

CALIFORNIA BROKER

VOLUME 36, NUMBER 2

SERVING CALIFORNIA'S LIFE/HEALTH PROFESSIONALS & FINANCIAL PLANNERS

NOVEMBER 2017



CALIFORNIA'S AFTERSHOCKS

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

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

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

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GIVING BACK TO LOCAL COMMUNITIES

Insurance Industry

Charitable Foundation

By ALISA BREESE



Editor's Note: In the spirit of Thanksgiving, Cal Broker took a break from our usual focus on insurance/financial legislation, products and trends. Instead, we asked the Insurance Industry Charitable Foundation (IICF) to contribute a guest editorial about the organization's work and the importance of the insurance industry giving back to local communities. In this time of upheaval and dramatic debate over insurance issues, IICF's work is a nice reminder of what this industry and its people are about! Indeed, #insurancegivesback.

Giving back to the community. It's seems a simple enough concept and one without controversy. Yet giving back, in a way that will evoke meaningful change and truly help those in need, should be conceived in a thoughtful way with defined goals, and this is precisely the approach taken by IICF and the insurance industry in helping communities and enriching lives.

IICF is a unique foundation in that we work with professionals from solely one industry – the insurance industry – including carriers, agents and brokers, reinsurers and legal, technology, human resource and other firms specializing in supporting the industry. Our mission is to help communities and enrich lives through grants, volunteerism and leadership by uniting the collective strength of the industry. Since 1994, we've

given back to communities throughout the United States and United Kingdom with nearly \$29 million in grants and more than 240,500 hours of volunteer service.

The concept of supporting communities is an inherent part of insurance. Insurance providers are there for their policyholders in their times of need – often at their most dire time of need – helping to protect families, businesses

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*Gift cards are for illustrative purposes only. CCSB does not offer gift cards in lieu of health benefits coverage. **Insurance companies vary by region.

and communities against loss. It's only natural, then, for the professionals who make up this industry to unite in volunteer service to give of their own time, talent and resources to help others.

This dedication to community was in evidence most recently with the overwhelming response of IICF supporters in the devastating aftermath of Hurricanes Harvey, Irma and Maria. More than 1,000 individual insurance professionals, along with many insurance company supporters of IICF, generously contributed more than \$475,000 to the IICF Hurricane Disaster Relief Funds. A

full 100 percent of these contributions will benefit those affected by the hurricanes, and IICF is working with local nonprofit organizations providing direct assistance to individuals and families in the communities. Collectively, initial estimates of total industry contributions to Hurricane Harvey relief alone are estimated at \$15 million to date, and expected to increase.

For almost 25 years, IICF volunteers have been supporting local nonprofit organizations and charities, focusing on the many areas we champion that range from education and at-risk children to

environmental issues, food insecurity, disaster preparedness, veterans and homeless causes and more. Month in and month out, IICF supporters can be found helping at a food bank in Los Angeles, a homeless shelter in Chicago, a child care center in New York, assisting military veterans in Dallas or helping with a literacy program in London.

Our most impactful, single week of volunteering each year is the IICF Week of Giving, held during the second week of October, when we bring together thousands of insurance industry *(Continued on Page 10)*

ANNUITY SAMPLER

OCTOBER 1, 2017

Company Name	Ratings			Product (Qual./Non-Qual.)	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 10/2/17. Current interest rates are subject to change on new issues. **Commission may vary by issue age and state. See Commission Schedule for details												
American General Life Insurance Companies	A	A+	A+	American Pathway Solutions MYG (*Guarantee Return of Premium) (Q/NQ)	S	2.50%** 2.80%**	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	1.45%** 2.45%**	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	2.45%** 3.45%**	7 yrs.	None	9%, 8%, 7%, 6%, 5%, 4%, 2%, 0%	No	\$5,000 (NQ)	3.00% age 0-85 1.50% age 86-90
*(Guarantee return of premium Q/NQ) *CA Rates Effective 6/2/17. First year rate includes 4.0% bonus 1 st year. a (less than \$100K) b (100K or more)												
Great American Life	A	A+	A+	SecureGain 5 (Q/NQ)	S	2.05%	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 8/7/17 Includes .25% first-year bonus and is for purchase payments over \$100,000. Escalating five-year yield is 2.30%. For under \$100,000 first-year rate is 1.90%. Escalating rate five-year yield 2.15%												
Great American Life	A	A+	A+	SecureGain 7 (Q/NQ)	S	1.60%	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 8/7/17. Includes 1.00% first-year bonus and is for purchase payments over \$100,000. Escalating seven-year yield is 2.49%. For under \$100,000 first-year rate is 1.50%. Escalating rate seven-year yield 2.39%												
Great American Life	A	A+	A+	Secure American (Q/NQ)	S	1.55%*	1 yr.	N/A	9%, 8, 7, 6, 5, 4, 3	No	\$10,000	5.75% 0-70 4.65% 71-80 *Effective
8/7/17. Eff. yield is 2.57% based on 1.55% first year rate, 1.00% available portion of 10% annuitization bonus (available starting in contract year two) and 0.02% interest on available portion of bonus at the rate of 1.55%. Surrender value interest rate 1.55%. Accepts additional purchase payments in first three contract years. COM12255												
North American Co. for Life and Health	A+	A+	A+	Guarantee Choice II (Q/NQ)	S	2.25%** 2.50%**	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 10/3/17 - a (less than \$200K) b(200K or more)												
Reliance Standard	A+	A	A	Eleos-MVA	S	3.55%*	1 yr.	None	8%, 7, 6, 5, 4	Yes	\$10,000	3.25%**
*Effective 12/2/16. Includes 1.50% 1st yr. bonus. Min. guarantee is 1.00%. **Reduced 20% ages 76-80, and 40% ages 81-85												
Reliance Standard	A+	A	A	Apollo MVA (Q/NQ)	S	4.25%*	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 7/17												
Symetra Life, Inc.	A	A	A	Custom 7 (Q/NQ)	S	3.10%*	7 yrs.	N/A	8%, 8, 7, 7, 6, 5, 4, 0	No	\$10,000	Varies
*Effective 10/10/17. 2.60% base rate with no guaranteed return of purchase payments. Plus 0.50% bonus for \$250,000 and above.												



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(Continued from Page 8)

professionals for volunteer projects to serve local nonprofits and community organizations. Volunteer projects are designed to allow industry volunteers the opportunity to give back to the local communities where they live and work. In 2016, we had 8,500 volunteers, volunteering for projects in 115 cities in the U.S. and UK.

Giving back through volunteerism is just one aspect of the IICF. Our thought leadership on important, top-of-mind issues is well known, including our Women in Insurance Conference Series that focuses on diversity and inclusion in the insurance industry. IICF's philanthropic leadership is at the forefront with its Early Literacy Initiative, which aims to help provide every young child the opportunity to learn, read and write – regardless of economic means.

The IICF Early Literacy Initiative was conceived in 2013 when the Foundation's national leadership identified improving literacy opportunities for vulnerable young children, ages 5 and under, as a critical social need where IICF could make a meaningful impact – and truly give back to the community. This idea, and supporting ones bolstered by initiatives of The Pew Charitable Trusts and now ReadyNation, Council for a Strong America, arise from the ongoing crisis in childhood literacy and how increasing deficits in reading proficiency levels affect the long-term global competitiveness of the U.S. workforce and lifetime opportunities for our children. This initiative was enthusiastically embraced by IICF's industry-wide network of insurance professionals in their desire to unite in service to their communities.

Our next step was to join with an educational expert in early childhood literacy, and we found the perfect partner in Sesame Workshop, the New York City-based nonprofit behind Sesame Street. In 2013, IICF and Sesame Workshop launched Every Day is a Reading and Writing Day – a free, multimedia and bilingual early literacy program, including activities, games, videos and tips, that parents, teachers and caregivers use to engage children in improving their reading and writing skills (www.sesamestreet.org/toolkits/literacy).

IICF and Sesame Workshop renewed their partnership in 2016, includ-

"Our most impactful, single week of volunteering each year is the IICF Week of Giving, held during the second week of October, when we bring together thousands of insurance industry professionals for volunteer projects to serve local nonprofits and community organizations."

and bilingual resources, and give back in a significant way as IICF volunteers begin distributing 100,000 free copies of Book Buddies to children in underserved communities through schools, libraries and community organizations and through IICF volunteer-organized literacy events. Research tells us that in lower income neighborhoods there is on average only one book per 300 children, while there are 13 books per child in mid to higher income communities. So for some children, Book Buddies may be the very first book they can call their own.

IICF's dedication and action within local communities is an integral part of who we are. Our volunteers are hands-



ing a second \$750,000 grant from IICF, for our largest Foundation grant totaling \$1.5 million over six years. In September we released exciting new components of Every Day is a Reading and Writing Day that include the introduction of our new, free storybook, Book Buddies, featuring beloved Sesame Street characters in English and Spanish. Other new resources are a free online professional development course, Building a Reader, for preschool educators and a volunteer webinar developed for IICF's extensive network of volunteers, designed to provide guidance on how best to use Every Day is a Reading and Writing Day materials as they volunteer in their communities.

The insurance industry has the opportunity to directly impact a child's future by delivering these valuable, free

on with projects and helping those in need. We reinvest locally with grants to nonprofits where funds are raised, for greatest community impact. IICF leadership is provided in the local communities where our supporters live and work. We are steadfast in acting locally as we fulfill our mission of helping communities and enriching lives. Our hashtag sums it up clearly, #insurancegivesback! ★

Alisa Breese is the director of marketing and communications for the Insurance Industry Charitable Foundation. Breese directs and manages the Foundation's comprehensive global communications strategy, while supporting initiatives at both international and national levels along with division and chapter needs. Breese has more than fifteen years of experience in leadership positions in the insurance industry. For more information about IICF, including involvement opportunities, go to www.iicf.org.

HEARING BENEFITS LISTEN UP!

By MIKE REHA

HEARING LOSS IS #1 WORK RELATED INJURY

Most people are surprised to learn that nearly one in five Americans suffer from hearing impairment severe enough to make communication difficult. Noise induced hearing loss (NIHL) is one of the most prevalent occupational conditions and occurs across a wide spectrum of industries. Occupational NIHL is defined as hearing loss that is a function of continuous or intermittent noise exposure and duration, and which usually develops slowly over several years.

Approximately 22 million U.S. workers are exposed to hazardous noise levels at work of whom 18 percent have hearing loss. An additional 9 million workers are exposed to ototoxic chemicals that may cause hearing loss. Both of these factors combine to make occupational hearing loss (OHL) the most common work-related injury in the United States.

Occupations such as construction, mining, manufacturing and law enforcement are commonly recognized as having increased noise exposure and therefore are at risk for OHL. Many people do not realize that workers in other professions, such as teaching and business, also suffer from OHL.

Working in a noisy environment can create physical and psychological stress, reduce productivity and interfere with communication and concentration. While the usual reason to control noise in the workplace is to protect the hearing of the workers, a study conducted by researchers from National Public Health Institute of Quebec in Quebec City, Canada, uncovered another major reason --workplace safety. Noisy environments can contribute to



workplace accidents and injuries by making it difficult to hear warning signals.

The study, published in the journal *Injury Prevention*, reveals that hear-

ing loss, combined with noise in the workplace, increases the risk of serious work injury. Based on the study, the researchers estimate that the combination of severe hearing loss and working in a noise-exposed environment of 100 dB increased the risk of injury by 3.6 times, compared with workers with neither factor.

Workers rely on their hearing not only for their safety and the safety of those around them, but also to participate in meetings, do business over the phone and receive directions. With this vital sense compromised, workers with untreated hearing loss are often less productive than their peers with healthy hearing. Luckily, there are cost-effective hearing benefit solutions.

