

CALIFORNIA BROKER

VOLUME 35, NUMBER 1

SERVING CALIFORNIA'S LIFE/HEALTH PROFESSIONALS & FINANCIAL PLANNERS

OCTOBER 2016



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to 100 Should Make You
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An Urgent Need for Change in Long-Term Care Options

By BONNIE BURNS

We face a steadily growing population of aging adults with no clear system to pay for long-term care. Baby Boomers are entering retirement with more poverty and disability than in past generations. Having fewer children and having more divorces in this generation reduces access to family caregivers who would allow them to get care at home.

The middle class has been priced out of the long-term care insurance market with no good alternative to cover these expenses. In particular, women face greater obligations as caregivers, greater potential of facility care when they are single, divorced, or widowed, and less earnings and resources to cover the cost of insurance. They now also face premium surcharges because of their gender. Many say that without long-term care insurance, massive numbers of people will flood into Medicaid. But, that may happen anyway.

Stand-alone policies were built on an outdated cycle of care, with home and community care benefits grafted onto nursing home policies. Products need to be redesigned to reflect changes in the increased use of home care as well as technological advances.

New policy designs should recognize the value of home and community care. Care at home is preferred; its where benefits are more often used and exhausted. The Medicaid program has improved its coordination of services, and it's focus on home- and community-based care, but these changes have not occurred in long-term care insurance products. Expanding the potential for care at home, using public or private dollars or a combination

of both, could delay or even prevent needing care in a more expensive setting or turning to Medicaid.

Families should be able to decide about where and how care needs will be met. The benefit package should include a certified care manager and on-going care coordination. Geriatric care managers should be included as a benefit in newer product designs. They have the expertise in linking public and private care resources in the insured's community.



Another issue is that current insurance policies don't cover modern devices, which could enable a family caregiver to keep their job while monitoring their family member electronically. Monitoring systems can relay medical information and alerts to medical providers.

High net worth buyers, who can pay a lump sum premium or make premium payments, appreciate the newer hybrid, or combo products that accelerate a death benefit, or annuity benefits with options to pay for long-term care.

But since the benefit structure is difficult to understand, the benefits may not perform the way people expect. Regulators need closer scrutiny of the multiplicity and complexity of benefit designs linked to financial products.

Policy designs might offer declining death benefits or lower-than-expected benefit payments based on the present value of a current death benefit at the time of claim. Also, the consumer may have to make additional premium contributions. These are consumer land mines. Consumers must have clear and understandable information about any option that combines long-term care with life insurance and annuities. Benefit periods and payments should be expressed in dollar amounts, not duration. Benefit statements should show the dollar amount of benefits remaining with each benefit payment.

Some say that building cash-value or other features into long-term care insurance could increase the value of coverage. But it's difficult to see how adding cash value to stand-alone long-term care insurance could be successful, given the pricing problems that the industry already faces.

It is also unclear how many younger Baby Boomers could afford to pay long-term care premiums. Medicare premiums, Part D premiums and cost-sharing, and Medicare Advantage or Medigap coverage all add up to post-retirement medical costs.

There should be a reassessment to see whether it still makes sense to offer asset protection in return for purchasing a Partnership product. There might be other Partnership options to

(Continued on Page 42)

THREE WAYS TO EARN MORE

Oct 1, 2016 through Jan 1, 2017

New Small Group Incentive Program

1 Earn up to \$7,000 Per CCSB Group

For CCSB groups enrolling 51-100 employees, be rewarded **\$50 per member** Oct. 1, 2016 through Jan. 1, 2017 effective dates.

