less than \$100K) b (100K or more)												
Great American Life	A	A+	A+	SecureGain 5 (Q/NQ)	S	2.90%	5 yrs.	N/A	9%, 8, 7, 6, 5	Yes	\$10,000	2.50% 18-80 (Q), 0-80 (NQ) 1.50% 81-89 (Q&NQ)
Effective 2/5/18. Includes .25% first-year bonus and is for purchase payments over \$100,000. Escalating five-year yield is 2.90%. For under \$100,000 first-year rate is 2.75%. Escalating rate five-year yield 2.40%.												
Great American Life	A	A+	A+	SecureGain 7 (Q/NQ)	S	3.10%	7 yrs.	N/A	9%, 8, 7, 6, 5, 4, 3	Yes	\$10,000	3.50% 18-80 (Q), 0-80 (NQ) 1.50% 81-85 (Q&NQ)
Effective 2/5/18. Includes 1.00% first-year bonus and is for purchase payments over \$100,000. Escalating seven-year yield is 2.99%. For under \$100,000 first-year rate is 3.00%. Escalating rate seven-year yield 2.89%.												
North American Co. for Life and Health	A+	A+	A+	Guarantee Choice II (Q/NQ)	S	2.90%** <sup>a</sup> 3.20%** <sup>b</sup>	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 4/5/18- a (less than \$200K) b(200K or more)												
Reliance Standard	A+	A		Eleos-MVA	S	3.00%*	5 yrs.	None	8%, 7, 6, 5, 4	Yes	\$10,000	2.50%**
*Effective 2/2/18. Includes 1.50% 1st yr. bonus. Min. guarantee is 1.00%. **Reduced 20% ages 76-80, and 40% ages 81-85												
Reliance Standard	A+	A		Apollo MVA (Q/NQ)	S	4.70%*	1 yr.	None	9%, 8, 7, 6, 5, 4, 2	Yes	\$5,000	4.00% to age 75**
Includes 2.00% 1st yr. bonus. Min. guarantee 1.00% **Reduced 20%, ages 76-80, and 40% ages 81-85. Effective 2/2/18												
Symetra Life, Inc.	A	A	A	Custom 7 (Q/NQ)	S	3.55%*	7 yrs.	N/A	8%, 8, 7, 7, 6, 5, 4, 0	No	\$10,000	Varies
*Effective 2/8/18. 3.05% base rate with no guaranteed return of purchase payments. Plus 0.50% bonus for \$250,000 and above.												

# IICF HONORS CHUBB'S JIM DARLING AT HORIZON AWARD GALA

Spirits soared in mid-March as the Insurance Industry Charitable Foundation Western Division hosted more than 300 insurance professionals and supporters at its annual Horizon Award Gala. Held at the 100-year-old Globe theatre in downtown Los Angeles, Jim Darling, regional executive officer, pacific region of Chubb, was guest of honor. Darling received a standing ovation when he accepted the 2018 Golden Horizon Award for his outstanding personal and industry leadership and philanthropic commitment, including helping to raise more than \$1.5 million in funds for the Cystic Fibrosis Foundation over the past 30 years. On Darling's behalf as the honoree, IICF presented a \$10,000 grant to the Cystic Fibrosis Foundation. The event also featured a special grant presentation of \$15,000 to the Los Angeles Fire Department Foundation, a nonprofit organization that serves as the major source of private

financial support for the Los Angeles Fire Department and provides support for needs not met by the city budget.

Many companies Cal Broker readers will recognize – including AIG, Chubb, Gallagher, The Hartford and Lockton – helped sponsor the Horizon Award Gala and the sold-out event raised over \$300,000 with ticket sales and a live auction! All proceeds will benefit local nonprofit organizations throughout the Western states, focused in the areas of education, at-risk children, and health and human services. Centerpieces made with mile-high magenta peacock feathers and the art deco atmosphere of the theatre were definitely stand outs. But the real show stopper: a room brimming with positive vibes. This is why, says Bill Ross, CEO of IICF, there's nothing like giving back to boost morale. "We all want to know that the companies we work so hard for are contributing to the good of the world,"



Jim Darling

said Ross. "It really does matter."

The next big event for IICF is the Women In Insurance Conference June 21 at the Millennium Biltmore in Los Angeles. For more info, visit [women-conference.iicf.org/western](http://women-conference.iicf.org/western). ★

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# Technology Is Changing Our Industry Your Survival Could Be at Stake

by JESSICA WORD

**T**echnology continues to change the way all of us interact, both personally and professionally. In the health insurance industry, technology advances and improvements have been a result of increased consumerism, health care reform and enactment of the Affordable Care Act (ACA), and today's "I want it now" society.

While technology has certainly helped make most of our jobs easier (at least at some level), there are still barriers that prevent some brokers from adopting and using new technology. Unfortunately, that resistance could be detrimental to the future growth of your business. Increased automation is the direction we are headed, and it's what more and more clients want . . . and expect.

What was once a paper-driven industry is, increasingly, transitioning to an industry where more activities are online: quoting, enrollment, reporting and administration. It is easy to understand why, with reduced errors in data and insurance calculations, faster group processing, increasing mobile app use (in people's everyday lives), a new generation of workers (who are comfortable doing more things online and on their smartphones), and increased outsourcing of benefits administration by employers.

## DRAMATIC MOVES IN LESS THAN A DECADE

The drive to online enrollment and increased automation – for even smaller organizations – cannot be ignored. It's a trend that is likely to continue, and accelerate. Consider these statistics:

1) A 2017 survey on employee benefits by Guardian Life Insurance Company of America found a 165 percent growth rate in the proportion of employees who use some combination of web-based technology to enroll in



their benefits.

- 2) Guardian found 40 percent of employees enrolled via computer-only (versus 12 percent five years earlier).
- 3) Thirty-six percent used paper only enrollment, down from 58 percent in 2012.
- 4) Sixty-one percent of enrolling employees used a computer for a portion of their benefits enrollment.
- 5) Among full-time employees who used computer-based technology for at least a portion of their benefits enrollment, 92 percent cited convenience as the top reason.
- 6) Eighty-seven percent said online access to benefits saves time and 73 percent said it gives them more control.

Business Insurance reported in March 2018 about a Buck Consultants survey that found 93 percent of employers communicate benefits information to employees via websites – and 80 percent of those organizations say that three-quarters of their workforces are online.

Online enrollment simplifies benefits selection for all parties: brokers, employers, and employees. It gives brokers and employers insight into an active enrollment and highlights those employees who have – and have not – completed their benefits

selection. It helps solve for missing information by requiring specific input by enrolling employees before allowing them to complete an enrollment. That means expedited case approvals and a smoother enrollment process. Researching and matching your needs and those of your clients to the right enrollment technology partner is vital. You want to be sure you select an organization that continues to evolve their digital tools – one with a past and a future.

With regard to enrollment, because technology is improving, information today can be far more personalized than in the past. Employees are now able to see only what they need to see – and only what's relevant to their individual or family enrollment. Consequently, technology is helping employers communicate benefits information more effectively. There is less employee confusion and higher employer satisfaction. HR departments that used to get a lot of calls during open enrollment no longer have to staff-up to address that influx.

Application Program Interface – API – is also critical, so data about the group is shared more easily and quickly, eliminating or reducing the required re-entry of benefits and employee information.



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This helps expedite enrollment, and facilitates carrier processing (or processing by an administrator if your client group, for example, selects coverage from a multi-carrier exchange).

Beyond enrollment, employers are looking for HR and benefits management systems or platforms that can help them reduce redundancy and provide greater clarity for employees. They want services that allow employees to shop and compare plans, enroll, and provide real-time access to help them manage their benefits online and/or on their smartphones throughout the year. When you're looking at what's available, ask if the system offers paperless onboarding and employee benefits management, with all documents, enrollments and terminations in one place. There are resources in the marketplace that deliver this simplicity.

It's equally important – and some would say even more important – that you look for and identify a tech partner with an array of mobile tools. It's not just beneficial for you as your client's broker, it's important for employers and their employees, with more being done "on the go." One example is a Mobile ID Card. This gives enrolled employees and their dependents access to their member ID information immediately on their smartphone, so if they need medical care before their plastic or paper ID arrives in the mail, they can be treated more quickly.

Today, employers of every size – and their employees – want and expect a seamless experience when it comes to employee benefits, as in other aspects of their lives. It is an on-demand world, and our industry has to embrace it . . . or be left behind. Brokers are now expected to be year-round advisers on employee benefits, reporting and HR-related matters. You will thrive if you research and adapt changing technology to help you better serve your clients' needs and find a partner that can offer the technical solutions very quickly becoming the norm. ★



*Jessica Word is president of the Word & Brown General Agency, which is headquartered in Orange, California, and serves brokers throughout California and Nevada.*

# A Cheat Code for the InsurTech Game

By MIKE ALBERT



**S**poiler alert: Insurance is a tech laggard. If you've been around more than a week or two you already realize that. Any industry where high-profile, "automation" projects center around scanning paper or optimizing email and form-based workflows is probably not an industry on the bleeding edge.

That said, a less-than-stellar industry technology track record has created a host of opportunities for companies approaching technology differently, using it to overcome common pitfalls, and run more profitable businesses with happier customers. Whatever "InsurTech" means to you, it's an inescapable fact that outside pressure is forcing us all to step up our game. Let's get after it...

## TAKE RISK, GET PRACTICE

Brokers and insurance companies alike are in business to help clients assess and mitigate and/or avoid risk. This means the industry has a built-in handicap when it comes to implementation of new tech – risk aversion is in its very DNA. With the new, comes a level of uncertainty, a level of unpredictability. Recent industry commen-

tary suggests that companies should only look at advanced technology with significant, strategic business applications, positive customer impacts, and an already proven implementation record. While that may seem intuitive, it neglects the obvious risks which may have to be taken in pursuit of the right technology. Let's face it, every business has the same objective in the long run – to make money. Getting there probably means lots of happy customers. This likely makes some measure of risk necessary. If you have reason to believe any given piece of tech might help your customers or the bottom line, go! Get out there and find out for certain. Start experimenting. Fail fast or succeed big. Organizational ability to implement technology is not unlike any other skill. You get better with practice, but you'll get nowhere fast sitting on the sidelines overanalyzing things.

## ON THE "BUSINESS SIDE"

If your company uses phraseology like "she's on the business team," or "he's on the IT team," you might be doomed. In 2018, is there really any difference?



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SilverScript Choice is a Prescription Drug Plan with a Medicare contract offered by SilverScript Insurance Company. Enrollment in SilverScript depends on contract renewal. SilverScript Insurance Company is an independent company whose products and services are not Blue Shield of California products and services. SilverScript Insurance Company is solely responsible for this prescription drug coverage.