Brokers can help their clients by directing them to hearing care plans with large accredited networks of hearing care providers that have distribution relationships with all major hearing aid manufacturers. Hearing plans are available in a variety of funding options including: fully insured, ASO (administrative services only) and value add (discount) plans as well as a complementary, online wellness rewards programs where members can save on their hearing care purchases. ★

Mike Reha is director of sales and marketing for EPIC Hearing. For more information about the EPIC Hearing Service Plans, contact Reha at (877) 606.3742 x2156 or mreha@epichearing.com.



Where Were You When the Lights Went Out?

RECOGNIZING INSURANCE PROS AS SECOND RESPONDERS

By STUART SLONIN

"Within 4 minutes there was a total blackout! It quickly spread throughout New York, to Boston, Connecticut, Vermont and Canada."

While this seems like a rhetorical question, it might very well be followed by that NYPD Blue interrogation question: "Where were YOU during the hours of _____ and _____?" We can all trace personal experiences where either one or a variation of these questions came into play. Since 1963, because of the John F. Kennedy assassination, we've developed the habit of asking: Do you remember where you were when?

For me, it got more personal at 5:16 P.M. on November 9, 1965. I was taking a

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final exam in an Optional Graduate School Conducting class at Queens College in New York. My name put me last of those waiting to conduct a movement of a Mozart concerto. Just as I stepped to the podium, the lights began to flicker. Within 4 minutes there was a total blackout! It quickly spread throughout New York, to Boston, Connecticut, Vermont and Canada. This blackout experience repeated in the Northeast in 1977 and 2003 (more than 50 million people lost power). Fourteen

the Harvard School of Engineering and Applied Sciences (SEAS) predict that by 2050, wildfire season will be three weeks longer, twice as smoky, and will burn a larger portion of the West. Since 1999, the acreage burned by wildfires in the U.S. has tripled from 2.2 million to 6.4 million annually.

So after FEMA and the other first responders have left the disaster area, what are people doing in response to "Where were you when....."? They have either decided to rebuild,

long it may take to return to a degree of normalcy.

We've recently experienced hurricane disaster. Working our way through a disastrous 2017 season of 17 named hurricanes, experts are tallying the financial impact of hurricanes Harvey and Irma. The early potential loss figures are \$25 to \$40 billion for Hurricane Harvey, and \$20 to \$50 billion for Hurricane Irma. But beyond pure loss figures come the bizarre real life happenings during storms and disasters. Some of them can even be inspiring, such as women giving birth to healthy children even as disaster strikes.

Those of us who are life licensed recall our early training in life Insurance needs. They were called the FEMER needs. Those included: Final expenses, Education, Mortgage, Emergency, Retirement and later we added: Disability, Critical Illness and Long Term Care. In this whole discussion of addition by subtraction, we could see where this kind of needs planning comes into play. How many babies were conceived during any of those events? Did you receive any of those phone calls yet. For those working in the family planning, business and / or estate markets – these are not surprise events. Mother Nature does not always work in mysterious ways. Some events are quantifiable.

So this addition by subtraction occurs on many different levels, every day of our working professional life. Adding a new child, moving to a new residence and having to re-finance the move, adding a new car to replace one lost in a storm, moving a business due to the destruction of a workplace location, having to replenish emergency funds which were used during the disaster. While FEMA and other first responders are the first line of defense – aren't we with our FEMER / DI, CI, LTC training the actual second line of defense? So consider this if ever you question your occupational value: yes, you're an insurance professional, but you're also one of our nation's second responders. ★



years after that Great Blackout of 2003, the electric grid is stronger. But, could it happen again?

People across the country have stories to tell of their brush with natural tragedies. Natural catastrophes are among the most threatening perils in the nation. Our compatriots in P&C know that without comprehensive coverage, the result can be devastating losses for clients.

Every year brings a new litany of natural disasters: severe heat waves, winters of record precipitation and torrential rainstorms, mud slides, drought conditions, rampant wild brush fires, flooding, and some severe earthquakes. Environmental scientists from

left the area entirely to start a new life somewhere else, or looked to local or federal authorities to financially help them rebuild their lives. Maybe that takes stronger state and local building ordinances, maybe it's just a local community determined to rebuild or a church or synagogue determined to help worshipers with financial help. Maybe it's all of the above. But we are in the insurance business and we understand this "addition by subtraction" concept. We know that sometimes it's up one, down two. We've shared these experience with clients trying to rebuild their lives after one of these experiences. We know the personal pain, the financial pitfalls they face and how



Stuart Slonin, LUTC, RHU, CBC, IFA, is president of Boynton Beach, Florida-based S.I.G. Consulting Resources, LLC.

A LOOK BACK INTO THE FUTURE

SDAHU's 30TH ANNUAL SALES EXPO

JANUARY 18, 2018

8:30 am – 2:30 pm

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- **Faith Lane**
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2017 LARGE GROUP VIEW FROM THE TOP EXECUTIVES WEIGH IN ON LARGE GROUP ISSUES

Here it is...
California Broker's
2017 Large
Group Health: View
from the Top. This is our
opportunity to get direct
insight from some of the
more knowledgeable
folks in the business.



This year, we've included questionnaire responses from:

- **Patrick Burns, vice president of community outreach, CAHU, and managing member of Burns Employee Benefits**
- **Rob Carnaroli, vice president, sales, Sutter Health Plus**
- **David L. Fear, Sr. RHU, president/CEO, Shepler & Fear General Agency**
- **Jeff Papenfus, senior vice president, California sales, Warner Pacific**

Find out what these industry insiders have to say about large group trends, the transition from large to small-group for the 51-100 crowd and much more...

California Broker. What are some major trends affecting large groups?

Burns, CAHU: Costs are always a major issue with large group benefits, but this year, in particular, much of the focus in health care has been on what is happening in Washington and the reaction at the state level. Planning for possible changes to the ACA, to taxability of benefits through possible limits on the employer exemption, the re-imposition of the HIT tax and other changes are worrying many employers. At the same time, cost drivers such as pharmacy, and consolidation of provider groups and networks continue, driving up actual health care costs. Add to this the reduction in unemployment and businesses are starting to have to eat the increased cost for benefits as opposed to passing them along, to retain or attract employees.

Employers and carriers are working to eliminate the cost drivers through referenced based pricing strategies, defined contribution strategies at the lower end of the market and searching for solutions in the pharma area. State legislatures are also getting more involved. California as of today has at least three bills targeting pharma costs, including a state purchasing pool, which would be available to all employers as well as any state entity.

Finally, technical solutions out of Silicon Valley are proliferating while employers are trying to figure out a way to eliminate cost in their HR offices and deploy benefits in a more efficient manner. At the same time, transition

costs to the new systems can be time consuming and costly, diverting attention from other key deliverables.

Carnaroli, Sutter Health Plus: Millennials are the largest generation in the labor force today. Attracting and retaining quality talent from this pool is changing how we think about employee benefits. Even the way employers communicate with employees is changing—from social media to text messaging, information should be instantly accessible from a smartphone.

Employers are also looking to give employees access to care beyond the traditional primary care office setting. For example, we're seeing on-site clinics and retail clinics gaining popularity. While telehealth hasn't taken off like many expected, it remains a viable option for seeking convenient medical care.

Finally, some trends continue to be top-of-mind, such as higher cost-sharing plan designs, high-deductible health plans, defined contribution options and private exchanges.

"Now that the implementation of the ACA employer mandate is over I think the most pressing issue that faces large groups is the continual rising cost of health care services and increased utilization – especially in the area of prescription drug costs."

Fear, Shepler & Fear: Now that the implementation of the ACA employer mandate is over I think the most pressing issue that faces large groups is the continual rising cost of health care services and increased utilization – especially in the area of prescription drug costs. Large employers are demanding that the carriers with whom they contract not only offer longer term contracts that will keep their rates level but are willing to change carriers in order to obtain this kind of arrangement. Carriers are now responding by tightening up their provider networks and attempting to negotiate better payment deals. Larger employers are making the change to self-funding in increasing numbers and are looking at more innovative payment arrangements with providers.

Papenfus, senior vice president, Warner Pacific: Here are some major trends affecting large groups:

- Due to rising costs of pharmacy contracts, renewal trends have increased and carriers are looking to more limited formulary listings.
- ACA fees are attributable for up to 4 percent on top of the trends on pooled products.
- Technology is a huge driving force at the moment. As we move to more online enrollment options, administrators and HR teams are becoming acutely aware of HRIS platforms. Carriers and Warner Pacific are rolling out their own proprietary platforms to stay competitive, offer more onboarding support and be more efficient in this new environment.

California Broker. How smooth was the transition from large group to small group for the 51-100 segment? Were there unexpected consequences?

Burns, CAHU: There was a good degree of disruption – some positive and some negative. For many, moving to a guaranteed issue plan with guaranteed pooled costs saved them money. For others, losing the benefit of their good experience was an additional cost. About 30 percent of employers in the 51- 100 segment had a cost increase, while about 30 percent saved money and the rest ended up about the same. The administrative costs of moving were probably more complicated to measure - moving to an age banded rate is disruptive and difficult to manage and communicate for those who have not had to deal with that. Also, the lack of similar benefits may have been a significant issue for those who were on the higher end of the benefit spectrum. Many small group platinum plans did not carry the same level of coverage as mid-sized plans do. So there was disruption there for those employees who lost benefits. Also, the extension of the self-funding limitation for small group into that market segment did cause some significant disruption for those groups, leading some to exit that market.

Carnaroli, Sutter Health Plus: Brokers who specialized in small group and the smaller-sized large group market understood the change in the market, the rating implications and the differences in benefit designs. Their expertise in helping their clients understand the changes and preparing them for the transition was key. Fortunately, there was a long enough lead time to adapt, and as a result, the impact was minimal.



Fear, Shepler & Fear: The transition probably went as well as could be expected. Most mid-sized employers were given plenty of notice of the change in both rating and benefit structure before they had to convert to small group. For some who had previously had very good rates and an attractive risk adjustment factor under the old large group products, the change was very hard as they were forced into community rates without

any risk adjustment factor. For them the transition was hard and many brokers struggled in late 2016 to get them enrolled into new small group plans. Some carriers did better at handling this than did others. An unexpected consequence was that mid-sized employers who had previously had a tough time changing carriers due to poor claims experience now could do so without too many problems since the small employer market is both guaranteed issue and guaranteed

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Increasing competition?
Narrowing networks?
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rated. We found that many mid-sized employers were not too happy about having to change to the “metal” plans when they had previously had “customized” benefits. Or that they went from composite rated to member-level rated plans. And finally, others found that “alternative funded” plans are not as available in the fully insured small group market in California. For this reason, we saw a lot of mid-sized employers finally move to HRA or level-funded plans in 2016/2017. That trend continues today.



Papenfus, Warner Pacific: The transition was difficult to traverse and with it brought a number of questions surrounding the transition and what was involved. We saw a huge influx of groups that renewed December 1, 2015, in order to fully delay the roll over into their new small group segment. These large groups had been used to composite rates, dedicated account management, wellness incentives and

more. The transition to small group was a culture shock for many groups who no longer felt they were receiving a white glove, hands-on experience. Also, new rating methodology for small groups drastically effected rates for a big percentage of groups. Warner Pacific was there to offer assistance to clients who were making the transition through the use and development of our group transition 411, while offering solutions to truly provide an education to the agents and clients we service.

California Broker: How are you advising brokers to deal with all the uncertainty about health insurance reform?



Burns, CAHU: First – so far nothing has actually changed. It does appear that wholesale changes to the marketplace will not occur from the Feds, as it looks like federal reform will take place under Regular Order (as opposed to Reconciliation, which only requires 50 Senate votes). It has been difficult to gain agreement for wholesale changes. Most changes will happen around the fringes of the ACA. Most of

the ACA arguments in the legislature are going to be about

the individual marketplace, which while important, are most likely not going to impact the large group marketplace to a large extent. But there are two significant areas to be concerned about for the large group broker. The first is the tax treatment of benefits – including the re-imposition of the Health Insurance Tax (increase of over 2 percent on medical benefits) and the treatment of the employer exclusion. Both of those will increase the costs of benefits to your clients and make it more difficult to offer benefits.