2 Earn an Additional Cumulative Production Incentive on CCSB Groups 1-100

Total Members	Incentive Level	Total Incentive Earned
200	\$2,500	\$2,500
325	\$5,000	\$7,500
500	\$7,500	\$15,000
750	\$10,000	\$25,000

3 PLUS Earn a Very Competitive Standard Commission Starting at 6.5%

Key Provisions:

- Groups must enroll in Covered California for Small Business (CCSB) with initial effective date of 10/1/16 through 1/1/17 ("incentive period").
- Subscriber and member counts are based on medical enrollment at time of initial CCSB group effective date.
- Incentive in addition to standard commission and applies to new to CCSB groups only.
- Business written through partnering General Agencies qualifies.
- Eligible CCSB groups must remain in good payment standing 90 days after initial effective date.
- Incentive program available to all Certified Insurance Agents in good standing and must remain Agent of Record from initial enrollment through 90-day qualification period.
- All groups new to CCSB with initial membership of 1-100 meeting program rules stated above counts toward cumulative incentive opportunity.
- All groups new to CCSB with 51-100 FTEs enrolled in medical coverage at initial effective date qualify for \$50 per member enrolled incentive with maximum incentive of \$7,000 per group.
- Incentive payments will be reported on Forms 1099 and 5500 and as otherwise required by law, including reporting required by California AB 2589.
- Agents shall disclose to client(s) all compensation earned in compliance with legal requirements.
- Covered California for Small Business reserves the right to cancel and/or modify incentive programs at any time.

For a copy of the incentive program rules, please go to <http://bit.ly/CCSBAgentIncentiveProgram>