Blue Shield of California complies with applicable state laws and federal civil rights laws, and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. Blue Shield of California cumple con las leyes estatales y las leyes federales de derechos civiles vigentes, y no discrimina por motivos de raza, color, país de origen, ascendencia, religión, sexo, estado civil, género, identidad de género, orientación sexual, edad ni discapacidad. Blue Shield of California 遵循適用的州法律和聯邦公民權利法律，並且不以種族、膚色、原國籍、血統、宗教、性別、婚姻 狀況、性別認同、性取向、年齡或殘障為由而進行歧視。

Aren't we all on both? Generally, this is a warning sign of a siloed culture that won't be very good at either tech or business in 2018. How can a developer on a project at your company possibly be effective if she doesn't understand why a solution is being built, and for whom? Similarly, how can a project's executive sponsor be effective at making critical decisions about scope and partner selection if the individual doesn't understand modern tech? The notion that the "business" is one thing, and the "technology" is another, is a mistake. It's all the same.

**SHARE. IT FEELS GOOD.**

The insurance industry has a problem with sharing. Too often, organizations believe that keeping cards close to the vest is a strategic benefit, or a competitive advantage. Sure, in certain strategic cases it may be important to keep secrets, but a general aversion to openness creates interoperability problems, both human and technical. This is especially an issue on the distribution side.

Take, for example, something as basic as risk appetite. For some insurers, the fear of a competitor not finding out a certain segment of the insurance market is desirable to them takes precedence over making sure the company's own brokers have that information. There is a reluctance to communicate to the market what the company even sells. If Amazon were run like some insurance companies, you'd email in the name of a product you were looking for and two to five days later someone would respond to tell you if the product in question is even sold by Amazon. Want to find out how much it costs? Two more days.

**DARE TO BE SIMILAR**

At times, convention can be a good thing especially as it pertains to the common business processes brokers undertake with insurers. Workflows are often seemingly designed in a vacuum by internal teams trying to revolutionize the business. Even if what they eventually roll out is high quality, it's often very different than the experience of other insurers. Coverages and fields take on different names from insurer to insurer. Workflows, processes



and timeframes all vary too. For the independent agent/broker, the consequence is that staff need to learn all of the little idiosyncratic quirks of the systems of every insurer they work with. It means training people that "x" means "y" when dealing with Insurer A, but "x" means "x" when dealing with Insurer B. Systems don't speak the same language and can't work together. Simply put, it's an efficiency nightmare, and frankly, a total hassle.

Flipping this on it's head, what if an insurer put its data model on github, and shared it with the world? What if an insurer or broker released a first-class API to encourage and guide interactions with third-party partners? And, that doesn't mean some lipstick-on-a-pig, SOAP wrapper around an ESB that's been struggling to service requests in under 240 seconds for the decade it's been coughing along in the server closet. It means the good stuff. Bite-sized, functional services, sub-second response times, websockets, REST, JSON. If I lost you on that last thought, just know that APIs are absolutely essential in 2018 – APIs are the way technology "shares." APIs increase interoperability, drive down cost, and mitigate risk, but not all APIs are created equal. APIs are probably something worth learning more about if the subject matter is not exactly in your wheelhouse.

Sharing, interoperability and commonality create efficiency. Efficiency drives deal volume. Deal volume juices the bottom line. The bottom line drives bonuses. Bonuses drive vacation time.

See where I'm going with this? Buy me a drink when we meet up in Turks a year from now.

**THE CHEAT CODE**

So, what's the cheat code to the InsurTech game (other than up, up, down, down, left, right, left, right, b, a)? Draw influence from outside the industry. Outsiders are investing in the space at a fever pace because of the opportunity the industry's bad tech and lack of utilization of emerging tech to transform business processes represents. These outsiders see the opportunity, but don't know the ins-and-outs of the business like industry veterans. So, try to look at insurance from the outside in by focusing on how retail has adapted to the modern world. Are there patterns insurers can borrow from? What about other financial services sectors? How have such "sister industries" used technology in ways that parallel the insurance business? What about the tech sector? Get past the cliché innovation stuff, and find some real examples of how other industries have used new technology to drive the bottom line or build happier customers. The bad news is that the insurance industry is behind. The good news is that there are plenty of great examples to copy. ★



*Mike Albert is the co-founder of Ask Kodiak. He can be reached for further information or comment via email at [mike@askkodiak.com](mailto:mike@askkodiak.com)*

The State of the Internet of Things (IoT) and Insurance

# Insurance and THE DATA EXPLOSION



By 2020, up to 50 billion connected devices will be generating 194,000 exabytes per month around the world.<sup>1</sup>

Historically the insurance industry has made great strides in using data and analytics to drive decisions ... however, a recent LexisNexis® Risk Solutions survey of nearly 500 U.S. insurance professionals, revealed that there is a big opportunity when it comes to connected data sources.

Most insurers are not using data from IoT sources, but a large majority agree that it is important.



Sources of IoT data for Insurance are all around us

Insurers recognize IoT's importance for the industry's future

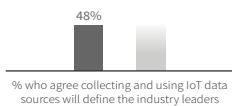
Click the circles to compare perceptions of line of business with the overall total.



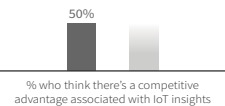
\*Interactive PDF features are best viewed on a computer (using Acrobat, Chrome or Internet Explorer) vs. mobile device.

■ Total □ Line of Business

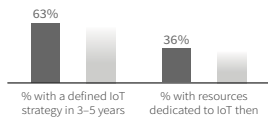
Carriers think IoT data collection and usage will shape the direction of the insurance industry:



Nearly half think insights from IoT data will give carriers a competitive edge:

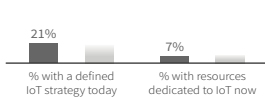


More than 6 in 10 predict they'll have a strategy in a few years, but only half that expect to have resources:

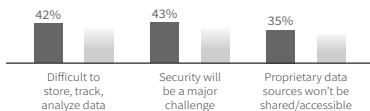


## Barriers exist for carriers today

With a minority having a defined IoT strategy, even fewer have resources dedicated to IoT today:



... But perceived barriers (difficulties in data governance, security concerns, proprietary issues) hold many back:



## Be ready for the Internet of Things

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1. Cisco, Alte, May 2017

### WEARABLES

- Fitness Device**
  - 119 BPM, 15K steps
  - 5th run this week
- Smart Pacemaker**
  - Heart rate: elevated
  - Cardiologist monitored

### CONNECTED CAR

- App-based Telematics**
  - Drives <20 miles a day
  - Score of 72 out of 100
- OEM Telematics**
  - High risk driver
  - Tight cornering

### CONNECTED BUSINESS

- Driver Tracking**
  - Low risk driving style
  - Truck not used at night
- Fleet Analytics**
  - 82% low-risk drivers
  - 3 new driver alerts

### CONNECTED HOME

- Smart Home Monitoring**
  - Environmental sensors
  - Police + fire notifications
- Security System**
  - Actively monitored
  - Cloud-based recording

# Are You Marketing Managed Care

*What No One Is Telling You  
About the CA Department of  
Managed Care Regulations*

# Medicare and Other Plans Blindfolded?

By SUSAN HATCH

It is near impossible to understand why one state department rather than another has jurisdiction over a particular product or company. The California State Department of Insurance employs about 1,403 people with an annual budget of \$264 million dollars for 2016.

AB 78 was passed in 1999 which created the Department of Managed Health Care. The DMHC is part of the California Health and Human Services Agency. It was established in 2000 and is responsible for enforcing the Knox-Keene Health Care Service Plan Act of 1975, and other related laws and regulations. To stay up to date and know California state laws, insurance agents must do their own research with regard to California state laws. Unfortunately, the majority of insurance agents that represent Medicare Insurance products have never even heard

of The California Department Of Managed Health Care (DMHC).

Agents who focus primarily on Medicare Insurance products test and certify every year for all of the various Medicare Insurance products with each of the companies they wish to represent. With the yearly certificates in hand, some agents believe that they are an "expert" after passing. Those tests and trainings are focused on federal laws, rules, and regulations, not any state laws. However, The California Department of Managed Health

***"The shockingly simple math is: there are over 320,000 insurance agents in California. In 18 years time, the DMHC has had approximately 32 enforcement actions against agents, compared to over 3,210 enforcement actions of approximately 139 Health plans in California."***

Care has jurisdiction over all managed health care plans in the state and there is no mention of that on any test, from any company!

Only in the state of California, regulation and oversight of health insurance is split between two completely different state departments. The Department of Insurance and DMHC, regulator of all health maintenance organizations, HMOs, some PPOs, Covered California Plans, employer small and large group plans, Medi-Cal HMO plans, Medicare-Medi-Cal HMO Plans, Medicare Advantage plans, three Medicare Medigap Supplement plans that are California based, dental plans, independent practice association (IPA) risk bearing organizations (RBO), COBRA and Medical groups – just to name a few, but not all.

To make this even more confusing, not all health plans in California are under the jurisdiction of the DMHC. For example, some PPOs are regulated by the California Department of Insurance (DOI). In addition, self-insured or ERISA plans, offered by some large employers, are under the jurisdiction of the U.S. Department of Labor.

Ignorance of California state laws is never an excuse. Independent insurance agents can not rely on insurance companies to teach or even inform agents about all of the state laws. If you violate a California law, it falls on your back – not theirs. For example, when it comes to generic advertising, the type font size cannot be smaller than a 12 point font. All phone numbers type font cannot be bigger than the license number listed on the ad or business card. Those laws are not even mentioned in any company's testing or certification. That is state law, not federal law.

Also, an agent cannot list themselves in print on anything as a Medicare expert, senior specialist, and hundreds of different combinations, etc. That is state law under the California state Insurance code 785-789.10. There is no federal law about this at all. You will never see this mentioned on any test. I was at a local event and an agent had a nametag that said she was a "Medicare Insurance Agent." I explained the state law to her and she thought I was insane. After all, she had tested and was certified. She informed me that she read every page in the Medicare marketing guidelines and there is no mention of anything of the sort!

**DON'T DARE THE DEPT. OF MANAGED HEALTH CARE**

The DMHC works to aggressively monitor and take timely action against plans that violate the law. Since 2000, the DMHC has assessed more than \$58 million in fines and penalties against the health care industry and has required plans to make the necessary changes to comply with the law.

For example, one insurance company left Covered California in 2018 after years of heavy fines by the DMHC.

Below is a summary of the fines paid by that company.

<b>2008 – 10 million</b>
<b>2009 – 3 million</b>
<b>2010 – \$852,500</b>
<b>2011 – \$805,500</b>
<b>2012 – \$197,500</b>
<b>2013 – \$190,000</b>
<b>2014 – \$276,000</b>
<b>2015 – \$3 million</b>
<b>2016 – \$3 million</b>
<b>2017 – \$6 million</b>

It is no wonder this insurance company left Covered California. Over \$27 million dollars in fines in 10 years, for just one insurance company! I find this deplorable due to the fact that the insurance companies are constantly harping on insurance agents to obey all of the laws, so they do not get in trouble. The insurance companies as a whole need to obey the laws themselves. It's costing them millions. This only makes premiums and deductibles rise and benefits shrink.

The shockingly simple math is: there are over 320,000 insurance agents in California. In 18 years time, the DMHC has had approximately 32 enforcement actions against agents, compared to over 3,210 enforcement actions of approximately 139 health plans in California. It looks like agents are not the biggest problem when it comes to violations of the laws.