The second area to be concerned about is the California state reaction to whatever comes from Washington. While single payer health care effectively ends our business in the state, there are significant hurdles to that path, most especially the costs involved. However, health care reform is on the state’s agenda, and there will be significant legislation over the next year or two, especially after the next governor is elected. All statewide offices during the next election cycle have health care as a major focus of their campaigns.

“...there are two significant areas to be concerned about for the large group broker. The first is the tax treatment of benefits – including the re-imposition of the Health Insurance Tax (increase of over 2 percent on medical benefits) and the treatment of the employer exclusion”

Carnaroli, Sutter Health: While the situation with the ACA is still very uncertain, the most important factor in any future proposal is that it protects health care coverage and keeps the existing reforms that have positively transformed health care delivery in place. Employers expect their brokers to quickly understand and explain any changes on the horizon that will affect their business. Brokers who do this and don’t allow the current environment to detour them from the role as their clients’ trusted advisor will do well.

Fear, Shepler & Fear: We advise agents to tell their clients that they should not start dismantling all of their ACA compliance plans. The process of changing the ACA may take years or may not even happen at all. Congress remains deadlocked. And California will probably be the last state to change its ACA compliance laws. Many political things will need to happen at both the Federal and State level in order for a full “repeal and replace” strategy to work, and for California, that is not going to happen anytime soon. Despite what they hear, health care reform is not changing much right now. For this reason, we advise brokers to become members of NAHU and pay close attention to the weekly updates of what’s happening in both Washington, D.C., and Sacramento. Clients expect their agents to be on top of things and in my opinion NAHU is a wealth of information that every agent should be accessing. The annual dues – about \$300-\$500 – are a small

price to pay for some of the best information you can get on health care reform!

Papenfus, Warner Pacific: Live in the now. Work on your business and within the ACA as it stands today. I have been in this business for 28 years and there has always been uncertainty, which creates tremendous opportunity for brokers to grow their business.

"Live in the now. Work on your business and within the ACA as it stands today. I have been in this business for 28 years and there has always been uncertainty, which creates tremendous opportunity for brokers to grow their business."

California Broker. What are the most effective ways to sell to large groups?

Burns, CAHU: Right now, a focus on simplicity and cost savings seems to be working. Benefit plans are becoming more and more sticky – once you have an administrative system in place and a quality medical provider, you will really need to have a quality solution for moving that client. Most businesses are doing more with less, and require you to manage the process. Simply being the broker is no longer enough.

There are a ton of tools available today to help brokers of all sizes to step up and play in the large group marketplace if you are willing to take the time to understand the capabilities and uses of the tools, from plan selection to administrative solutions, to data analysis and educational services. Invest in your business first to build your platform, and then leverage your high level of service and your tools into a relationship of trust and service.



Carnaroli, Sutter Health: Successful brokers communicate early and often—large groups need timely information from a trusted advisor to navigate the changing marketplace. When brokers are present, transparent and practical, they demonstrate the value they bring to their clients. It's also important for brokers to invest in the latest technology available to access, process and manage data—knowing how to leverage that data is a key driver to success. Large group

clients are sophisticated buyers, and brokers who offer solutions that help them increase employee satisfaction, productivity and loyalty are precisely what they want in a benefit advisor.

Fear, Shepler & Fear: Offer to conduct an ACA compliance analysis for them. Then review their current plans to see if they comply with benefit and discrimination rules. That should be followed by determining their level of risk assumption as large employers can and should rely less on carrier solutions and more on their own ability to take and fund for more risk in the health plan(s) they offer. The consultative approach works much better than sounding like you are trying to sell them something off the shelf as is now done in the small group market. Look to large group carriers for new products and services that they may not be getting currently. Most large employers expect to negotiate broker compensation and/or that their broker will provide value added services. Be prepared for that to happen. Finally, make sure you work closely with their HR and finance people because both are critical in how changes are implemented within a large group. Finance has one view of things that may be 180 degrees different from how HR sees it. The broker must be

"At the end of the day most large employers expect better service and more attention from their broker. We see a growing number of employers who are changing their brokers of record because they are unsatisfied with the level of service they get (or don't get) from their current broker."

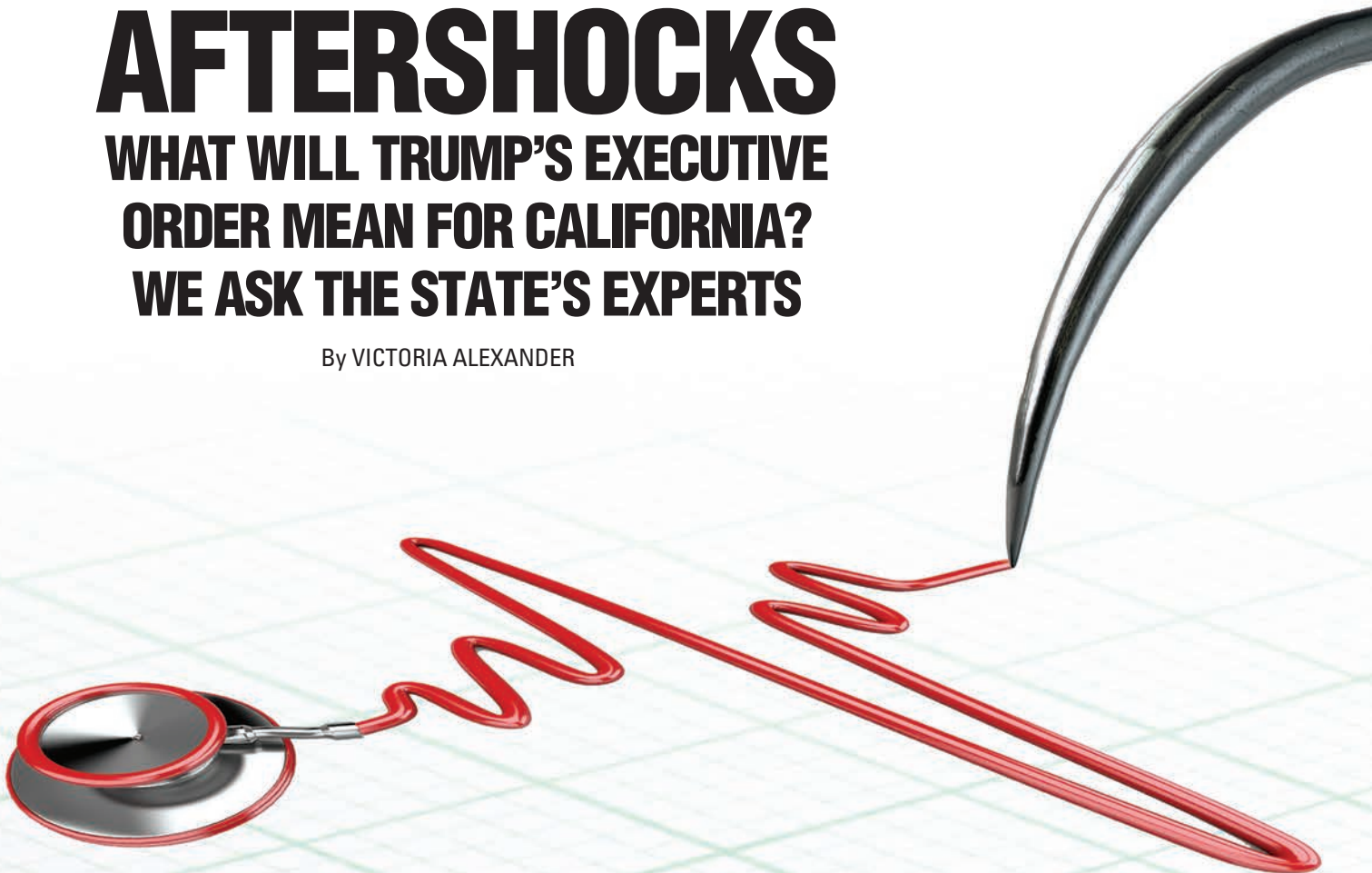
able to work with both in order to craft a successful implementation strategy. Pay attention to what they ask and respond quickly to their requests. At the end of the day most large employers expect better service and more attention from their broker. We see a growing number of employers who are changing their brokers of record because they are unsatisfied with the level of service they get (or don't get) from their current broker.

Papenfus, Warner Pacific: The most effective ways to sell to large groups are to offer a comprehensive approach, provide a full package of value-added services and demonstrate out-of-the-box thinking with strategic carrier alliances. Find a partner who has all of the knowledge and tools that can help make you more productive. Make it less about rates. Sell them on all of the benefits of working with you and your agency. Approach the sale from a consultant prospective to make sure that you have a complete picture of the group's needs and what they're trying to accomplish by offering employee benefits. Find out what they are really interested in. ★

CALIFORNIA'S AFTERSHOCKS

WHAT WILL TRUMP'S EXECUTIVE ORDER MEAN FOR CALIFORNIA? WE ASK THE STATE'S EXPERTS

By VICTORIA ALEXANDER



In mid-October, President Trump signed an executive order he said was aimed at lowering premiums and expanding choices for health insurance. The executive order includes three basic categories of changes:

- It directs the secretary of labor to look into ways to use association health plans, allowing employers in a similar industry to band together, even if located in different states, to buy insurance. The insurance could flow through an existing association, such as the Chamber of Commerce, or could be a new organization formed for the purposes of acquiring health insurance. The plans are not subject to the same regulations as the Affordable Care Act, and the administration is looking for ways to allow individuals to enroll in these types of plans.
 - It directs the departments of labor, treasury and health and human services to change the rules governing health reimbursement arrangements, which allow employers to contribute to workers health benefits.
 - It directs the departments of labor, treasury, and health and human services to investigate ways to expand the coverage options of short-term insurance, which are plans that operate lawfully outside of the Affordable Care Act's rules to cover individuals for a few months.
- Trump's executive order will not result in any immediate changes to the law and won't help or harm any consumers shopping for the Nov. 1 open enrollment. The order will merely start the process of trying to find ways to work within existing rules to expand options. The various agencies will be

given 180 days to report to the president about any other changes that could be made, at the state or the federal level, to increase choices for consumers. Once new rules are issued by the agencies, they could be subject to legal challenges, depending on how they are crafted.

The Trump administration is touting the law as providing relief to consumers. Democrats are pointing to it as another act of sabotage against the Affordable Care Act, saying it aims to make bare-bones junk insurance legal and encourage healthy individuals to leave the market. Of course, the more the ACA market loses healthy people, the worse the rates for those who remain. Quite simply, it will be difficult to evaluate the true scope of the order until the rules are known.

With this in mind, however, Cal Broker sought out a few industry insiders to offer first blush insight into how the rules could potentially play out here...



David L. Fear, Sr., RHU, is president / CEO of Shepler & Fear General Agency, specializing in large group, small group, and self-funding plans. Fear is a 36+ year veteran of the employee benefits industry who has been heavily involved in legislative and regulatory affairs both at the state and national levels.

I just read the executive order (EO) this morning and I'm still looking at it from different perspectives. Here are some first thoughts I can share:

- Three things stood out: expand association health plans, HRAs and short-term medical plans. I'm highly supportive of the expansion of HRAs except that you may see it diminish the small group market if smaller employers drop their group plans and let employees purchase IFPs and reimburse them for the cost of IFPs on a tax-free basis. On the other hand, HRAs are a good thing because they encourage purchasers to buy HDHPs and "self-fund" the deductible, which can be a good long-term strategy to control premium and health care costs.
- With regard to association health plans (AHPs) I expect this will be a highly contested issue in many states because some states – like California – are very suspect of AHPs and you get little or no support from carriers in this market.

On the other hand, given that the IFP market is going to be severely impacted by the EO to eliminate subsidies, perhaps allowing AHPs to contract for group coverage for their members – many of whom are individuals/sole-proprietors – might bring some stabilization to the market by actually expanding small group programs to individuals and one-man groups. I think the initial AHP idea was to get fully insured products sold across state lines (which is something the Republicans all believe will solve the problem and which I do not agree with), and doing such through AHPs might be a quick way to do that – based on where the association itself is domiciled. Of course, California regulators will not support this because they want to be the sole regulator of insured coverage and therefore won't want to allow this to happen in California. I'm not sure that a self-funded MEWA will work in California either. I'd look for the state to sue the feds over that issue because it would deprive the right of California to regulate these plans. Historical note: States have had the ability to regulate MEWAs since 1982

"...with upcoming open enrollment and the loss of subsidies for enrollees in the exchange, things may really implode in some markets. I expect California to feel effects in the individual and family plans market."

and California treats them as an insurance company so a MEWA must meet all capital and reserve requirements of an insurance company.

- I think California has a fairly stable individual and family plan market and I'm concerned that elimination of subsidies will cause rates to increase here in spite of the EO allowing carriers to offer less expensive plans than are allowed under the ACA. Hopefully President Trump will allow California to continue to formulate its own rules with regard to health care reform and that means that California will probably maintain most – if not all – of its current ACA rules and laws.

From a self-funded perspective, I don't see the EO having any effect on the self-funded market here. We still have SB-161 to contend with and that has been difficult for 'small' employers to deal with given the amount of risk they must take due to the state's minimum stop-loss laws. If the EO causes the legislature to reconsider some of this (i.e. SB-161) then perhaps that is a good thing. Other than that, I don't see the EO affecting self-funded employers.

Regardless, this will take months to resolve as some states will resist the changes and may even sue to overturn the EO. That will tie things up in court for a while. On the other hand, with upcoming open enrollment and the loss of subsidies for enrollees in the exchange, things may really implode in some markets. I expect California to feel effects in the individual and family plans market.



Alan Katz, past president of the National, California and Los Angeles Associations of Health Underwriters, is a co-founder of Take 44, the company behind the NextAgency software for insurance agents. Previously, Katz held senior positions at health plans, general agencies and insurance agencies. Alan also served as Chief of State to California's Lieutenant Governor.

As it pertains to health care reform, we live in ridiculous times. Not interesting times. Not challenging times. Ridiculous times.

Think about it. The Patient Protection and Affordable Care Act passed in 2010. Traditionally (remember when American politics had traditions?), over the next several years the administration and Congress would fine-tune the legislation to clarify ambiguities and fix obvious errors. Lawmakers on both sides of the aisle would act to make it work. In the hyper-partisan world we now inhabit, very little of that happened.

Now President Donald Trump and Congressional Republicans have backed themselves into a corner. They need to pass health care reform, but seem incapable of passing anything.

This can be unsettling, especially given the whiplash inducing policy positions (I use the phrase "policy" charitably) coming out of the White House. As I write this, in just the past five days the President issued an executive order aimed at undermining the ACA, stopped cost sharing reduction payments, and endorsed bipartisan legislation that reinstates those CSRs. By the time you read this, another dozen positions will have emerged and at least some will contradict others.

What is a California broker to do? Is the health insurance market in the state going to implode?

No. Instead, we need a reality check.

Most of the health care reform ideas ("ideas" is used charitably, too) careening around Washington aim to give states greater control over their health insurance markets. This is good news for California brokers hoping for stability, but bad for those longing for "the good old days."

Prior to the ACA, states were the primary regulator of health insurers and their practices. The ACA took a lot of those decisions and put them in the hands of federal agen-

cies. These include matters surrounding who mandates to buy coverage, required health plan benefits and more.

Republicans in Congress want to send those decisions back to the states. The President will embrace whatever legislation Congress passes. If states get more say, will California's health care markets change? Not likely.

The ACA is popular in Sacramento. If given the power to undo it, California lawmakers won't. That's already happened. The ACA originally redefined "small groups" to include companies with up to 100 employees. All states, including California, passed legislation to match that. When Washington gave states the option of keeping the prior definition, most states did. California did not.

When you hear about changes to the ACA coming out of Washington, ask if the change moves authority back to the states. If so, it won't change your professional life much in California.

"...in just five days the President issued an executive order aimed at undermining the ACA, stopped cost sharing reduction payments, and endorsed bipartisan legislation that reinstates those CSRs. By the time you read this, another dozen positions will have emerged..."

If, on the other hand, the changes destroy the ACA, then expect disruption. Even California can't withstand the fallout of an ACA implosion. The odds of something destructive emerging from Washington, however, are small. The votes just aren't there. Which means after the sound and fury emanating from Washington dies down, Californians won't see much change.

Which is good. Because, frankly, we have other things on which to focus. Single payer anyone?



Michael Wolff is president of Los Angeles-based Dickerson Insurance Services. Here, Wolf shares his main bullet points:

- The Executive Order is a directive to the departments of

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labor, treasury and health and human services to consider proposing regulations or revising guidance around selling association health plans across state lines, the expansion of HRAs and the restructuring of short-term plans. The applicable departments have deadlines to report back to the President but, in short, the entire process will take months, if not years. Therefore, implementation is a ways off for carriers, agents and consumers. Whatever the outcome, Dickerson is well-prepared to maximize the opportunities for our broker partners.

- Association health plans have long been in existence with many still operating today. Selling across state lines is currently achieved with national carriers employing regional pricing differences that reflect local market demographics and provider reimbursements. There are solid economic reasons why plan rates vary from rating area to rating area. The same will hold true of vari-

"The expansion of HRAs is a positive move. As an employer, it is a better business decision to place money in an HRA for employees to lessen their out-of-pocket exposure than to raise salaries that will, in the end, result in unintended consequences."

ances between states. When associations pick the most favorably priced state in which to base their plan rates, and if association plans are not held to the same minimum benefit requirements as ACA-compliant plans, then carriers will experience adverse selection. Dickerson has and continues to manage trust plans and has enjoyed long-term premium and benefit stability among its participating groups.

- The expansion of HRAs is a positive move. As an employer, it is a better business decision to place money in an HRA for employees to lessen their out-of-pocket exposure than to raise salaries that will, in the end, result in unintended consequences. These include, but are not limited to: employees possibly moving to a higher tax bracket and increases in workers' compensation premiums and payroll taxes for the business.
- In today's market, short-term medical plans have their place in a well-structured benefit strategy. Dickerson has had a good amount of success selling these plans through its broker channels to specific demographic audiences. Whether an individual is seeking coverage without a qualifying life event or is not subsidy eligible and cannot afford exchange premiums, these plans provide limited inpatient and outpatient coverage (not ACA-compliant) for what is now a maximum three-month period in California.



Michael Lujan, RHU, CHRS, is chief strategy officer and cofounder of San Francisco-based Limelight Health. Lujan sits on the board of directors of the Silicon Valley Association of Health Underwriters and is the California Association of Health Underwriters Past President (2015-2016).

The president's executive order will likely face a huge legal battle over the possible violation of ERISA. Several attorneys general (including California's Xavier Becerra) could argue the federal government overreached by allowing associations to buy health coverage across borders that only complies with a single state's regulations. ERISA experts also commented that associations formed for the purpose of buying insurance are not employers under ERISA; an issue the Department of Labor would have to address in their draft regulations. Likewise, expanding the duration for short-term health plans to 364 days would create a parallel market that undermines the stability of the whole insurance market, as warned by the Academy of Actuaries, National Association of Insurance Commissioners, multiple consumer groups and health plans.

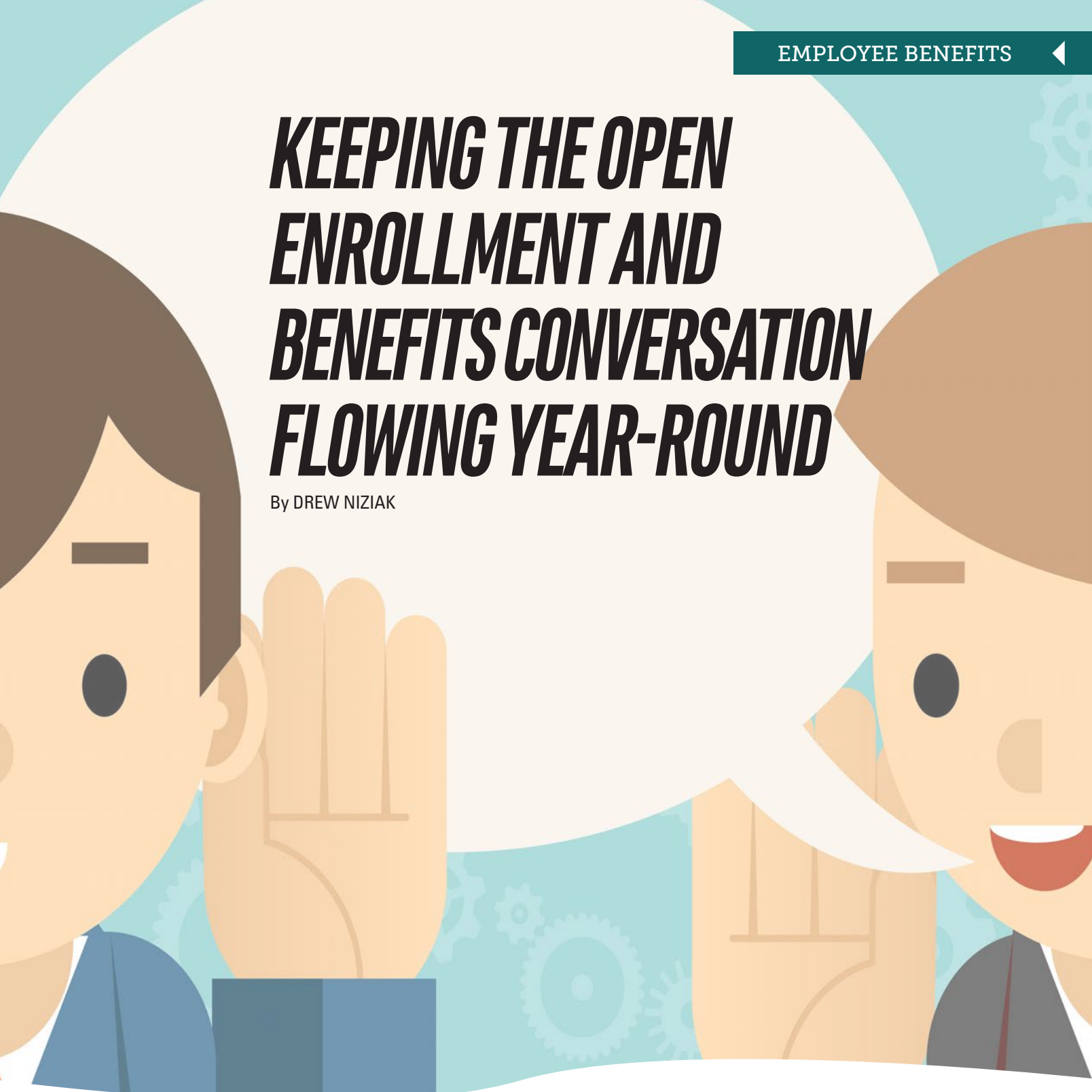
Early in my career, I worked for a now defunct TPA selling MET association health plans throughout California. From 1988 to 1992, AHPs were very popular and inexpensive compared to most traditional local health plans until most of these AHPs fell into bankruptcy, state receivership and left many consumers with unpaid claims. It was the wild west. This market instability led to the California small group reforms and consumer protections passed in 1992 under AB 1672, which essentially eliminated AHPs and multi-state plans in California.