**SOME AGENT VIOLATIONS HAVE BEEN:**

- False and misleading advertising.
- Enrolling deceased people.
- Enrolling people without their consent.
- Engaging in aggressive sales tactics.
- Theft from an elder.
- Saying they work for Medicare.
- Misrepresentation of the plan.
- Deceptive, misleading and fraudulent statements.
- Having a huge Medicare card in a senior meeting.

**TYPES OF VIOLATIONS BY HEALTH CARE PLANS & MEDICAL GROUPS:**

- Failure to establish and maintain a department approved enrollee grievance system.
- Failure to pay claims timely and to pay interest on late claims.

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- Failure to provide written acknowledgement to a subscriber within five days of receipt of complaint.
- Violation of confidentiality of Medical Information Act.
- Failure to comply that only a licensed physician or licensed health care professional competent to evaluate the specific clinical issues may deny authorization.
- Failure to specify to providers the specific services approved.
- Failure to communicate in writing to enrollee regarding denial, delay, or modification of services requested by provider.
- Failure to notify provider by telephone, fax, and in writing, including clear and concise explanation of clinical reasons, criteria or guidelines used regarding denial.
- Engaging in the practice of economic profiling.
- Failure to reimburse a complete claim, or portion thereof, as soon as practical, but no later than 30 working days (45 working days if plan is an HMO) after the date of receipt of the complete claim.
- Failure of the plan to provide additional medical records requested.
- Failure by a plan to update its printed provider directory or directories at least quarterly, or more frequently if required by federal law.
- Plan has engaged in conduct that constitutes fraud or dishonest dealing or unfair competition.
- Assignment of additional enrollees to a risk arrangement with an outside organization without prior written approval of the director.
- Failure to properly deny or contest a provider's claim for service.
- Provider balance billing a health care service plan enrollee for emergency health care services and unfair billing.
- Unlawful provision of bonuses or gratuities to induce or prolong enrollment.

**MEDIGAP-MEDICARE SUPPLEMENTS**

It is very interesting to note, that I can NOT find ONE complaint, penalty, violation, enforcement action or fine ever filed with the DMHC about Medigap- Medicare Supplement Insurance plans.

**NAUGHTY MEDICAL GROUPS CAN'T HIDE FROM THE DMHC!**

In December 2017, a rare and unprecedented move by the DMHC as they ordered nine health plans to terminate their contracts with Employee Health Systems Medical Group Inc. and transfer 600,000 patients to different health care providers, after a company affiliated with Employee Health Systems was accused of blocking patients' access to specialists to hold down costs.

***It's an unbelievable outrage that there is no official training, education or testing from the industry, or from the state about California state laws.***



**PHYSICIANS ARE NOT EXEMPT FROM THE DMHC**

One licensed physician in south Pasadena was ordered to pay \$562,500 for unlawful billing practices. This was an order from the Superior court to the victims, with assistance from the Department of Managed Health Care.

**COSTCO (NOT EVEN LICENSED) WAS FINED \$5,000**

A flyer was being distributed to some Costco members. The flyer indicated that, by signing up for health insurance through the Costco contracted insurance vendor, the member could receive a Costco cash card. California Code of Regulations, title 28, section 1300.46 (Rule 1300.46), prohibits any "person subject to the provisions of the [Knox-Keene] Act" from offering or

distributing "any bonus or gratuity to potential subscribers for the purposes of inducing enrollment."

**THE DMHC WORKS TO BE OBJECTIVE ON ALL SIDES OF THE HEALTH INSURANCE INDUSTRY**

Providers can file a complaint against a Medical group or an insurance company with the DMHC.

Enrollees can apply for an independent medical review (IMR) with the DMHC when a health care service or treatment has been denied, modified or delayed.

Insurance agents can file a complaint with the DMHC for non-payment of commissions from insurance companies, general agencies (GAs) or field maintenance organizations (FMOs).

Call The DMHC Help Center at: 1-888-466-2219 or go to the website <http://www.dmhc.ca.gov/> to learn more.

It's an unbelievable outrage that there is no official training, education or testing from the industry, or from the state about California state laws.

I suggest agents purchase the yearly updated 790-page California Knox-Keene Health Care Service Plan Act and Regulations book for only \$26.00. It has all California laws, rules and regulations for managed health care. Published by EXISNEXIS MATTHEW BENDER. 1-877-394-8826 Visit their online bookstore at [www.lexisnexis.com/bookstore](http://www.lexisnexis.com/bookstore) 2018 Edition ISBN: 9781522149309

You can also look up other California Insurance codes and laws online at:

<http://leginfo.ca.gov/faces/codes.xhtml> ★



*Susan Hatch (PHIAS --Professional Health Insurance of Advanced Studies) is a national speaker, author, educator, objective senior advocate, analyst and talk radio guest about Medicare supplements.*

*She is also a licensed, independent insurance agent who represents all supplement plan types. Awarded the #1 Medicare Supplement Agent in California, The NAHU Soaring Eagle and The NAIFA Quality Awards, Hatch has worked with AGA- Applied General Agency --for many years. Website: [MedicareToday.net](http://MedicareToday.net). Contact Hatch at: [CaMedicarePlans@sbcglobal.net](mailto:CaMedicarePlans@sbcglobal.net) or (559) 307-2287.*

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Wine Tasting Social  
4-9 pm

Friday, August 17th  
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***MORE DETAILS TO COME!***

# CMS Review of Provider Networks: A STEP IN THE RIGHT DIRECTION



By BILL KIRAY

**N**ews coming out of Washington earlier this year pertaining to the Centers for Medicare & Medicaid Services (CMS) review of Medicare Advantage provider networks was certainly welcome. The change that the White House authorized, which will change the manner and frequency in which provider networks are reviewed, is part of the larger discussion around addressing the Medicare Advantage member experience. This is a key subject for agents who work with Medicare recipients not only in California, but in all areas of the country.

Not surprisingly, provider choice is a key element of the decision-making process for consumers who are considering a Medicare Advantage plan. Most of these plans use a network of physicians and hospitals as part of their value structure. Consumer choices between Medicare Advantage plans often come down to which doctors or hospitals are participating in the respective plan's contracted network.

Until recently, however, CMS was only authorized to conduct a full network review when an insurance carrier introduces product into a new area or if there is some sort of qualifying event (acquisition or series of member complaints). This review would be specific to determine if a carrier had met certain adequacy standards. Those standards revolve around minimum numbers of providers and the concentration of types of providers in each county.

This new authority, which grants CMS a review every three years, should help to ensure network adequacy for members of Medicare Advantage plans. However, the accuracy of Medicare Advantage provider directo-

ries has also been called into question in recent years. A report published in October of 2016 found significant errors in the online provider directories of various carriers.

While a majority of the errors cited revolved around providers being listed at locations where they didn't see patients (but were part of that practice), the point

***"While putting more responsibility in the hands of the government is seemingly at odds with the origin and intent of Medicare Advantage, this change would seemingly make for positive change addressing key issues..."***

was that the carriers needed to do a better job of ensuring the accuracy of their directories. However, a simpler solution certainly seems to be available.

As part of managing the Medicare contracts for all providers who accept traditional Medicare – which at present is the overwhelming majority – why would CMS not also log what Medicare Advantage plans a physician accepts? This would position a number of really big wins for multiple stakeholders in the Medicare Advantage market:

- CMS – This would certainly provide to them all the data they would need to assess – more or less in real time – each carrier's geographic viability in reference to their membership. No separate data requests, audits,

or needs to interpret data feed or files in various formats. The information would be at their fingertips at all times in dashboard format.

- Consumers & Agents – A one-stop shop for provider information would eliminate a lot of time wasted during the sales process. This would allow consumers to list providers they deemed to be key to their decision making, and then allow agents to move forward with proposing products that they knew would meet the client's needs.
- Insurance Carriers – This change would eliminate significant time and capital investment in creating and maintaining provider directories. In order to offset CMS's costs in maintaining the database, each carrier could be charged a per contract fee to fund it.

The element of provider choice is the single most important element of a consumer's decision making process in regard to health insurance. Why not centralize that information, in a manner that strengthens the federal government's ability to regulate it, in order to make it as simple as possible for the end user to access it? While putting more responsibility in the hands of the government is seemingly at odds with the origin and intent of Medicare Advantage, this change would seemingly make for positive change addressing key issues that are already under review. ★



*Bill Kiray is chief marketing officer of Neishloss & Fleming, an Integrity Marketing Group company.*

## TRANSFORMING THE BUSINESS OF HEALTH

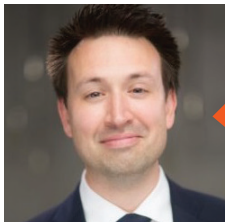
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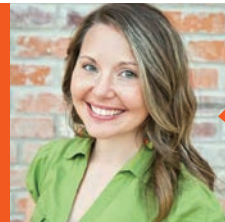
#### PIONEER SPEAKERS



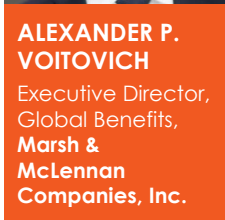
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# Medicare Advantage, the New Face of Medicare: MINORITY MARKETS BRING CHALLENGES, OPPORTUNITIES

By HOLLY ACKMAN

**T**ake a glance at the makeup of today's Medicare-eligible population and you will see a change is underway. The face of Medicare is taking on a new look as the number of ethnic and minority beneficiaries is on the rise, presenting promising new opportunities for the brokers and health plans that serve them.

Older adults today are more diverse in race, ethnicity and culture than ever before, and beneficiaries from minority and ethnic groups now represent more than 20 percent of the total Medicare population. Although still a relatively small portion of the Medi-

care population as a whole, some minority communities within the Medicare population (take the Korean and Chinese groups, for instance) are growing at a faster rate than the general population of those 65 and older. And since immigrant communities tend to be younger, this demographic bubble is only just starting to emerge as people in these markets are aging in.

As growth in these new markets begins to accelerate, there is potential for those of us serving the Medicare population in minority and multicultural communities to build new business

and provide valuable service and care to more seniors. Realizing this potential, though, does have its challenges. Issues such as language barriers, cultural differences and past experience with healthcare can impact an ethnic consumer's decision to purchase healthcare coverage—and make it difficult to keep him once he does. For independent brokers, agents and Medicare Advantage plans, meeting these challenges presents an opportunity to work together to expand our customer bases while helping our mutual clients and members get the best possible care and coverage.

**THE INDISPENSABLE AGENT**

Central, and essential, to this partnership is the individual broker or agent who lives or works in a minority or multicultural community and has relevant linguistic and cultural fluency. It's imperative not only to speak the primary language of these consumers, but also to understand what's important to this audience, the challenges they face and what services they want included in their health insurance plan. Brokers and agents with these qualifications are an invaluable resource to prospective and existing clients, as well as to insurers who find it challenging to hire staff to serve multiethnic markets.