While the new AHP rules could be different than before, it's hard to ignore the valuable lessons of our past and the understanding that AHPs may only lower premiums by providing skimpier or less-comprehensive coverage. The executive order is also an unfortunate distraction from the real work that could be happening to fix the ACA, stabilize the insurance markets and address the underlying cost of healthcare that drives insurance premium increases. That's where our focus should be. ★

Editor's note: Also check out Michael Lujan's recent posting on LinkedIn about the executive order: <https://www.linkedin.com/pulse/trumps-executive-order-obamacare-michael-lujan/?trackingId=mbfHRh8F8UIv0zIqFvDuyw%3D%3D>

KEEPING THE OPEN ENROLLMENT AND BENEFITS CONVERSATION FLOWING YEAR-ROUND

By DREW NIZIAK

An illustration featuring two stylized human figures from the chest up. The figure on the left has dark hair and is wearing a blue shirt. The figure on the right has light brown hair and is wearing a grey suit jacket. A large, white, hand-drawn speech bubble originates from the right figure, extending across the center of the page. The background is light blue with faint gear patterns. The overall style is clean and modern.

Fall is often a welcomed season for many of us. Everything from the first day of school, the start of football season and the season premiere of a favorite television show has people buzzing with excitement and anticipation.

There's a similar buzz this time of year at U.S. companies – open enrollment season. It's the time of year when human resources experts begin the annual drumbeat of sharing information

about benefits options available to employees during the enrollment period and also when benefits advisors have an opportunity to step in for meetings. While important, digesting all of the in-

formation on plan types, deductibles, copayments, coverage amounts, insurance needs, covered and non-covered illnesses and injuries, etc. can be overwhelming for many employees.

Many U.S. employees lack a full understanding of the coverage they choose, according to the Aflac 2017 WorkForces Report. In fact, 74 percent of employees admit there are at least some things they don't understand about their overall policies. Furthermore, 67 percent of employees say reading about benefits is long, complicated or stressful, and 15 percent would even prefer to file their taxes instead.

So, how can you help clients keep employees educated and engaged during and beyond open enrollment so that they can better understand the benefits process and make more informed choices? Here are a few options to consider.



1 Explain to clients that it doesn't stop at the "transaction."

Reassure clients that your support and expertise as their benefits advisor goes beyond the ink. Offer tips and educational recourses that clients can use to keep their employees informed and engaged – their employee retention rates could depend on it. Employers who use a broker or benefits advisor are more likely than those who don't to say that the benefits their company offers enable them to reduce turnover (77 percent versus 73 percent). Strong partnerships with benefits advisors better enable employers to offer more value in benefits options, which can often help increase retention.

2 Highlight the financial impact.
By checking boxes without full comprehension during open enrollment season, employees leave themselves vulnerable to unexpected costs. According to a survey by PricewaterhouseCoopers, 28 percent of employees say personal finances have been a distraction at work and, of those, 46 percent spend three or more

"Advisors can explain to clients that a robust health benefits offering can serve as a financial safety net for employees and help relieve some of their financial stress."

job hours each week dealing with or thinking about issues related to their finances. Advisors can explain to clients that a robust health benefits offering can serve as a financial safety net for employees and help relieve some of their financial stress. And in order to make the best possible decisions for their finances, employees must have the information they need about their benefits in a clear, concise format that's easy to understand. If employees can make good selections and feel prepared for the future, they can more easily focus on their work and day-to-day responsibilities.



3 Create regularly scheduled communications.
Advisors have an opportunity to help clients set up plans to ensure communications are distributed on a regular schedule. Clients can set up reminders at milestones timed to coincide with life events such as changing seasons, key birthdays and employee anniversaries.

4 Use technology.
Benefits advisors can also help clients stay up to date on the latest technology solutions available such as online and social media-driven resources available 24/7, 365 days a year by carriers. Employees can get access to benefits resources around the clock, receive enrollment deadline reminders and get detailed benefits statements, while clients can have access to ACA compliance reporting and be less likely to miss reporting milestones.

The bottom line is that employers can never communicate too much about employee benefits, as long as it's done the right way. By helping clients provide understandable, timely and bite-sized communications to their employees, benefits advisors can ensure clients reap the rewards of a year-round benefits conversation and a workforce that truly understands their options. ★



Drew Niziak has more than 25 years of experience in group sales in the insurance industry and is senior vice president of broker sales at Aflac. He is responsible for broker sales strategy as well as the development of national and regional marketing relationships with insurance brokers.



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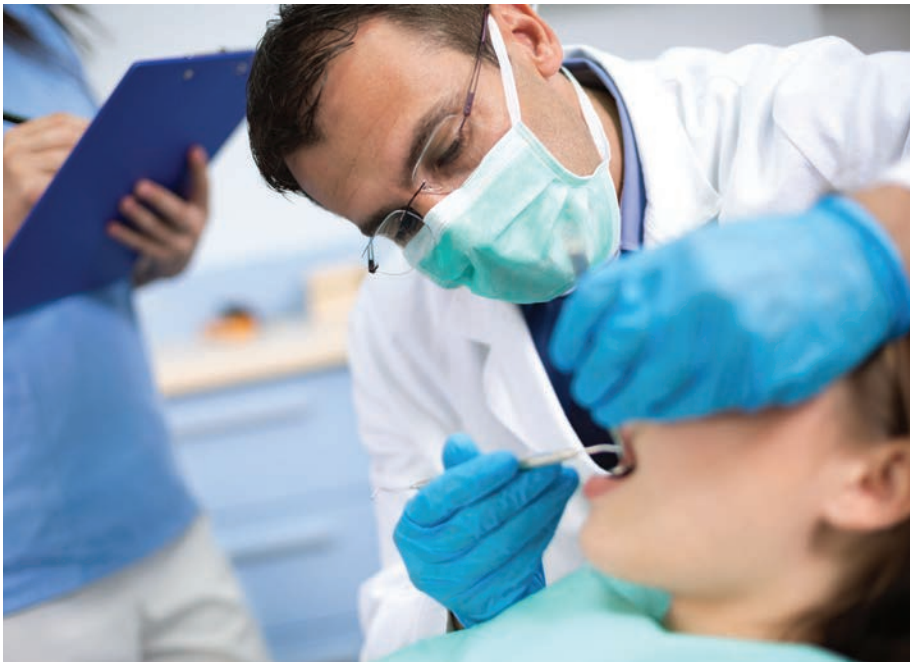


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BROKERS MUST HELP EMPLOYEE COMMUNICATION BRINGING DENTAL TO ITS MAX POTENTIAL

By CHRISTOPHER STEVENS



We all know that dental insurance is important to employees – many employed Americans cite it as the most important benefit to consider (outside of health insurance) when they're thinking about joining a company. Lincoln Financial recently conducted a research series that looks at consumers' perspectives on dental insurance and other benefits – as well as employers' views on the topic – identifying key gaps and areas of opportunity for employers.

Most consumers say dental insurance is “very important,” and more than half say it is a “must-have” benefit from their employer. This is consistent across generations – 80 percent of millennials, for example, say it's very important, and close to 60 percent say it is a must have. Generation X values dental coverage the most – 86 percent say it's very important and 65 percent say it's a must have.

The question is: are employees getting what they need from their employers regarding dental insurance? Simply offering a benefit isn't enough. Employers need to ensure that staff members are well-informed of their coverage details.

Lincoln's research finds that one in four consumers (25 percent) who have dental insurance say they have not been to the dentist in the past 12 months due to cost.

Yes, you read that right. Many consumers are simply skipping dental visits because they're worried about the expense, even though they have dental insurance, which typically fully covers preventive care (e.g. annual or biannual dental visits and cleanings). It seems that these individuals are simply not making that connection – they think a dental visit will be expensive, so they're not going at all. In fact, cost is the number one reason people don't go to the dentist.

HELP WANTED!

Employees are looking to employers as sources of information about dental insurance – 75 percent say they “expect” to receive educational materials on their dental plan through work.

But they're not necessarily getting the information they need and want. Only half of consumers say their employer is a good resource to help them understand what's covered under their plan.

Furthermore, just 35 percent of the employees who have dental insurance through their employer say they feel “protected” when it comes to their oral health. Even fewer (29 percent) say they feel “comfortable” about their oral health given their dental coverage – and a mere 14 percent agree that having dental insurance makes them feel “safe” regarding their oral wellness.

Again, a lack of knowledge could be contributing to this low level of confidence. People are unaware of the extent of their coverage, so they're not getting the feelings of security that dental insurance is designed to provide.

And what's the point of providing a great dental plan if employees don't know how to use it? Employers can help – with better, more targeted communication. And a broker can be a consultative partner in helping shape that communication strategy.

DENTAL BENEFITS COMMUNICATION: THE WHAT, WHERE AND WHEN

To educate employees on dental benefits, just about half of employers today provide opportunities for employees to meet with human resources (50 percent), 45 percent send emails about benefits, and 32 percent host health/wellness fairs.

It's perfectly fine to start a dental com-

munications strategy with the basics. Sixty-five percent of consumers simply want their employer to provide general information on what's covered. This number spikes for Gen X at 72 percent.

Fifty-four percent of consumers want a list of local in-network dentists with contact information that is easily accessible through their employer. Thirty-four percent say they would appreciate "ratings" or "rankings" of in-network dentists from their employer to help guide their choice.

Finally, 21 percent of consumers would like recommendations of dentists for children. Older millennials (ages 30 to 39) are particularly interested in this information.

Employers are the top source consumers turn to for information on non-medical benefits – more than insurance carriers' websites, coworkers or even friends and family.

And while many employers choose to provide benefits information to their employees only during their open enrollment period, which is typically in the fall, that approach might not always be the right one.

Nearly 60 percent of employees say they would like to receive information on their workplace benefits year-round – not just during enrollment time. This makes perfect sense. If it comes time to use your dental insurance, but you haven't talked about it or seen any information about it in months, it's probably going to be hard to remember the details of what's covered. It might just be easier to skip the dental visit than to dig out the paperwork from last year.

If employers can provide a steady stream of benefits communication, the messages have a much better chance of "sticking" with employees.

Employers can leverage a variety of tactics – benefits newsletters, articles on an intranet site, maybe even an internal "blog" from an HR-pro with benefits tips and tidbits.

One thing is critical to remember – make the benefits real for employees. Try to find examples of how staff members have used your benefits in the past and share those stories. This helps make insurance coverage seem less like a bunch of legal jargon on a brochure, and more like a valuable financial

protection or savings tool.

Employers spend a lot of time, money and energy on crafting benefits packages for their employee populations, and brokers are a critical piece of the puzzle. Taking the time to help employers think through their communication strategies can ensure all that work goes to good use, and help more employees take advantage of benefits offered.

Benefits communication doesn't stop at enrollment. As Lincoln's research shows, getting employees to enroll is only step one when it comes to dental insurance. Next comes understanding the coverage and, finally, taking action to use it. ★



Christopher Stevens is vice president of specialty health and head of dental product management at Lincoln Financial Group, leading the firm's dental and vision insurance product lines. He holds a bachelor's degree in math and actuarial science from the University of Wisconsin-Madison. Also, he is a member of the Society of Actuaries and the American Academy of Actuaries.

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We Asked, You Answered

In Cal Broker's weekly e-newsletter, we recently wondered if readers watched the late September debate between Sens. Lindsey Graham, Bill Cassidy, Bernie Sanders and Amy Klobuchar that aired on CNN. We'd noticed that some of the debaters had little good to say about the insurance industry. We asked: Have you experienced an uptick in negativity from acquaintances because of your role in the insurance industry? Has a changed public sentiment about insurance and the insurance industry impacted you? We wanted to hear how you handle insurance industry haters.

(<http://www.calbroker.com/insurance-insider-newsletter/insurance-industry-haters-a-problem/#healthcare>)

HERE ARE A COUPLE OF THE RESPONSES...

"I had to stop the lead article at on CNN the other night.....why on earth would I watch CNN? Of course they are insurance haters and biased in their debate tactics." – Paula from the Riverside area (Editor's note: We didn't notice anything untoward with the CNN commentators. The people debating – memorably Graham, Cassidy and Sanders – took most of the jabs at the industry. We encourage you to see for yourself: <http://www.cnn.com/2017/09/25/politics/health-care-latest/index.html>)

"I discuss a few topics with people to dig into the true problems with the health insurance industry. I have a basic equation to simplistically model health insurance premiums: Health Premiums = Healthcare Costs (doctors, labs, hospital, imaging, rx, etc.)/(Medical Loss Ratio). This is a simple way to show what variables will have the greatest impact on reducing premiums. Even if you set MLR to 100 percent the net effect is that the healthcare costs drive the premiums and those are the variables that need to be addressed to reduce premiums. The other issue I discuss is the fact that we do not have a healthcare market with rational pricing. Frequently people will call me explaining that they need an MRI and the imaging center offers a cash price that is about \$500. The imaging center states that if they run it through insurance it will cost about \$2,500. If

they are willing to accept \$500, then the insurance carrier should also pay \$500. Thus, insurance carriers in this example are paying 500 percent more than a cash pay patient. Any reform effort being considered should focus on these types of structural issues. It is not always the insurance carrier that is the problem." – Jeff R. from Mission Viejo.

Thanks for your input!

Actuaries Urge Congressional Action on CSR Reimbursements

The American Academy of Actuaries' Health Practice Council is urging Congress to help stabilize the individual health insurance market by permanently funding cost-sharing reduction (CSR) reimbursements to insurers under the Affordable Care Act, considering the Trump Administration's decision to immediately end the payments. "Higher premiums are necessary when CSR reimbursements to insurers are not made," said Academy Senior Health Fellow Cori Uccello. "In states where rates for 2018 were filed assuming federal CSR payments would be made, premiums may be insufficient to cover the cost of care, which could lead insurers to reconsider their decisions to participate in the market. Permanently funding the CSR reimbursements through congressional action is needed to avoid further premium increases and insurer market withdrawals that could lead to a loss of coverage." Under the ACA, low-income enrollees are eligible for CSRs to decrease their out-of-pocket spending requirements, reducing the financial barriers to receiving health care. The law stipulates that insurers provide the CSRs to eligible enrollees. The law also stipulates that the federal government reimburse insurers for the CSRs, and until now the federal government has done so. However, these payments were legally challenged and a U.S. District Court ruled that they are subject to congressional appropriation. Absent these reimbursements, insurers would need to raise premiums accordingly to cover the costs of the CSRs. "Enrollees who receive premium subsidies would be insulated from the full increase in premiums caused by the end of CSR reimbursements,

but enrollees who don't could face the full brunt of the increase, potentially reducing enrollment, increasing the uninsured population, and deteriorating the risk pool," said Uccello. "Permanent congressional appropriation of CSR reimbursements could prevent these destabilizing effects." In addition, in the absence of CSR reimbursements, federal spending will likely rise. The Congressional Budget Office estimated that the increase in federal premium subsidies would exceed federal savings due to eliminating CSR reimbursements to insurers. For more info, see the Health Practice Council FAQ published this past summer: http://www.actuary.org/files/publications/Cost_Sharing_Reductions_072417.pdf

IBM Announces Insurance Industry Platform

IBM announced it is building an industry-first insurance platform on the IBM Cloud that aims to improve the processes and economics for new product development, underwriting and benefits delivery. Built in collaboration with MetLife and Majesco, the IBM Insurance Platform will feature cognitive computing, data analytics and integration and security capabilities designed to help insurers expand access to their products and capture new customers. "Our industry platforms are designed in collaboration with our clients and partners and intended to dramatically improve traditional business models using deep industry expertise and advanced technologies such as AI, cloud and block chain," said Bridget van Kralingen, senior vice president, IBM Industry Platforms. "In the case of insurance, carriers will be able to inject greater innovation and speed into their operating models, and consumers will experience a broader range of products tailored to their individual needs." IBM works with many of the world's top insurers. By combining insights from those engagements, and with deep industry expertise from MetLife, the IBM Insurance Platform aims to help carriers better harness their expansive data sets to improve product mix and customer experience. Delivered as a service, the platform will also help insurers sense and respond to the market faster while reducing IT infrastructure and maintenance costs. "

Covered California Adds Cost-Sharing Reduction Surcharge to Silver Plans

Covered California announced in early October the final rates for its health plans in 2018 and that health plans will include a surcharge on silver-tier plans due to the ongoing uncertainty at the federal level. The surcharge is necessary because of a lack of commitment from the federal government to fund cost-sharing reductions (CSRs), according to Covered California. The average CSR surcharge increase on rates is 12.4 percent, although the surcharge will vary for each health insurance company and will range from 8 percent to 27 percent. However, because the surcharge is only being loaded onto silver-tier plans, those who purchase coverage without getting federal help — whether through Covered California or by buying directly from health insurance companies — can be protected from paying the surcharge. Covered California says that most consumers who receive financial help in the form of an Advanced Premium Tax Credit, or subsidy, will not see a change in what they pay for their insurance in 2018 because of the surcharge, and many will end up paying less because their subsidy amount will increase more than the surcharge. “Covered California worked hard to come up with a plan that ensures a stable market and protects as many consumers as possible from an unnecessary price hike,” said Peter V. Lee, executive director of Covered California. “While some consumers will face higher costs than expected this year unrelated to the CSR surcharge, they can still shop for a better deal to reduce the impact of the surcharge.” A Covered California analysis on the impact of the CSR surcharge found that 78 percent of subsidized consumers would either see no change in what they would pay for insurance in 2018, or would pay less than what they would have paid if there had been no CSR surcharge. The remaining 22 percent will see some form of higher net premium because of the CSR surcharge, and about half of them will see increases of less than \$25 per month. More information is available at www.CoveredCA.com.

Health Net’s Bay Area Network Expands to Include Canopy Health

Health Net, Inc. one of California’s largest health insurance companies, announced its partnering with Canopy Health in 2018 to provide more Health Net members in the San Francisco Bay Area with access to the combined doctor and hospital networks of Canopy Health, which includes John Muir Health and UCSF Medical Center. More information can be found at <http://www.businesswire.com/news/home/20171003005997/en/Health-Net%E2%80%99s-Bay-Area-Network-Expanded-Include>

Gov. Brown Signs Pharma Law



Last month California Gov. Jerry Brown signed SB-17, a sweeping drug price transparency bill that will force pharmaceutical manufacturers to publicly justify substantial price hikes. “Californians have a right to know why their medication costs are out of control, especially when pharmaceutical profits are soaring,” said Brown. The new law will require drug companies to give 60 days’ notice to anytime they plan to raise the price of a drug by 16 percent or more over two years on drugs wholesaling at \$40 or more. They must also explain why the increases are required. The advance notification provisions take effect Jan. 1, while other reporting requirements don’t take effect until 2019. More information can be found at <https://www.gov.ca.gov/news.php?id=19995>.

Covered CA: Agents Still Need to Get the Word Out

Covered California recently released a study titled “A Quantitative Study on Current Attitudes of Uninsured and Select Insured Californians Toward Health Insurance Coverage.” The gist of the study is that awareness of ACA plans and subsidies is high in California, but “nearly 75 percent of subsidy-eligible uninsured Californians either wrongly assume they do not qualify

for financial help or are unsure whether they do.” Covered California says potential customers still need more education and outreach to understand their eligibility. A graphic display of the major findings from the study can be found at <http://www.coveredca.com/news/pdfs/OE5-Research-&Creative-Board-Meeting-10.5.17.pdf>

CNO Honored for Treating Employees Well

CNO Financial Group, a holding company for several national life and health insurers that serve middle-income working Americans and retirees, was recognized by the National Business Group on Health for having one of the best workforce health and well-being programs in the nation. CNO Financial received, for the third consecutive year, the Best Employers for Healthy Lifestyles® Platinum award – the highest designation – for its commitment to promoting a healthy work environment.

Bad Actors in Viaticals Brought Down

A Georgia-based viatical firm that advertised on the Rush Limbaugh radio show and preyed on the vulnerable and misinformed is being brought down by the U.S. Securities and Exchange Commission. The company, Credit Nation, and founder Jim Torchia are under investigation. Other associates, including Georgia attorney Marc Celello and ex-CFO Michael Sullivan, are also implicated. The SEC is calling Torchia’s actions with Credit Nation – as well as with his former company, National Viatical – ponzi schemes. More information can be found at <https://www.sec.gov/litigation/litreleases/2015/lr23416.htm>.

Events

NAILBA 36 – NOV. 16-18, HOLLYWOOD, FLORIDA

Registration is now open for the National Association of Independent Life Brokerage Agencies (NAILBA) 36th Annual Meeting, NAILBA 36. The meeting will take place at the Diplomat Beach Resort. It will attract high level representatives from brokerage general agencies, life insurance carriers and insurance industry vendors. For more information, go to <http://www.nailba.org/nailba36/home> ★



Medicare/Medicaid

ENGAGING WITH DUAL ELIGIBLE MEMBERS TO STRENGTHEN RELATIONSHIPS AND ENCOURAGE LOYALTY

By RICK BEAVIN

In the overlap between Medicare and Medicaid is a somewhat overlooked medical plan known as a Dual Eligible Special Needs Plan, or a D-SNP. Many people who qualify for both Medicare and Medicaid are over the age of 65 and are low income. This means that D-SNP seniors include a vulnerable population that requires diligent care, as they could be living on limited means during this stage of their lives.

Patience and reinforcement go a long way to helping this group access the medical services for which they are eligible. By providing this specialized attention, brokers can strengthen relationships with these members and earn their loyalty.

WHO IS ELIGIBLE FOR A D-SNP?

D-SNP plans are designed to provide targeted care and services to individuals with unique needs. For example, dual-eligible members require targeted services as they use more in-patient, emergency room, home health and skilled nursing facility services than non-dual members.

Medicare eligibility is based generally on a person's age, and Medicaid assistance is provided based on financial need. While dual eligibility requires both factors, an increase in income can result in disenrollment. If a member's income rises above the eligibility threshold for any reason, they can be involuntarily disenrolled from the plan. This can affect a lot of people, as 10.2

million people in the U.S. are fully or partially dual-eligible.

DUAL-ELIGIBLE SENIORS VALUE SIMPLE, PERSONALIZED COMMUNICATION

To provide the best possible assistance to dual-eligible seniors, it is important to understand who they are and what they value.

Within this demographic, there is a distinct preference for personal communication—either by phone or face-to-face. Healthcare and insurance are complex issues, and seniors want someone to help walk them through the details.

In most cases, a phone conversation provides the greatest level of comfort. Members can ask specific questions

and get clarification on what they don't understand.

While there are many questions that can be answered with a quick online search, the Internet is not usually seniors' go-to source for information. Dual-eligible seniors didn't grow up with computers or the Internet, and there is a wide range of online literacy within this group. Thus, the key to effective communication for this demographic is to be thorough, clear and supportive of their questions.

In the instance that a broker must provide written communication either as a supplement or as the sole form of communication, it must be easy to comprehend. Keep the terminology simple and consider providing it in Spanish, Chinese, Korean and Vietnamese, as well as English.

One feature of D-SNPs that can be problematic for carriers is that members can switch plans at any time, not just during enrollment. The down side is that some seniors are easily influenced to switch for the wrong reasons or without fully understanding the ramifications of their decision.

Education and clear communication are the keys to helping dual-eligible seniors obtain the best possible medical care. Make sure dual-eligible seniors are educated about their plans, including their own obligations, like annual re-enrollment. In doing so, work to establish a relationship with members, providing courteous, compassionate and complete assistance when they call.

WHY THEY SWITCH

Voluntary disenrollment is often centered on unresolved customer service issues. Dual-eligible seniors value prompt, thorough and respectful customer service. If they have to navigate a complicated call center or wait too long for return phone calls, they may switch to a different plan.

As they age, dual-eligible seniors place greater importance on good health and insurance. Mobility is key to independence, and these seniors know it. Like anyone else, they want to continue living independently and doing the things they enjoy. Most dual-eligible seniors feel positive about having medical insurance because it allows them to take care of health issues that

they may not be able to otherwise. Still, they find the complexity of the system to be daunting at times.