Even though potential customers do more research online when shopping for coverage, a minority consumer's final decision still often leans on word of mouth from the people he knows and trusts—his family, friends and neighbors, including his helpful insurance agent around the corner. As a local leader in a minority or immigrant community, an independent agent is a familiar and reliable source of information and support for people when making important decisions about their healthcare coverage, care options and so much more. This trusted adviser brings together the people of the community, local healthcare resources and the wider healthcare system, including providers and health plans. At SCAN, we consider our broker partners our indispensable "feet on the street," not only because they are key to helping prospective minority and immigrant shoppers understand who we are, what we offer and how we can meet their healthcare needs, but also because they provide us with insightful and otherwise hard-to-gather guidance on how we can better serve these communities.

That last point is important. Because while ethnic markets represent an opportunity for brokers and health plans to build their businesses by increasing market share, we cannot do so at the expense of member satisfaction. Once the plan's benefits and services have been clearly communicated and the client enrolls, the health plan has to deliver. This means that health plans looking to attract minority and ethnic customers will have to step up and do more

than simply translate marketing materials into Korean or sponsor an event in a Hispanic neighborhood. Creating and fostering a positive experience for their members with unique cultural needs should be the focus as health plans develop services and delivery channels for these demographics.

Health plans should ask themselves a number of critical questions. Can our member service staff and provider groups adequately respond to cultural differences in language, traditions and approaches to health? Is there an adequate number of providers in the community so that minority and ethnic members can get the care they need when they need it? For non-English speaking members, are there providers available in the network who

***"The Medicare-eligible population will continue to become more racially and culturally diverse, especially in markets like California. It's a trend that holds promising opportunities for new business..."***

can speak the patient's native language so that every visit to the doctor results in effective care and a positive member experience? In the areas that SCAN serves, for example, there are more than half a million Hispanics who are over the age of 65, and half of them are likely interested in at least some Spanish-language services.

**A LASTING RELATIONSHIP**

This brings us to another important role for brokers and agents—one that extends beyond enrollment. Insurance can be complicated for anyone, perhaps especially so for members of minority groups. Research tells us they are less likely to have been insured before becoming eligible for Medicare, have had fewer interactions with the healthcare system in general and have little to no experience with managed care. Cultural beliefs about disease and healthcare can also get in the way

of a senior in an immigrant community getting the care needed. While they may be excited (or relieved) about new benefits and coverage, if there are barriers when the time comes to access it, they may turn again to the trusted person who signed them up for assistance.

The most successful brokers and agents continue to be a reliable and ongoing resource for these clients when they need help understanding their benefits, how their Medicare Advantage plan works or what to do when they need care and services. Often, this means going beyond the normal insurance representative-client relationship. For example, we know agents who've translated plan communications for their clients. So for brokers, having a reliable health plan partner committed to the member experience is invaluable. You want to not only be able to get answers for your clients, but also to transition them to the plan's member service with confidence that they will be served well. This is something we take very seriously so we work hard to support our broker partners and deliver the level of assistance they expect and their clients deserve.

The Medicare-eligible population will continue to become more racially and culturally diverse, especially in markets like California. It's a trend that holds promising opportunities for new business while helping the seniors in these areas receive more services and better healthcare. So, now it's up to us. We look forward to working together with community-based brokers and agents to meet the needs of these seniors so that they can be healthy and independent—and longtime customers. ★



*Holly Ackman is vice president of sales operations for SCAN Health Plan, one of the nation's largest not-for-profit Medicare Advantage plans with more than 190,000 members in California. In addition to Medicare Advantage, SCAN Health Plan also offers special needs plans for those with chronic conditions or who are dually eligible for Medicare and Medi-Cal. For more information visit [scanhealthplan.com](http://scanhealthplan.com), visit us on [facebook.com/scanhealthplan](https://www.facebook.com/scanhealthplan) or follow us on [twitter @scanhealthplan](https://twitter.com/scanhealthplan).*

# GUARDIAN'S STUDY SHEDS LIGHT ON DENTAL

**G**uardian recently released its Fifth Annual Workplace Benefits Study, Dental Benefits: A Bridge to Oral Health & Wellness. The study found that employers whose employees regularly use their dental benefits see fewer claims for major and restorative work, resulting in lower premiums for employers and reduced out-of-pocket costs for employees. That makes perfect sense.

What doesn't make great sense: although there are numerous benefits to good oral health, the study found that more than one in four adults fail to go to the dentist regularly. And millennials are among the least likely to visit the dentist. Cal Broker asked Dr. Randi Tillman, chief dental officer at Guardian, and Jenn Walsh, senior VP and partner at Woodruff Sawyer & Company and a Guardian advisory panel member, for more insight.

**Cal Broker:** Why do you think there's a generational difference in use of dental benefits? According to the study, millennials are the least likely to visit the dentist. Do we know why?

**Dr. Tillman:** According to Guardian's Fifth Annual Workplace Benefit Study, millennials are among the least likely to go to the dentist two times a year, although more than 75 percent of them have some form of dental coverage. Many millennials have little direct experience with the



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more serious ravages of tooth decay and gum disease. Baby boomers grew up in an era when there was a national epidemic of tooth decay and know the risks associated with dental decay such as pain and lost teeth. Periodontal (gum) disease, which is now believed to be correlated with certain systemic diseases such as diabetes and heart disease, among others, is insidious and in most cases, produces more subtle signs of its presence than dental pain. Therefore, based on their personal experience and that of many of their peers, millennials may not think it is necessary to visit the dentist on a regular basis. I think that for many baby boomers, we knew firsthand of friends and/or family members who suffered dental pain and tooth loss, and surely don't want that to happen to us.

**Cal Broker:** Do you have a sense of whether attitudes/use of dentistry has changed over time? Are we more or less likely these days to take care of our teeth?

**Dr. Tillman:** Our heightened awareness of the importance of good health has had a positive impact on our attitude toward oral health. Increasingly there is scientific literature which



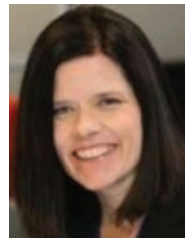
shows a correlation between poor oral health and poor systemic health. Today it is thought that inflammation is the most likely common denominator between oral health and systemic health. We have known for many years about the relationship between oral health and diabetes and oral health and pregnancy, for example. Current research is working to quantify the relationship between oral health and other systemic conditions.

Good oral health is like many other healthy behaviors, it is strongly dependent on patient compliance. According to Guardian's study more than one in four fail to go to the dentist even once a year, despite the fact that a majority have dental coverage that includes at least one annual preventive visit.

How many times does a physician tell us to watch our diet and exercise; and yet, how many of us follow our physicians' recommendations? Dental disease can, in most instances, be managed by diligent attention to home care routines. Nevertheless there are still many people who don't floss on a daily basis. This never ceases to surprise me!

**Cal Broker:** What are some of the key ways brokers can help clients realize the benefits of regular dental checkups and getting necessary dental work?

**Jenn Walsh:** Whether it's part of their onboarding process as a new hire or during the annual open enrollment process, there is a lot of information for employees to digest. We're



asking these individuals to actively engage and choose the right coverage for their personal circumstances from an expanded menu. It's challenging for clients to balance how much information to share at these particular points in time as they seek to inform without being overwhelming. Wellness messages are lost in the shuffle at these junctures. Timing is everything! This is what we know:

- Drip campaigns are more effective than trying to overload employees with information all at once
- Analyze utilization for a particular location/facility and be more specific in the communication i.e. "Great news – nearly 90 percent of our employees here at ABC plant have taken advantage of the free cleanings we include in our dental plan." Or: "Fifty percent of our employees are leaving money on the table by not maximizing their plans."
- Open enrollment is focused on choosing the right plans, but post-open enrollment provides an opportunity to educate on maximizing the plans that have been chosen.

As part of their communication or wellness strategies (or both), brokers should be reminding their clients the value of preventive dental work and making it simple for employees to be provided reminders through the following resources:

- Benefits administration portal
- Intranet
- Internal social networking
- Email
- Print/home mailers
- Town halls/webcasts
- Newsletters
- Video

**Cal Broker:** Thanks, Guardian! If you'd like to learn more about the Fifth Annual Workplace Benefits Study, visit [guardiananytime.com](http://guardiananytime.com). ★



# Update from the NAHU Washington Trip

By NAAMA POZNIAK

I was thrilled to attend the NAHU Capital Conference this year, which I've attended each of the past 12 years in Washington, D.C. I was so energized by the feeling in Washington this time! For the first time, I really heard from both sides of the aisle that they are wanting to work together. It was thrilling to be there and feel like a part of a solution.

Brokers like me met with federal law makers to explain what's happening to our clients, how the insurance business works and how to get the system working better for all people.

Some of the points we addressed:

- Preserve the employer tax exclusion
- Allow any person to purchase catastrophic coverage regardless of age or income status
- Continue federal funding for Cost Share Reductions (a part of the ACA which President Trump defunded in 2018 that caused high increases for 2018)
- Employer-Based Market: Preserve the employer tax exclusion. The employer-sponsored health insurance system provides private-sector, market-based coverage for more than 175 million Americans, including those covered by unions. Proposals that would cap the maximum value of the exclusion or eliminate it altogether would be detrimental to the stability of the employer-based market and would negatively affect middle class.
- We showed support of the permanent repeal of the Cadillac/Excise Tax (H.R.173) and the repeal of the Health Insurance Tax (H.R.246).
- For the individual market: we truly stressed the important of market stabilizers to reduce and improve the individual risk pools.
- Allow greater flexibility for states

applying for 1332 waivers under the ACA. States should be able to apply without having to go through their legislatures, and shortened review time should be required by HHS.

- Medicare: Allow Cobra coverage to count as credible coverage for Medi-

and family plan clients. He truly understands the weight of monthly premiums and listens to our suggestions. I'm so glad to have him in our corner.

- Chris Coons (D-DE) has a lovely sense of humor, saying "It's not the Olympics with gold, silver and bronze, it's healthcare!" He experienced first-hand purchasing a policy off the exchange and knows what the consumers are facing. He is committed to improving its function.



- Dr. Ami Bera (R-CA) shared with me a holistic approach to healthcare and the improving of our healthcare system. We have to look at the whole picture to get a better understanding of both our systems and our well-being.

- Billy Long (R- MO) has a playful manner and a good heart, proudly wearing a cartoon tie from his time working with Children's hospitals. He emphasized the importance of working together. I was so inspired by his unifying thoughts.

Yes, change is in the air. But I'm starting to get a great feeling about it! ★

care beneficiaries just as an employer-sponsored coverage does.

- Many Medicare beneficiaries are classified as being on "observation," which can result in significantly higher claims and prevent Medicare coverage from being applied for nursing home care for patients who do not have three-day inpatient stay for Medicare coverage of skilled nursing facility. H.R. 1421 would allow observation stays to be counted toward the three-day mandatory inpatient stay for Medicare coverage of skilled nursing facility.