Automated billing and phone systems can be confusing, especially when they can't get their questions answered or are told that someone will call them back. It is common for these seniors to disenroll from a plan and switch to another one if they become dissatisfied or frustrated with poor customer service.

"...dual-eligible seniors just want to feel that their concerns and values are understood, and to trust that their needs are being met. If their broker can ensure them that this is the case, through education and clear communication, dual-eligible members will be less likely to switch plans..."

Also, keeping their current physicians or specialists is extremely important to this demographic. To ensure seniors know whether their preferred providers are in a D-SNP's network, encourage them to ask you questions.

It is important to note that failure to re-enroll annually—while often unintentional—is still considered voluntary disenrollment. If a member is disenrolled, they may not find out until they go to pick up a prescription or visit their doctor, and are told they are not covered. Provide D-SNP seniors with re-enrollment reminders to help them avoid this from happening.

In addition, seniors who were previously in an employer's health insurance plan may not realize that they need to affirmatively enroll for a D-SNP. Be sure to reach out to these members to ensure they understand their options for coverage.

Phone calls and TV ads tend to have a great influence on this population. Unfortunately, this population may also fall prey to other sales tactics that are expressly not permitted, such as door-to-

door sales. They are easily persuaded to switch plans, and even a suggestion that they might not be adequately insured may be enough to make them switch. If a member does call to switch plans, agents should discuss any concerns the member has about their plan to ensure they are enrolled in a plan that meets their needs.

Continuously assessing their needs to ensure they have the option best for them and assuring them of that will encourage them not to switch, and much of that can be achieved through education. At the same time, however, loyalty also requires a sense of trust.

BUILDING PARTNERSHIPS TO CREATE LOYALTY

It is important to approach dual-eligible members as partners. Education and frequent communication from their insurance carrier can help alleviate dual-eligible seniors' concerns about not having the right health insurance coverage. When they feel a sense of partnership, members are less likely to disenroll from their current plan.

By understanding the dual-eligible population and what their needs and values are, brokers can better tailor communications to not only help dual-eligible seniors find the best plans for their unique needs, but also to build a trusting relationship with them to encourage loyalty.

At the end of the day, dual-eligible seniors just want to feel that their concerns and values are understood, and to trust that their needs are being met. If their broker can ensure them that this is the case, through education and clear communication, dual-eligible members will be less likely to switch plans and more likely to trust that their broker has their best interest in mind. ★



Rick Beavin is Humana's California Medicare Market President. Humana has both D-SNP and dual-eligible look-alike plans (plans that have similar benefits as D-SNPs) throughout California. For more information, brokers may contact: Orange County, (949) 623-1447; Los Angeles County, (424) 246-4834; Riverside County, (951) 780-0180; San Diego County, (760) 918-0152; Central California, (559) 221-2522; and Northern California, (925) 255-0910.

All Eyes on Vision

Helping Employees See the Benefits of Premium Vision Coverage

By TIM CARNEY



Open enrollment is in full force—and while providing the best possible health care at a reasonable price is top-of-mind among employers, it’s also a consideration among employees as they navigate through their options. While all eyes may be focusing on the basics, it’s important to make sure your clients—and their employees—are seeing the benefits of taking advantage of a comprehensive vision plan.

Premium vision benefit offerings are not only becoming increasingly desirable to employees, but they are also an economical option for employers due to their relatively low cost and high return-

on-investment. Consider that a routine eye exam can detect eye health issues that can become a burden to employers and employees from both a financial and productivity perspective. Regular,

dilated eye exams can even help to detect serious overall health issues, such as diabetes and hypertension—leading concerns for employers.

Beyond eye and overall health is-

sues, regular eye exams are the best way to determine common, and typically correctible, vision problems—such as trouble seeing up-close and far away. Eye exams are also a forum for employees to access eyewear and lens options that not only correct vision problems, but also help to protect the eyes from UV rays, harmful blue light and trauma, while alleviating eyestrain, fatigue and headaches caused by glare and other workplace and environmental settings. But with so many options to choose from, brokers must play an important role in making sure employers have access to the right education and resources to better understand the value of premium vision benefits and ultimately encourage their employees to not only enroll in a vision plan, but to take full advantage of the benefits that are being offered.

PREMIUM VISION BENEFITS... MATTER TO EMPLOYEES

The popularity of vision benefits is on the rise—making this offering a cost-effective way for employers to attract and retain top talent. According to the 2016 Transitions Optical Employee Perceptions of Vision Benefits survey, vision benefits are tied with dental as the second most popular election beyond standard medical benefits. And, vision benefits are becoming increasingly desirable among younger employees, who are making up a larger portion of today's workforce. In fact, one in four millennials say that vision coverage is the most appealing element of their benefits package.

One possible reason for this uptrend could be the increasing emphasis that millennials are placing on their eyewear and, more specifically, protective lens options and enhancements. Harmful blue light and its effects on vision, for example, is becoming an increasingly hot button issue. Nearly eight in 10 (78 percent) employees overall say that blue light protection is important to them when choosing eyewear, according to the Transitions Optical survey. Millennials, as a subgroup, are the most likely of all generations to value harmful blue light protection.

The survey also uncovered that brand name matters when it comes to choosing their eyewear—with nine

out of 10 saying that coverage of premium brands helps them select stylish eyewear. Giving employees access to vision plans that allow them to choose their lens enhancements, as well as brand name frames and lens options, is important to them—and can help employers stand out from the crowd.

PREMIUM VISION BENEFITS... HELP IDENTIFY SERIOUS EYE AND OVERALL HEALTH ISSUES

Employees' increase in desire for premium vision benefits is a step in the right direction for tackling eye health issues. Regular eye exams help identify and correct existing vision problems, as well as detect eye diseases—often in early stages when vision loss can be slowed or avoided all together. Additionally, comprehensive eye exams can even serve as an initial diagnosis for costly and serious overall health issues, such as diabetes and hypertension.

"Employees' increase in desire for premium vision benefits is a step in the right direction for tackling eye health issues."

Offering access to vision benefits is the first step employers can take toward ensuring a happier and healthier workforce—but reinforcing the importance of utilizing these benefits is just as important. The message that regular eye exams can serve as a preventive health measure resonates well with both employers and employees—so offering ample education on this topic is important.

We've been taking great strides to place a strong emphasis on the importance of vision benefit education. Our newly released vision loss simulator lets users experience sight the way people with various vision diseases or conditions experience it. Users, for example, can view an everyday backyard scene and see what it looks like through the eyes of someone with glaucoma, cataract, diabetic retinopathy or macular

degeneration. Users can even see how glare—which can be alleviated with the right eyewear options—can affect healthy sight. The simulator illustrates the moments the viewer will miss as they click through each condition and move through the scene. The simulator can be viewed on desktop, mobile or through a virtual reality experience at davisvision.com/visionloss—making it easy for employers to share with their employees.

PREMIUM VISION BENEFITS... SAVE EMPLOYERS MONEY

Early detection and treatment of vision problems and eye or overall health issues can ultimately lead to significant savings for both employers and employees—in terms of money spent and increased productivity. In fact, the Vision Council estimates that employers can gain as much as \$7 for every \$1 spent on vision coverage.

To help employers calculate the savings possible with a premium vision benefit, Davis Vision—in partnership with Transitions Optical—offers a Vision Plan ROI Estimator. Found at davisvision.com/medicalsavings, the online calculator allows employers to input their workforce's demographics by age, gender and ethnicity. The tool shows how comprehensive eye exams—that provide early diagnosis and treatment of eye diseases and health issues—can lead to cost savings. It also shows how selecting premium eyewear options—such as photochromic lenses and anti-reflective or no-glare coatings—can enhance and protect an employee's vision. At the end of the calculator, employers can see the total potential savings for their workforce.

We also offer an individual Sight on Savings Calculator that can be shared directly with employees. Found at davisvision.com/whatsmyrisk, employees can enter their demographic information to learn more about their eye health risks and the time, money and sight they can save through a premium vision benefit.

PREMIUM VISION BENEFITS... BOOST EMPLOYEE PRODUCTIVITY

Premium vision benefit offerings can also boost overall employee productivity—saving time at work and even



potentially avoiding sick days due to headaches and other vision-related problems. Visual disturbances are extremely common among employees. In fact, nearly three out of four employees (74 percent) say that visual disturbances bother them at work. Vision problems and disturbances—such as eyestrain and fatigue—can lead to employees taking extra breaks and time away from work. Nearly half (45 percent) of employees admit to taking breaks during the day to rest their eyes, and 38 percent say they do so multiple times each day.

One common problem among today's workers is bright light or glare, including light reflecting off of a computer screen or surface. Today's premium vision packages offer coverage of or discounts on lens options that can alleviate glare—and related eyestrain, fatigue and headaches. Anti-reflective lenses, for example, provide glare protection. Photochromic lenses take this a step further—changing their level of tint outdoors to offer added protection against glare. Many photochromic

"Setting your sights on vision benefits this open enrollment season and showing your clients the possible savings through premium offerings can help reinforce that you have their best interest and bottom line at heart."

lenses also offer protection against UV rays and harmful blue light—indoors and out.

But while this protection is important to employees, many do not understand how their plans work or what exactly they cover—and they want this information from their employers and their vision plans. In fact, nine out of 10 (93 percent) of employees say that their vision care plan should provide information on how certain lenses can protect

their eyes – like lenses that help protect against harmful light or reduce eye fatigue and glare.

Harmful blue light, often associated with electronic devices and screens, is present both indoors and outdoors with the sun being the largest singular source. Long-term exposure to harmful blue light has been linked to an increased risk of developing age-related macular degeneration. Exposure to harmful blue light can also reduce contrast and lead to eyestrain and fatigue. However, less than one in five employees know that the largest source of blue light is the sun, creating an opportunity for employers to educate their employees about lens technologies that can help protect against harmful blue light.

Many vision plans and companies offer complimentary education on the various eyewear options available to help enhance and protect vision. HealthySightWorkingforYou.org, for example, offers information as well as resources that employers and employees can access directly.

Setting your sights on vision benefits this open enrollment season and showing your clients the possible savings through premium offerings can help reinforce that you have their best interest and bottom line at heart. Be sure to take advantage of complimentary resources and tools to position yourself as an expert and help your clients uncover tailored information about the needs of their specific workforce and potential savings possible through a vision benefit. ★



Tim Carney is senior vice president, sales and exchange development, Davis Vision. With a record of driving operational success and rapid business transformations, Carney has over 28 years of experience in the health care industry. He has an extensive background in sales leadership and account management, having served five years as senior vice president of sales and marketing at Delta Dental of Arkansas, vice president of national accounts for AlwaysCare Benefits and most recently as chief operating officer and executive vice president for Ascentian, LLC, prior to joining Davis Vision. At Davis Vision, Carney maintains executive responsibility for all third-party client and commercial account sales.



Seeing Sense: Why Employers Should Integrate Vision Benefits

By JOHN THORP

Employers make hundreds of decisions every day—big and small. What they choose in each of the scenarios affects them, their business and the people who work for them. In this way, they're caretakers. While they must balance making the best choice for the health of their business, they also have to decide how best to ensure the health of their workforce.

Choosing the right health benefits plan is one of the most important—if not the most important—decisions they will make for their employees. There are many benefit types to choose from beyond basic medical care and coverage. With this in mind, and with more than a decade of experience in the health benefits field, I always urge employers not to neglect vision benefits.

Offering vision benefits is mutually beneficial to employer and employees. Employees receive access to quality vision care and employers have healthier, happier employees. In fact, according to a recent Transitions Optical, Inc. survey, 98 percent of employees believe that offering vision coverage as part of an overall health package shows their employer cares for their wellbeing.

"Through integrated vision benefits, employees have a chance at maintaining and improving their health, while reducing their exposure to potentially increasing health care costs."