What a joy to meet the representatives and senators serving our fine country. A few shout outs:

- Brad Sherman (D-CA) has been working tirelessly with us in California to try to help out our individual



Naama O. Pozniak is Paz Holding Inc.'s ( dba A+ Insurance Service) CEO and strategic health insurance adviser, being of service in the industry for almost 30 years. Naama is also a yogi and a Primordial Sound Meditation Instructor, certified by the Chopra Center. Since a very early age, Naama has been practicing yoga and meditation. She is currently a certified Healthcare Reform Specialist and a Covered California Champion Certified agent. Pozniak has been recognized as the Most Influential Woman in Benefit Advising for 2016 and 2017. She is recognized nationally as the Top of the Table producer and holds the prestige life time Soaring Eagle Award. She is currently serving as the PAC & HUPAC Chair for LAAHU and as NAHU Region 8 LPRT Chair.

# CRITICAL ILLNESS

## EXPANDED COVERAGE AND ENHANCED ENROLLMENT OFFERINGS

By DANIELLE LEHMAN

**A**s the average cost of health care benefits continues to rise, employers are revamping their benefits plans to offer more cost-effective options to employees. This often includes shifting to a high-deductible health plan (HDHP). However, moving to an HDHP can result in higher out-of-pocket medical expenses for the employee.

When an unexpected serious illness occurs, these out-of-pocket costs can be expensive and at times financially crippling for an employee. Research shows that 22 percent of individuals experienced a major unexpected medical expense that they had to pay for out of pocket in the prior year. Forty-six percent of those who say they had a major medical expense report that they currently owe debt from that expense.

To help reduce the financial burden on employees, you can recommend clients offer supplemental coverage like critical illness (CI). Here's what you need to know about the coverage to be well-informed at your next client meeting.

### HOW COVERAGE WORKS

For many clients, when they hear the words "critical illness," they often think about cancer. While cancer is covered under CI insurance, today's plans can also include more than 20 additional illnesses. Certain CI plans cover heart attack, stroke, organ failure, amyotrophic lateral sclerosis (ALS), Alzheimer's

disease, multiple sclerosis and Parkinson's disease.

CI plans pay a lump-sum cash payment upon diagnosis of a covered illness. This money can be used to pay for medical-related expenses — such as deductibles, out-of-network coinsurance and alternative or experimental treatments — or even everyday living expenses, including mortgages, utilities and groceries. Having coverage for these unexpected expenses can help provide peace of mind to employees during these challenging and stressful times.

Additionally, most of the CI plans offered today are compatible with a Health Savings Account (HSA), allowing clients to offer these plans without impacting their employees' tax-free contributions. And employees can leave their HSA untouched by using their CI benefits to pay for medical expenses.





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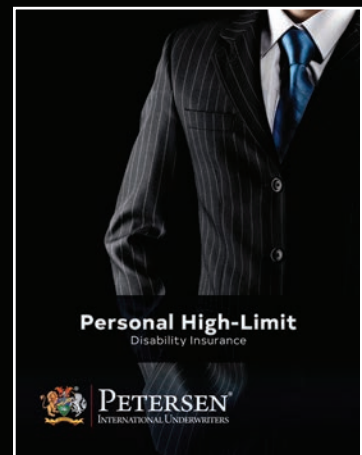
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Today's CI products can provide clients and employees with additional wellness benefits to encourage preventive care. These benefits pay an annual cash amount to an employee and his or her covered family members who receive a covered health screening procedure.

These procedures help identify illnesses or symptoms in their early stages, which means treatment can start earlier in the disease process, resulting in a higher survival rate. Research shows that half of all cancer deaths can be prevented and the substantial cost of the treatment of advanced diseases could be reduced through the use of existing evidence-based prevention and early detection strategies.

Remind clients that it can be helpful to promote this benefit in conjunction with their overall wellness program offerings to increase employees' participation in the program.

**COVERAGE FOR FAMILIES**

While no parent likes to imagine themselves or their children being diagnosed with a critical illness, it's important to highlight how CI plans can help provide additional coverage should the unexpected occur. Today's CI insurance plans often provide children with the same coverage as their parents, including coverage for many congenital conditions, such as cerebral palsy, cystic fibrosis, Down syndrome, muscular dystrophy and spina bifida.

***"As the health care landscape changes, help ensure your clients are aware of the gaps in medical coverage their employees may be exposed to and highlight how products, such as CI insurance, can help protect their workforce and their families."***

The additional coverage of CI insurance can help employees know they have coverage for themselves and their children if someone is diagnosed with an unexpected illness. And regardless of where life takes an employee, most voluntary insurance benefits are portable. This means coverage can remain in effect for the employee, their spouse and dependent children (until the age of 26), even if the employee moves to another job.

**TECHNOLOGY SOLUTIONS TO ENHANCE THE ENROLLMENT PROCESS**

Not all employees have the same benefits needs, whether it's due to lifestyle, age or personal buying preferences. Some voluntary benefits carriers have developed enhanced decision support tools to help clients better educate employees on product offerings and provide a more customized enrollment experience.

New tools assign employees to a persona, which can help ensure benefits information is presented in a way that resonates with them. Persona-based decision support tools can help employers convey the value for certain coverages, such as CI plans, by explaining the benefits based upon an employee's communication preferences.

These decision support tools usually use a claims example of a critical illness diagnosis to explain the type of expenses that could be incurred — including deductibles, coinsurance and travel expenses — and then provide the actual dollar amount that would be paid back to the employee under their employer's CI plan. Tangible examples and lifelike scenarios are often a great way decision support tools can help educate employees about the benefits of voluntary insurance.

Persona-based decision support tools also may be particularly valuable to your clients who are seeking more insight on employee motivators and preferences. For these clients, it's important to look for support tool offerings that allow employers to aggregate employee data. These reports can break down persona types within an organization, and provide insightful recommendations on how to communicate best with employees — ultimately helping clients sell through the value of their entire benefits portfolio.

As the health care landscape changes, help ensure your clients are aware of the gaps in medical coverage their employees may be exposed to and highlight how products, such as CI insurance, can help protect their workforce and their families. ★



*Danielle Lehman, senior voluntary product manager at The Standard, is responsible for the product strategy and development of the company's supplemental product offerings. Danielle has strong ties to the voluntary industry with 10 years of experience developing voluntary products, including life, disability, critical illness, accident and hospital indemnity. She holds a bachelor's degree from Bowling Green State University and a master's from Franklin University.*

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# LONG-TERM CARE



## PROTECTION FOR YOU AND YOUR CLIENTS

By WILLIAM UPSON, CLU, ChFC

**L**ong-term care insurance is an essential product for clients in a society with a growing aging population. It is almost a guarantee that every individual will need some form of long-term care in their life. Advisers must guide clients to obtain coverage while they are still healthy to secure high-quality policies at low premiums. If clients wait until the care is needed, it may result in denial of coverage or extremely expensive premiums. When a traditional policy is not an option for clients, encourage them to consider supplemental and non-policy based solutions for care.

### IMPLICATIONS FOR CLIENTS AND THEIR FAMILY

Clients can plan for long-term care and take additional steps to give themselves peace of mind. For instance, medical alert systems help elderly people ensure safety and maintain their independence. Individuals can also select power of attorney and/or appoint a family member who will determine and communicate their decisions in certain circumstances should they not be able to do so in the future. Most importantly, clients can obtain long-term care insurance to make choices about who and how they will be cared for

when the need arises without depletion of their financial resources.

Many individuals do not account for potential health conditions later in life, or do not anticipate the costs associated with required assistance. Some assume their family can and will provide aid with little to no interruption in their own lives. Clients then realize the amount of assistance they actually need when the time comes and are often reluctant to ask for help.

Family members and potential caretakers may not have the financial resources to secure third-party

care and may need to take on the responsibility themselves which can be viewed negatively as an obligation. These responsibilities could prompt disruptions in personal work schedules to either be more available or take on additional hours to obtain more financial resources. Caregivers typically need to make sacrifices in their own lives to provide care, like physically relocating or balancing the care of their own children. Long-term care insurance is a way for clients to ensure their family will have financial resources available to help with care with minimal disruption to their

own lives. Typically, the last thing clients want is to be a burden to those around them.

### STRATEGIES TO CUSTOMIZE AND SUPPLEMENT LONG-TERM CARE PLANS

Clients have many alternatives for long-term care dependent upon their background, location and financial capabilities. With these options, clients can use financial resources at their discretion and maintain control over their future medical expenses. Consider all the possibilities available to your client to couple with traditional financial products and discuss potential means for long-term care.

#### • Financial Planning and Investment Alternatives

Smart financial planning is one solution to acquire funds for long-term care needs. Advisers can offer insights to a variety of investment alternatives that can increase financial resources to pay for long-term care premiums and unexpected costs.

Several new hybrid life insurance policies can also provide long-term care through a rider that provides a long-term care benefit matched against a death benefit. If a client ultimately requires long-term care, they receive a monthly tax-free payout from the life insurance policy's value. Others with cash resources available can purchase an asset-based product and receive two or three times the invested amount for long-term care under the Pension Protection Act.

#### • Life Insurance Conversions and Hybrid Policies

Some permanent life insurance policies can be converted into a form of income distribution as another source to fund long-term care. Conversions are an attractive alternative for clients who can no longer afford premiums, or whose beneficiaries may no longer depend on the death benefit. Hybrid products allow clients to maintain flexibility in their financial plans for unexpected life changes.

#### • Appreciated Assets

Appreciated assets, such as real estate or stock portfolios, can be used to fund a long-term care policy. Tax-free asset sales can help preserve a client's assets and financial legacy, and free up

income that can be leveraged for long-term care coverage. Strategic sales can prevent tax payment if the assets are used as a living benefit or estate tax if used as a death benefit for beneficiaries. Alternatively, charitable remainder trusts will donate any unused or remaining funds as an ongoing income stream to a client's chosen charity.

#### • Veteran Organizations

Military veterans may be entitled to long-term care coverage options through veterans benefits. Assistance may include a monthly tax-free benefit that can be used to cover any medical expenses or long-term care needs. Although qualification depends upon

***"Long-term care insurance is a protective product that safeguards a client's wealth, legacy and family. Discuss long-term care with clients and motivate them to obtain coverage for the highly likely future situation in which they will need care beyond their capabilities."***

the veteran's income, health conditions, location and time of service, benefits are commonly available. This additional source of income provides veterans with another access point to cover long-term care needs outside of a policy.

#### • Community Organizations and Service Providers

Local community-based services and organizations that provide specialized programs for aging residents can be an alternative or supplement to traditional long-term care. Programs vary by community and are dependent upon the client's location, but services can help aging and dependent residents retain independence and lessen the strain on caretakers. A common new program pairs able-bodied seniors with those who cannot drive or take transportation on their own for free transit and ride sharing. In addition to their primary services, community-based ini-

tiatives typically also foster a stronger sense of community and interpersonal relationships.

### HOLISTIC ADVISING AND PRACTICE PROTECTION

As a trusted partner in clients' overall financial wellbeing, advisers must offer and document counsel related to long-term care to protect clients and their own practice. It is an adviser's responsibility to act in their clients' best interests and discuss all potential coverage they may need, regardless of the client's decision to purchase coverage. Because long-term care insurance is vital to protect finances in the future, particularly for aging clients, an adviser can face legal consequences if they do not discuss the risks.

Documentation of risk-based conversations, presented policies and alternatives is imperative. Beneficiaries of clients who do not plan for long-term care and face financial hardships as a result are entitled to take legal action against advisers. Proof of provided counsel and information – ideally in the form of a simple signed letter of acknowledgment – alleviates any culpability from an adviser, even if clients deny coverage. Without proof of a conversation, errors and omissions insurance will not cover any potential legal action.

Advisers should strive to maintain relational approaches in client interactions instead of transactional relationships in which a sale is the end goal. Long-term care insurance is a protective product that truly safeguards a client's wealth, legacy and family. Discuss long-term care with clients and motivate them to obtain coverage for the highly likely future situation in which they will need care beyond the capabilities of their family. ★



*William M. Upson, CLU, ChFC is an author, financial adviser and registered principal with a FINRA/SIPC member firm. He is a 24-year MDRT member with 19 Top of the Table and 17 Court of the Table honors. His primary focus is income and estate planning for his clientele of high net worth individuals, successful professionals, business owners and retirees.*

# 401(k) BEST PRACTICES PLAN DESIGN

By ROBERT C. LAWTON



**H**aving worked as a 401(k) plan consultant and investment adviser for more than 30 years, I have seen a wide variety of plan designs. For example, Apple, Trek Bikes, and IBM all have unique corporate cultures that are reflected in the design of the 401(k) plans they offer their employees.

Your clients' firms have a culture that is expressed in their 401(k) plans too. I don't think they should lose that. However, they may want to look at some plan design elements that have become standard in leading-edge 401(k) plans.

These features have been proven as best practices in helping participants achieve retirement-ready balances. I've listed them here. Following these is a section that includes what I believe will be the next wave in 401(k) plan design. Finally, I have shared plan

design features that limit plan sponsor liability that all plan sponsors should incorporate into their plans.

## **Current 401(k) Plan Design Best Practices**

### **AUTO-ENROLLMENT**

With opt-out rates of less than 10 percent, auto-enrollment has become the most effective way to combat employee inertia at enrollment. If you aren't auto-enrolling new hires right now, you really

need to think about starting soon. Initial default contribution percentages are increasing to around 5 or 6 percent (from what was the standard 3 percent).

### **AUTO-ESCALATION**

Studies show that participants need to add at least 15 percent to their 401(k) accounts each year to accumulate a retirement-ready balance. Annual auto-escalation of 1 percent per year to at least 10 percent helps them get there. If you are auto-enrolling, you should be auto-

escalating as well. They go hand-in-hand.

### **IMMEDIATE 401(k) CONTRIBUTION ELIGIBILITY**

Very few progressive employers make their participants wait to begin making 401(k) contributions. Immediate eligibility for both regular pre-tax and Roth 401(k) contributions is the norm now.

### **A STRETCHED MATCH**

To encourage a higher level of participant contributions, many employers are stretching their matching contributions over a broader employee deferral. A traditional match had been 50 percent of the first 6 percent of employee deferrals (resulting in a 3 percent employer match). A stretched matching contribution will provide the same 3 percent matching contribution over a larger employee deferral – 25 percent of the first 12 percent, for example.

### **ROTH 401(k) DEFERRAL OPTION**

Many young participants will benefit from a contribution strategy that includes the use of Roth 401(k) accounts. After five years, balances in these accounts may be distributed tax-free (for qualified distributions). Participants who contribute to Roth accounts for their entire careers may build an enormous tax-free balance. Also, your executive group will appreciate having the option to use these accounts to execute tax-planning strategies.

### **LEAKAGE MANAGEMENT**

Protecting plan participants from themselves has become an important plan design feature. One way of doing that is eliminating opportunities for leakage by reducing or eliminating plan loan and withdrawal options (unless a hardship exists). Loan balances are often defaulted when participants change jobs, permanently removing assets from their retirement balances.

### **PARTICIPANT INVESTMENT ADVICE**

The time when all 401(k) participants have access to professional investment advice from multiple sources is here. Many recordkeepers now offer at least two types of investment advice: algorithm based (think robo-adviser) and a more personalized version (either a proprietary option or through a firm like

Financial Engines, or both). Costs range from free to 100 basis points.

### **PROFESSIONALLY MANAGED BALANCED OPTION**

This normally takes the form of a target date series in most plans. Remember, the vast majority of your 401(k) participants want someone else to manage their 401(k) account for them. Stay away from risk-based solutions, model portfolios, and customized target date series. Although sold as being less expensive, they usually aren't and have a number of inherent problems.

### **The Next Wave of 401(k) Plan Design Best Practices**

#### **ANNUAL RE-ENROLLMENT**

Many employers are re-enrolling non-participating employees each year and defaulting their investment choices into target date options. Use of annual re-enrollments typically increases plan participation to at least 90 percent.

#### **HSA INVESTMENT OPTIONS**

If you offer a high deductible health plan (HDHP), then you should also offer health savings accounts (HSAs) to your employees. It is smart retirement planning for all employees to max out their HSA contributions each year. Since it is possible to carry HSA balances into retirement and use them to pay health care expenses, having investment options in HSAs to help balances grow is becoming more important.

#### **LESS PROFIT SHARING AND MORE MATCHING**

Progressive employers understand that profit sharing contributions are less valuable in terms of motivating participants to contribute than employer matching contributions. If possible, replace any employer profit sharing contributions with employer matching contributions.

#### **ONLINE EDUCATION**

Many progressive employers have realized that their employees need help with financial literacy. Not only will improved financial decision-making skills help them make better employee benefit decisions, but those skills will also help them do their jobs better. These employers are combining financial lit-

eracy/wellness education with 401(k) plan education and hiring firms to deploy online access to 10- or 15-minute modules. An online approach ensures that education opportunities are offered to millennials where and when they want them -- on their smartphones at a time of their choosing.

### **Litigation Protection Elements**

#### **ELECT TO COMPLY WITH 404(c)**

By complying with ERISA section 404(c), employers can shield themselves from lawsuits brought by participants relative to the investment options offered in the plan. Investment advisers should be prepared to outline what clients need to do to comply.

#### **DESIGNATE A QDIA**

Employers designating a Qualified Default Investment Alternative (QDIA) receive protection from participant lawsuits relative to losses participants may suffer in the QDIA investment. Again, investment advisers should explain this to clients.

#### **SAFE HARBOR PLAN DESIGN**

If the employee group is small (100 employees or less), it is very likely the owners would benefit from using a safe harbor plan design. These plan designs provide exemptions from non-discrimination testing requirements if a mandatory level of employer contributions is made.

Keep in mind that progressive plan design supports plan objectives that are regularly communicated to employees. Best news: most of these features cost very little to implement. ★



*Robert C. Lawton, AIF, CRPS is the founder and President of Lawton Retirement Plan Consultants, LLC. Lawton is an award-winning 401(k) investment adviser with over 30 years of experience. He has con-*

*sulted with many Fortune 500 companies, including: Aon Hewitt, Apple, AT&T, First Interstate Bank, Florida Power & Light, General Dynamics, Houghton Mifflin Harcourt, IBM, John Deere, Mazda Motor Corporation, Northwestern Mutual, Northern Trust Company, Trek Bikes, Tribune Company, Underwriters Labs, and many others. He may be contacted at (414) 828-4015 or bob@lawtonrpc.com.*

# Helping Small Businesses Adopt Best Practices When It Comes to Benefits

By JERAMY TIPTON



**N**ational Small Business Month is a good time to remember that any small-business clients you might work with are focused on how their companies can control costs and stay competitive, while attracting and retaining a high-quality workforce. Fortunately, brokers can help ease their minds with solutions that can be quickly implemented without significant costs or increased administrative burdens. Below are three points for brokers to address when discussing benefits and health care costs with small-business clients.

## USE BENEFITS AS A RETENTION AND RECRUITMENT TOOL

By offering a robust benefits package, employers are allowing employees to choose coverage that fits their financial or personal situation. A married man or woman with two children will need different benefits than a young professional who is just starting his or her career and living alone. Understanding that the employer offers a wide range of benefits can help boost employee satisfaction. In fact, according to the 2017 Aflac Happiness Report, more than half of small-business employees note that health insurance was the biggest influence on their decision to work for their current company. By showing how benefits are a tool for retention and recruitment, brokers can help employers of all sizes understand that adding a variety of health care benefits is worth the effort.

## CHANGE IS NOT ALWAYS GOOD

Even though small-business employees might be satisfied with their pay, company environment and their day-to-day work, they still may be lured

away by better benefits at a different company. In the midst of the changes to health care, and the confusion that accompanies it, there are employers who are unsure about which decisions to make. One thing is for sure: Making drastic reductions to employee health care benefits may have unintended consequences that employers do not anticipate.

Employers look for insights from their benefits advisers, and they need to know how vital it is to maintain current benefits and even add a range of health insurance options for employees. While there are several factors that contribute to job satisfaction, employees are more satisfied and secure when their employer provides them with benefit options because it shows that employers care about the health and wellness of their workforce.

## VOLUNTARY INSURANCE BENEFITS ARE MORE IMPORTANT THAN EVER

Businesses rely on brokers to provide solutions that help reduce and manage employee health care costs, while delivering on the coverage demands of a workforce. According to Willis Towers Watson, 92 percent of employers in the U.S. view voluntary benefits as important to their employee value proposition as an inexpensive way to boost their benefits portfolio. Brokers can alert decision-makers that a robust benefits package that includes voluntary insurance is an important way to help provide peace of mind, while helping keep employees engaged, productive and loyal. Voluntary insurance, provided by companies like Aflac, such as accident, disability, critical illness, or hospital products, complement major medical insurance coverage and

serve as an extra layer of protection to help employees with their financial security. Considering only 33 percent of small-business employees say they are satisfied with their current benefits, there is room for improvement when it comes to benefits packages.

There is yet another reason to tout voluntary: the growing focus on corporate social responsibility. Companies today are increasingly judged by their impact on the environment, on the communities in which they do business, on their civic and social contributions and, last but not never least, on the way they treat the employees who depend upon them for financial security. In fact, 87 percent of consumers and investment professionals at least somewhat agree that responsible companies offer health insurance to their full-time workers, even if they are not legally required to do so, according to the 2017 Aflac CSR Survey.

## LENDING THE EXTRA HAND

So, what does all of this mean? For brokers and agents, it reiterates the importance of employee benefits and how knowledge and insights can steer small businesses to make smart decisions. With all the recent shifts to the health care landscape, brokers have an opportunity to position themselves as experts and grow their list of clients. ★



*Jeremy Tipton is vice president of distribution expansion and sales enablement at Aflac. With 18 years of experience in sales and marketing, Jeremy has led teams through the development and design of many industry firsts in enrollment technology, decision support and marketing capabilities.*

## AIG Debuts Online Tool to Help ID Life Insurance Solutions, Offers Tips for Generational Outreach

American International Group, Inc., has launched Generation Station, a new online tool to help financial professionals quickly pinpoint potential types of life insurance solutions based on a client's age, gender and a few other attributes. The tool and related resources are available online at [aig.com](http://aig.com).