The best way to offer vision benefits is through an integrated health care plan. Integrated health care is relatively simple: it connects a patient's medical and specialty benefits—like vision and dental care—through his or her insur-

ance provider. The three most compelling reasons to offer integrated vision benefits are that it 1) improves health outcomes of employees, 2) simplifies administration and 3) lowers overall medical costs.

BETTER HEALTH THROUGH EARLY DETECTION

When an employee has access to integrated vision care, they are usually covered for an annual eye exam. These regular vision checkups are critical to maintaining vision health and overall wellbeing. Even more than that, vision exams are critical in the early detection of eye disease arising and certain common health conditions, like diabetes, hypertension, and cardiovascular disease. If detected early, ap-

appropriate management can minimize further damage even while symptoms remain invisible to the naked eye. In fact, in 2016, one health plan identified 26,000 patients with diabetes through vision exams. This is especially important because the early detection of chronic conditions is crucial to care and disease management.

benefits management for employees is simplified with one ID card, one on-line service and more.

LOWER COSTS THROUGH DISEASE MANAGEMENT

The early detection of some diseases through vision exams sets the scene for a third major benefit of offering and

management plan to deter further decline. The progressive forms of many chronic diseases drive huge health care costs, so if conditions can be caught early, quality of life for the patient improves and costs are reduced. Through integrated vision benefits, employees have a chance at maintaining and improving their health, while



Through an integrated plan, a person's health care data flows securely between that person's health care providers. This means if a patient uses their vision benefits to get an eye exam, and the exam reveals they have signs of a chronic condition, that information will be available to their other health care providers, who can collaborate to form the best care team and treatment plan.

SIMPLIFIED ADMINISTRATION THROUGH BENEFITS INTEGRATION

Integrating secondary benefits like vision care with an employer's primary health benefit has the added benefit of not only improving health outcomes, as seen above, but also of simplifying the administration of these benefits. When vision and health benefits are administered together – typically through an insurance carrier – the employer saves time with one enrollment process, one bill and one contact. And

"It's clear to see: offering integrated vision benefits to employees produces a huge return for only a small investment. They have comprehensive, effective health care and an employer has a happier, healthier and more productive workforce."

integrating vision benefits into employees' health plans. Chronic conditions are incredibly costly and early detection is critical to help manage those costs. For example, if a diabetic's eye disease is caught early, there can be a delay or prevention of further damage and an opportunity for a disease

reducing their exposure to potentially increasing health care costs.

Early detection cuts costs for employers as well. The healthier and better cared for a workforce is, the lower the cost to the business. It's clear to see: offering integrated vision benefits to employees produces a huge return for only a small investment. They have comprehensive, effective health care and an employer has a happier, healthier and more productive workforce. ★



John Thorp is the president of Anthem Blue Cross Vision business. Since joining the company in 2006, he has served in a number of key roles, including product director and senior product director for the company's vision business. Thorp earned his bachelor of arts degree in economics from Denison University, and his master of business administration degree from Xavier University.

Curtain Raise: Unveiling the Severity of Today's Long Term Care Problem

By LARRY NISENSEN

If you ask your clients how they are planning to pay for long term care (LTC) services, chances are they haven't given it much thought. For as critical as long term care is to every retirement plan, consumer engagement levels are still quite low. A consumer sentiment survey Genworth recently conducted found that 60 percent of adults believe they will need long term care services at some point in their lifetime, but only 22 percent have actually taken specific action toward financing future long term care expenses. This is especially perplexing given that



a majority of respondents said their greatest fear regarding long term care was a “lack of money to pay for the care that’s needed.”

That fear is justified. In today’s environment, long term care costs are rising at a time when government funding for programs such as Medicare is tightening. According to Genworth’s 2017 Cost of Care Survey, the annual median cost of long term care services increased an average of 4.5 percent from 2016 to 2017, the second-highest year-over-year increase for nursing homes and home care since the study began in 2004.

What’s particularly concerning is that 66 percent of respondents in our consumer sentiment survey expected government programs like Medicare to pay for some or all of their long-term care needs. While this is certainly not the case, it may very well explain consumers’ complacency. The severity of these misinformed perceptions should put all financial professionals offering retirement planning services on high alert. In 10 years, the oldest baby boomers will be turning 80, which is when most people begin to require long term care supportive services. During that same time span, the number of people age 65 and older with Alzheimer’s disease will increase 40 percent to an estimated 7.1 million people.

THE LTC COST CONUNDRUM

Wealthy people can afford to self-insure for these expenses. People with limited income may be eligible for Medicaid. But there are many more in between that have too many assets to qualify for Medicaid, but not enough assets to cover the cost of long term care services.

And although most people prefer to receive long term care at home, where costs are less than facility care, those costs are also escalating because of higher labor costs. According to our survey, home health aide services increased 6.7 percent from 2016 to 2017.

As traditional sources of funding from government programs become more re-

strictive, it’s clear that individuals must take more personal responsibility to fund their own long term care expenses. They need to understand the costs as well as the various options available for closing any funding gap they may have.

where they want to receive care.

Your job as a financial professional is to have that conversation with your clients and to help them close gaps in financing with the many options that are available, whether it’s increasing their savings or buying individual or group long term care insurance. Insurance is leverage and should be considered another form of asset allocation.



“...long term care costs are rising at a time when government funding for programs such as Medicare is tightening. According to Genworth’s 2017 Cost of Care Survey, the annual median cost of long term care services increased an average of 4.5 percent from 2016 to 2017...”

WE ALL PLAY A ROLE

So how do we fix this? Our job as carriers is to offer a range of solutions that meet various levels of risk and affordability, including smaller, simpler long term care insurance policies. We need to provide products that align with the interests of people in the middle who don’t want to be a burden on their families or spend down their assets, but who want to maintain choice and control over

SHOW CLIENTS PATH FORWARD

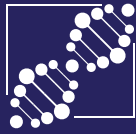
The retirement planning industry is at an interesting juncture. During a time marked by an oversupply of available information, there is a shortage of knowledge and understanding. There’s a clearly established need for solutions like long term care insurance, but a lack of clarity for many about what it is, how it works and what it costs. And while we can be certain that this need is growing exponentially, many are still uncertain about the proper path forward.

That’s why it’s incumbent on financial professionals to ensure that clients are fully informed and to provide them with the tools and solutions to enable them to age on their own terms. As a carrier, that means doing our best to make sure we’re consistently engaging our distributors and advisors, understanding their clients’ needs, and moving away from a one-size-fits-all approach to designing products directly aligned with how much risk they want to cover.

And as for the individuals who form today’s burgeoning retiree and future retiree demographic, that means taking personal responsibility for financing their long-term care needs with the ultimate goal of maintaining their lifestyles as well as choice and control over where and how they will receive care should they need it down the road. ★



Larry Nisenson is senior vice president, chief commercial officer, at Genworth’s U.S. Life Insurance division, where he is responsible for distribution and product marketing.



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WHAT MAKES PET INSURANCE POLICYHOLDERS TICK? *ONE KEY FACTOR STANDS OUT*

By MARK COLONNESE



With pet insurance clients in the United Kingdom and the United States, my colleagues and I at Aquarium Software have a unique opportunity to understand the workings of both markets and what makes them tick. Brokers who want to sell pet insurance can, of course, clearly use some of what we've discovered.

Our research has led us to uncover surprising similarities and differences

between the Canadian, U.S. and U.K. markets. Our initial assumption was that there would be many similarities between the world markets. Even if we just narrow it down to the U.S. and the U.K., shared language and shared cultural norms reinforce the assumption that the markets for pet insurance in each country should be similar. And they are in many ways. Yet they aren't in others.

YouGov questions asked in both

countries showed less than 5 percent variance on average between the opinions of U.S. and U.K. pet parents overall, with many uncanny similarities in terms of owner emotional ties with their pets. Broad agreement that pets are just as important to the family as humans (U.S. 72 percent agree; U.K. 69 percent agree) and a majority in both nations would save their pet first if both their pet and a stranger fell into a river.



While the broad emotional wellspring is consistent, variants come in attitudes to health insurance, both human and animal. You would think the established health insurance market in the U.S. would mean more Americans recognize the value of policies for pets. But while 71 percent of Americans have private health insurance (compared to just 11 percent of the U.K.), a staggering 74 percent of Americans have never had pet insurance. Only 42 percent of people in the U.K. have never had pet insurance. That's a whopping 32 percent difference.

There does appear to be a special relationship (as we Brits like to say!) between the U.S. and the U.K. in terms of their respective pet insurance markets that industry watchers have been slow to realize. Emotional attachment is the unifying theme that binds pet parents, as well as insurers and brokers alike. This is unlike any other insurance product. The exciting thing is, if these similarities and differences hold true worldwide, they represent a roadmap; a royal road to successful globalization and commercialization of the pet insurance market. That, of course, is what we're all working on.

WHY DOES THIS MATTER?

Those of you who offer health and life insurance already understand how to sell a product that can have a fairly strong emotional tie. But some in-

urance companies that were in pet insurance early on didn't understand emotional choices at all. A number of insurers pulled out of the U.K. market, finding it hard to make a profitable transition to pet insurance. Problems

"Pet parents do not buy pet insurance based on common sense, or if it will save them money in the long term. It's a decision based on emotion rather than necessity and this feel-good factor must be accounted for when considering marketing the product."

arise if anyone starts thinking that buying pet insurance is no different than buying any financial product. Insurers and brokers who have made such assumptions have struggled. Too often, the approach has been to see the family pet in similar terms to the family Ford or retirement fund, but the difference is considerable -- a fact successful brokers both sides of the pond are beginning to wake up to.

Pet parents do not buy pet insur-

ance based on common sense, or if it will save them money in the long term. It's a decision based on emotion rather than necessity and this feel-good factor must be accounted for when considering marketing the product. Recognizing the overwhelming emotional drive delivers some fascinating insights. For example, the primary focus should be on new pet owners still in that 'honeymoon period' because this is when emotional attachment is at its height. This is even more true of first time pet owners. In the U.S., 67 percent of new pet owners take out pet insurance in the first 6 months. If you factor in the first visit to the vet plus being a new pet owner, this number rises to a massive 79 percent.

When searching for some insurance products, facts and figures sell. Not so when it comes to pet health. While money is always a factor, it is not a key driver because the figures show those who can most afford pet insurance seem to be the ones who see the least intrinsic value in having it.

Current advertising tends to focus on the cute pet. Can you guess why? That's right. Because it works. Pet insurance growth in the U.S. was triple the pace of accident and health coverage in 2014 and an industry worth over \$600 million is still expanding. However, to reach its full potential, the emotional element must be tailored to specific audiences and this means tapping into the social

patterns of emotion within the demographics concerned. It sounds complex, but it is really very simple.

Focusing on the emotional connection between pet and pet parent and its impact on the customer journey, are themes of critical importance to U.K. and U.S. pet insurance sectors, and also others. Asia and the Far East are pet projects (pun intended) for Aquarium and we are seeing there how emotion with regard to pets, coupled with respect for trusted brands, can deliver significant gains in market share.

Seventy four percent of Americans who have never had pet insurance represents a massive market opportunity.

Better understanding the role of emotion provides a way to reach them, and the right technology can help make this a reality. Once persuaded to purchase the policy, pet parents need the right customer journey to see the advantages of continuing to renew. Intuitive applications can help insurers improve their pet proposition while at the same time delivering a profitable pet insurance business model with long term viability.

To conclude, software developers, brokers, insurers, vets and everyone connected to the industry need to focus on the compassionate and caring reasons for having pet insurance. Many

of you already understand this very well. The challenge now is to communicate this to all the pet parents out there. Pet insurance offers a huge opportunity for brokers who can focus on tapping into the emotional underbelly of pet insurance and why owners make this purchasing decision. ★



Mark Colonnese is vice president of sales and marketing for U.K.-based Aquarium Software. Aquarium develops software for pet insurance and other insurance products. For more information visit www.aquarium-software.com.

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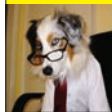
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