To further support outreach and service by distribution partners, AIG offers these generational tips:



### Millennials (born 1980-2000)

- Go digital. Acknowledge preferences to access information, people and products online.
- Make it quick and easy. Provide millennials with time-saving resources they can access virtually anytime, anywhere, such as online calculators, checklists and quoting tools.
- Include the client's inner circle. Focus on individual needs while understanding that millennials may crowdsource for information.
- Be transparent. Having grown up in a time when fact-checking can happen almost instantaneously, millennials can be quick to spot inauthenticity. To help win them as clients and referrals, be yourself.

### Generation X (born 1965-1979)

- Initiate research. Gen Xers have had ample time to learn how to make informed purchasing decisions. Substantiate your claims with research and stats from a variety of nonbiased sources.
- Give control. Many Gen Xers are leaders in both the home and the workplace. Allow them to be in the driver's seat and not in a position to feel painted into a corner. Consider multiple choices and worst-case-scenario options that offer clients a way out.
- Be succinct. Gen Xers are known for their work ethic and some also serve long hours as a primary caregiver to an aging parent. Rather than giving a lengthy pitch, focus on results.
- Remain connected. Millennials aren't the only consumers who research their purchases online. Use technology with Gen Xers to empower decision-making.

### Baby Boomers (born 1946-1964)

- Meet one-on-one. Respect client needs for face-to-face interactions. Create in-person opportunities to get to know as much as you can about each prospect - his or her family, interests, birthday and more.
- Show professionalism. Boomers have reached the age by which they've likely earned key credentials and achievements, so acknowledge theirs and share your own, as well as those of affiliated organizations.
- Think big picture. Boomers face potentially long retirements. Recommend a tailored, long-term plan that is specific to each client's unique needs and situation.
- Focus on the team. In the classic "we're in this together" spirit, concentrate on common goals and how your recommendation will add value - you are on their team.

## Oxford Life Intros InstaWrite

Oxford Life Insurance Company has initiated its new, simpler and speedier life insurance qualification process. The company says Oxford Life InstaWrite represents a streamlined and improved experience for both agents and clients because it features an almost instant health assessment. In the two-step process, an agent first chooses to complete either an electronic or paper application. Second, the agent calls to speak with one of the dedicated InstaWrite processors for a quick health assessment. The health assessment generates a qualified or not qualified decision in a matter of minutes. The InstaWrite health assessment can be obtained by calling (833) 705-4019 Monday through Friday, 9 a.m.-8 p.m. EDT (6 a.m.-5 p.m. PDT). Agents will soon have the option to bypass the phone health assessment and determine qualification status for their clients online. The electronic health assessment will be available via Oxford Life's agent portal 24-7. To learn more, visit [oxfordlife.com](http://oxfordlife.com).

## MIDCAP EQUITY PARTNERS INVESTS IN BENEFIX, SOFTWARE PROVIDER FOR THE INSURANCE BROKERAGE INDUSTRY

MidCap Equity Partners announced it has invested in BeneFix, a provider of state-of-the-art technology for independent insurance brokers. BeneFix has created an intuitive platform that allows small businesses and brokers to manage benefits. The aim is to overhaul the historically paper-drive process to make it simpler for businesses, brokers and carriers to stay organized, up-to-date and in communication.



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Armstrong & Getty  
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**Janet Trautwein**  
NAHU CEO



**Ann Marie Marciarille**  
University of Missouri

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# SWIFTPAGE OFFERS ALL-NEW ACT! PREMIUM PLUS CRM

Swiftpage, the provider of Act! client relationship management (CRM) software, a cloud-enabled platform aimed at helping small and mid-sized businesses grow, announced the availability of Act! Premium Plus, the newest addition to the Act! portfolio, and the release of the latest version of its Premium Platform, version 20.1, in North America, Australia and the United Kingdom. The Act! Premium Plus solution offers insurance providers the ability to tailor their CRM to meet the unique needs of their business, market and industry. This is achieved through the all-new custom tables manager and industry templates features, which allow companies to bring complex data sets, unique business processes, and specialized insurance industry practices together in Act! to better manage their business.



the latest version of its Premium Platform, version 20.1, in North America, Australia and the United Kingdom. The Act! Premium Plus solution offers insurance providers the ability to tailor their CRM to meet the unique needs of their business, market and industry. This is achieved through the all-new custom tables manager and industry templates features, which allow companies to bring complex data sets, unique business processes, and specialized insurance industry practices together in Act! to better manage their business.

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## CRYPTOWATCH

**B**loomberg.com's Paul Ford recently penned an article that says Bitcoin is ridiculous and blockchain is dangerous. Ford makes what we think of as a heroic attempt to explain Bitcoin, though:

"When you go to the ATM at a store and get money to buy a six-pack, you put in your bank card. The transaction processor verifies it somewhere in the ether, takes a fee, and spits out cash.



It's all powered by software. OK, deep breath. Acquiring Bitcoin is like using an ATM, except instead of government-backed money you get proof that a computer somewhere solved an automated puzzle faster than other computers, and instead of using an ATM card you're using an auto-generated token that only you have, and instead of connecting to a bank you're connecting to a decentralized network of computers that collectively maintain and update copies of a massive historical database of transactions—and that also collectively validate transactions, using, well, math, and spit out new Bitcoins from time to time, to reward the puzzle solvers. Slow exhale. Almost there. And instead of buying a six-pack from someone behind a counter, you're transferring some amount of Bitcoin to another anonymous token. Over time, all the transactions that people make get lumped into blocks and validated, and they get a special code that takes into account all the codes in the blocks that came before, and thus you have it: a blockchain."

Ford goes on to say that the Bitcoin phenom will crash because of course it will. Bubbles burst. The dabblers will go home, but eventually – it may take years or even decades-- the true believers will make something real out of Bitcoin/blockchain.

# LANDMARK ANNOUNCES INCREASE, NEW ACUPUNCTURE PLAN



Landmark announced it will increase the employee only rates by 3 percent for new business and renewals. The employee+one, employee+children and employee+family rates remain unchanged. Landmark's last increase was implemented in April 2017. Landmark is also adding Acupuncture Only and Acupuncture Plus Herbal Rider plans for groups of 2-50 employees. Previously, these were available only to groups with 51+ employees; however, they are now available to groups of any size. Rates and marketing materials are available at [lhp-ca.com](http://lhp-ca.com).

## DEBATE OVER AB3087



California Assemblyman Ash Kalra recently released details on Assembly Bill 3087. The bill calls for a government-run commission with nine political appointees who would set prices for all medical services that are not already controlled by the government. Labor unions and consumer advocates back the bill, but the California Medical Association (CMA) vehemently opposes it. In a written release, CMA charged that the bill "would increase patient out-of-pocket costs and result in a dangerous government intrusion into the health care market by creating state-sanctioned rationing of health care for all Californians."

# Hot Topic: Cyber Security



Our friends at the American Institute of CPAs (AICPA) say that 8 in 10 Americans are concerned about the ability of a businesses to safeguard their financial and personal information. That's according to their new survey, conducted by The Harris Poll. No wonder, either. In 2017 alone, roughly 143 million U.S. adults were hit by some form of malware, virus, spyware or phishing scam. Now AICPA says that nearly half of U.S. adults (48 percent) think it is at least somewhat likely identity theft will cause them financial

loss in the next year. The survey found four in five Americans (81 percent) said they've changed their behavior based on the threat of cyber breaches affecting credit card and debit card processing systems. Those changes include a majority increasing self-monitoring of credit and debit card accounts for fraudulent activity (56 percent), while about 4 in 10 are either using cash and/or checks more often (43 percent) or choosing to shop at locally owned stores more often instead of national retailers (40 percent). Help spread the word about protecting and mitigating damage. Share AICPA's National CPA Financial Literacy Commission tips with your clients:

- Monitor your credit report & set protections. You can request a free credit report from all three major credit reporting agencies once a year, including TransUnion, Equifax and Experian. Additionally, some monitoring services allow you unlimited access to your credit information year-round. These services are there to help you spot inaccuracies, potential fraud and more on your credit report. This should also be done for children. Theft of a child's ID may go undetected for many years such that by the time they are adults, the damage has already been done.
- Don't provide your Social Security number unless it's necessary. A space for it on a form doesn't necessarily mean that it is required. For example, your doctor's office may use a unique number issued by your insurance company to enter your claim but their form may have a space for SSN anyway. Don't be afraid to ask if they really need it.
- Make sure your WIFI network at home is secured with a password. A skilled data thief can access information on an unsecured network. Additionally, when away from home, avoid providing credit card or other personal information on unsecured Wi-Fi networks like those in airports or coffee shops.
- Don't provide personal information in response to any unsolicited communication. Even if the caller, text or email claims to be from a bank or credit card company needing to "verify" your account to "prevent fraud." If in doubt, call the number on your bank statement or the back of your credit card.
- What to do if it happens? Act quickly to limit the damage. Call your credit card company and report it. They will close your card and issue a new one. File a police report to ensure that you are covered for any damages that you may incur. If your Federal return is affected, call the IRS 800-908-4490 and file Form 14039 Identity Theft Affidavit.

For more information about what to do in the event of identity theft, go to [360financialliteracy.org](http://360financialliteracy.org)

## COMPANY BEHIND MYLIFEPROTECTED LAUNCHES BINDABLE

The company behind MyLifeProtected announced its newest incarnation: Bindable, an insurance technology company aimed to transform the affinity distribution of



insurance by providing a full stack of innovative, technology-enabled services. Under the Bindable umbrella, the company will offer a full suite of solutions for modern insurance distribution including:

- **MyLifeProtected** – launched in early 2016, the multi-product digital platform delivers private label and custom branded insurance marketplace solutions to partners.
- **Policy Crusher™** – the newest service under the Bindable umbrella serves as a SaaS platform and CRM for agents specifically designed for partner distribution models.
- **MassDrive** – a nationally licensed agency offering multi-carrier auto and home insurance comparison-shopping services available for integration with eco-system partners.

# MetLife Forms PlanSmart Alliance with EY

MetLife announced that it has formed a strategic alliance with Ernst & Young LLP (EY) that will drive the creation and delivery of a cutting-edge workplace financial wellness solution. Launching in spring 2018, PlanSmart® Financial Wellness will focus on behavioral change, giving employees the tools, guidance and support they need to improve their financial wellbeing. The offering builds on MetLife's PlanSmart workplace financial education program, which has offered workshops and one-on-one consultations for more than 20 years to over 2,000 group customers.



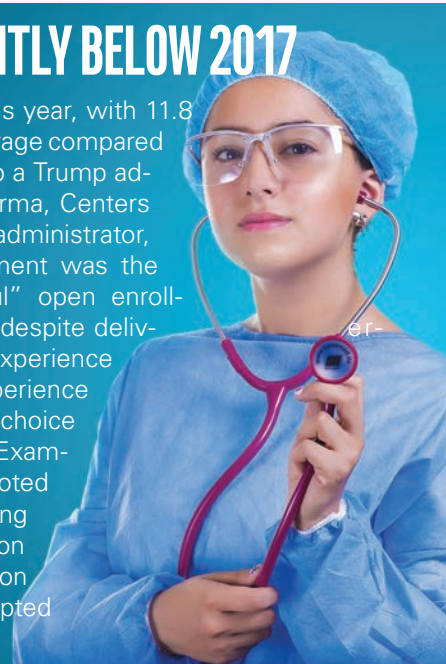
MetLife's experience in this space, along with in-depth research and customer feedback, will help shape the solution's new capabilities. PlanSmart Financial Wellness will bring together MetLife's decades of experience in delivering workplace benefit solutions and financial education with EY's innovative, high-tech approach to offering financial education and counseling. The result will be a customized, goal-oriented approach to financial wellness that will meet employees where they are, offering the tools via channels they prefer. This will include online and phone support, both offered by EY.

## MIDCAP EQUITY PARTNERS INVESTS IN BENEFIX, SOFTWARE PROVIDER FOR THE INSURANCE BROKERAGE INDUSTRY

MidCap Equity Partners announced it has invested in BeneFix, a provider of state-of-the-art technology for independent insurance brokers. BeneFix has created an intuitive platform that allows small businesses and brokers to manage benefits. The aim is to overhaul the historically paper-drive process make it simpler for businesses, brokers and carriers to stay organized, up-to-date and in communication.

## ACA 2018 SIGNUPS SLIGHTLY BELOW 2017

Obamacare enrollment fell slightly this year, with 11.8 million consumers signing up for coverage compared with 12.2 million in 2017, according to a Trump administration official count. Seema Verma, Centers for Medicare and Medicaid Services administrator, tweeted that the 2018 open enrollment was the "most cost-effective and successful" open enrollment ever. Verma also tweeted that despite delivering the most successful consumer experience to date, Americans continue to experience skyrocketing premiums and limited choice on healthcare.gov. The Washington Examiner was among the outlets that noted that part of the reason for the soaring premiums is President Trump's decision in October to halt cost-sharing reduction payments to insurers, which prompted them to raise rates.



## THE HEALTH CARE GAME CHANGER YOU MAY HAVE MISSED

Two months ago, Apple and 13 prominent health systems --including the likes of Johns Hopkins and the University of Pennsylvania -- announced an agreement that would allow Apple to download onto its various devices the electronic health data of those systems' patients -- with patients' permission. David Blumenthal and Anesh Chopra write in the Harvard Business Review that the announcement certainly didn't get the fanfare it deserved. There are obstacles to overcome, but nonetheless sharing of electronic health data could be a health

care game changer. "A world in which patients have ready access to their own electronic data with the help of facilitators like Apple creates almost unfathomable opportunities to improve health care and health. First, participating patients would no longer be dependent on the bureaucracies of big health systems or on understaffed physician offices to make their own data available for further care. This could improve the quality of services and reduce cost through avoiding duplicative and unnecessary testing."

## Former AIG and Athene Executive Joins Start-UP Denim as CTO



Charlie Turri

Startup Denim®, provider of an intuitive mobile and social media advertising automation platform for financial services companies, announced former AIG and Athene executive Charlie Turri is joining the company as chief technology officer (CTO). Turri's hire is seen as part of a larger trend in the insurance industry where executives are leaving jobs at well-established insurance companies to join startups. Denim's CEO and founder, Gregory Bailey, held positions at Athene and Pacific Life before starting the company in 2015. Look for more coverage on this emerging trend in Cal Broker!

## Colonial to Offer Dental/Vision

Colonial Life, known for its voluntary offerings including disability, life and accident insurance, announced it is rounding out its product portfolio with dental and vision coverage. Colonial Life's dental and vision benefits will use sister company Starmount Life Insurance, a national dental and vision carrier. The Colonial Life dental and vision plans are now available in 40 states. More info at [coloniallife.com](http://coloniallife.com).

## Fifth Circuit Vacates Fiduciary Rule, NAFA & DOL Agree to Drop Suit. But...

The National Association for Fixed Annuities Board of Directors announced it is withdrawing its lawsuit challenging the Department of Labor "fiduciary rule." In a filing with the U.S. Court of Appeals for the D.C. Circuit, NAFA and the United States Department of Justice agreed to a voluntary dismissal of the appeal. NAFA's decision comes on the heels of a March 15 ruling by the Fifth Circuit Court of Appeals, which vacated the Fiduciary Rule in its entirety. The NAFA lawsuit was one of two lawsuits challenging the authority of the Department of Labor to issue the rule. NAFA brought its challenge to the fiduciary rule nearly two years ago in the D.C. District Court, while the Chamber of Commerce and several other trade organizations brought a similar challenge in the Northern District of Texas. The lower courts in both cases ruled in favor

of DOL (upholding the rule), but, on appeal, the Chamber prevailed in the Fifth. NAFA believes the Fifth Circuit decision renders its case moot. Carol Buckman, writing for Employee Benefit News, however, says it's may be too soon to sound the death knell for the fiduciary rule. "...it was an en banc decision rather than a decision of the full court. The Department of Labor could request a rehearing before the full court or appeal. Every other court that has reviewed the fiduciary rule has concluded, contrary to the Fifth Circuit analysis, that the rule was a valid exercise of regulatory authority. This case could conceivably go up to the Supreme Court. I have even read opinions that if the Department of Labor refuses to defend the rule, courts might allow consumer groups or other parties to step in to represent the public," writes Buckman.



## EVENTS



### LAAHU May Meeting

May 17, 8am, Sportsmen's Lodge, 12825 Ventura Blvd, Studio City

Topic is marketplace changes in long term care with presenter Steve Cain, director of LTCI Partners. There will also be an election of directors. Nominations can be made from the floor at the meeting.

### IICF Casino Night

May 17, The Rotunda, San Francisco

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

### IICF Western Regional Forum

June 21, The Millennium Biltmore, Downtown Los Angeles  
The one-day regional format provides opportunities for greater participation and networking with colleagues here in the West and beyond. There will be ample time for networking with speakers as well. Topic this year is driving diversity: cultivating individual and industry confidence. Learn more at [womensconference.iicf.org](http://womensconference.iicf.org)

### NAILBA 37

November 1-3, Gaylord Palms Resort and Convention Center, Orlando, Florida

Detailed information about NAILBA 37 will be available soon. Info on exhibit hall and sponsorship opportunities available at [nailba.org](http://nailba.org) or contact [etoups@nailba.org](mailto:etoups@nailba.org) for more info.

# TRUMP ADMIN TRIES TO DEAL WITH INDIVIDUAL MANDATE NOW



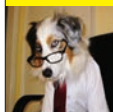
Of course, the individual mandate was repealed in the GOP tax legislation. But that's starting in 2019. Which means taxpayers must have insurance or pay a penalty this year. The Trump administration, however, made a move to remedy that situation for some people. The Centers for Medicare and Medicaid Services on Monday expanded the list of hardship exemptions for the law's requirement that individuals purchase health insurance. CMS said people who live in a county that has only one Affordable Care Act insurer can receive an exemption from the penalty. It also lets people avoid the fine if the only affordable plans available on the law's exchanges cover abortion. The current penalty is \$695 or 2.5 percent of household income, whichever is highest. CMS hasn't provided an estimate of how many people might use the new exemptions. The law already includes hardship exemptions for job loss or low income.

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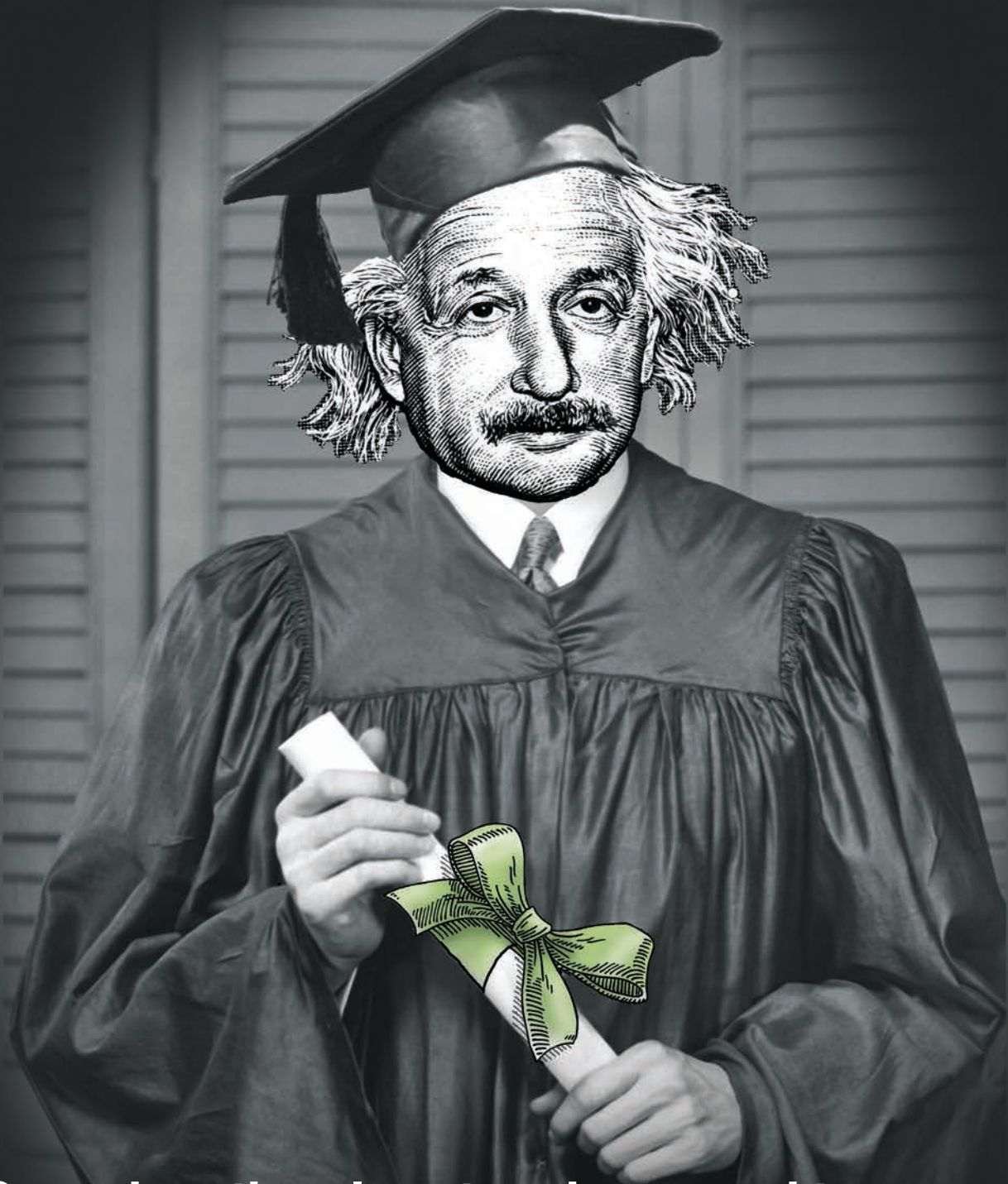
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