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FOR SMALL
BUSINESS

SEPTEMBER 1, 2016

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	Bests	Fitch	S&P									
American Equity	A-	A-	ICC13 MYGA (Guarantee 5) (Q/NQ)	S	2.15%*	5 yr.	None	9%, 8, 7, 6, 5, 0	Yes	\$10,000 (Q) & \$10,000 (NQ)	3.00%, age 0-75 & 2.10%, age 76-80**	
			ICC13 MYGA (Guarantee 6) (Q/NQ)	S	2.35%*	6 yr.	None	9%, 8, 7, 6, 5, 4, 0	Yes	\$10,000 (Q) & \$10,000 (NQ)	3.00%, age 0-75 & 2.10%, age 76-80**	
			ICC13 MYGA (Guarantee 7) (Q/NQ)	S	2.50%*	7 yr.	None	9%, 8, 7, 6, 5, 4, 3, 0	Yes	\$10,000 (Q) & \$10,000 (NQ)	3.00%, age 0-75 & 2.10%, age 76-80**	
*Effective 8/5/16. Current interest rates are subject to change on new issues. **Commission may vary by issue age and state. See Commission Schedule for details												
American General Life Insurance Companies	A	A+	A+	American Pathway Solutions MYG (*Guarantee Return of Premium) (Q/NQ)	S	1.80% ^a 2.00% ^b	5 yr.	None	8%, 8, 8, 7, 6, 5, 4, 3, 2, 1, 0	Yes	\$10,000 (Q&NQ)	1.5% age 0-75 .75% age 76-85
*CA Rates Effective 8/15/16. First year rate includes 1.50% interest bonus. a (less than \$100K) ; b (100K or more)												
American General Life Insurance Companies	A	A+	A+	American Pathway Fixed 5 Annuity (*Guarantee Return of Premium) (Q/NQ)	S	1.45% ^a 1.65% ^b	5 yr.	None	9%, 8%, 7%, 6%, 5%, 0%	No	\$5,000 (NQ) \$2,000 (Q)	2.00% age 0-85 1.00% age 86-90
*CA Rates Effective 8/15/16. Includes 2.00% 1st year bonus, 1.00% base rate subsequent years. a (less than \$100K) b (100K or more)												
American General Life Insurance Companies	A	A+	A+	American Pathway Fixed 7 Annuity	S	1.65% ^a 1.85% ^b	7 yrs.	None	9%, 8%, 7%, 6%, 5%, 4%, 2%, 0%	No	\$5,000 (NQ)	3.00% age 0-85 1.50% age 86-90
*(Guarantee return of premium Q/NQ) *CA Rates Effective 7/18/16. 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	1.85%	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 7/21/16. Includes .25% first-year bonus and is for purchase payments over \$100,000. Escalating five-year yield is 1.85%. For under \$100,000 first-year rate is 1.70%. Escalating rate five-year yield 1.70%.												
Great American Life	A	A+	A+	SecureGain 7 (Q/NQ)	S	2.15%	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 7/21/16. Includes 1.00% first-year bonus and is for purchase payments over \$100,000. Escalating seven-year yield is 2.04%. For under \$100,000 first-year rate is 2.05%. Escalating rate seven-year yield 1.94%.												
Great American Life	A	A+	A+	Secure American (Q/NQ)	S	1.25%*	1 yr.	N/A	9%, 8, 7, 6, 5, 4, 3	No	\$10,000	5.75% 0-70 4.65% 71-80 4.40% 81-89
*Effective 7/21/16. Eff. yield is 2.27% based on 1.25% 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 1.25%. Surrender value interest rate 1.25%. Accepts additional purchase payments in first three contract years. COM12255												
The Lincoln Insurance Company	A+	AA	AA	MYGuarantee Plus 5	S	1.00% ^a 1.15% ^b	5 yr.	None	7%, 7, 6, 5, 4, 0	Yes	\$10,000 (Q/NQ)	
*Rates Effective 7/8/16 (a-for premiums less than \$100K, b-for premiums \$100K or more), and are subject to change												
The Lincoln Insurance Company	A+	AA	AA	MYGuarantee Plus 6	S	1.10% ^a 1.25% ^b	6 yr.	None	7%, 7, 6, 5, 4, 0	Yes	\$10,000 (Q/NQ)	
*Rates Effective 7/8/16 (a-for premiums less than \$100K, b-for premiums \$100K or more), and are subject to change												
The Lincoln Insurance Company	A+	AA	AA	MYGuarantee Plus 7	S	1.25% ^a 1.40% ^b	7 yr.	None	7%, 7, 6, 5, 4, 3, 2, 0	Yes	\$10,000 (Q/NQ)	
*Rates Effective 7/8/16 (a-for premiums less than \$100K, b-for premiums \$100K or more), and are subject to change												
The Lincoln Insurance Company	A+	AA	AA	MYGuarantee Plus 8	S	1.25% ^a 1.40% ^b	8 yr.	None	7%, 7, 6, 5, 4, 0	Yes	\$10,000 (Q/NQ)	
*Rates Effective 7/8/16 (a-for premiums less than \$100K, b-for premiums \$100K or more), and are subject to change												
North American Co. for Life and Health	A+	AA-	A+	Gaurantee Choice (Q/NQ)	S	2.00% ^a 2.25% ^b	5 yr.	None	10, 10, 9, 9, 8	Yes	\$2,000 (Q) \$10,000 (NQ)	2.50% (0-80) 1.875% (81-85) 1.25 (86-90)
*CA rates effective 8/2/16 - a (less than \$200K) b(200K or more)												
Reliance Standard	A+	A	A	Eleos-MVA	S	3.25%*	1 yr.	None	8%, 7, 6, 5, 4	Yes	\$10,000	3.25%**
*Effective 2/13/16. Includes 1.50% 1st yr. bonus. Min. guarantee is 1.00%. **Reduced 20% ages 76-80, and 40% ages 81-85												
Reliance Standard	A+	A	A	Apollo MVA (Q/NQ)	S	4.05%*	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 7/19/16												
Symetra Life, Inc.	A	A	A	Custom 7 (Q/NQ)	S	2.50%*	7 yrs.	N/A	8%, 8, 7, 7, 6, 5, 4, 0	No	\$10,000	Varies
*Effective 9/13/16. 2.00% base rate with no guaranteed return of purchase payments. Plus 0.50% bonus for \$250,000 and above.												



LARGE GROUP HEALTH

View from the Top



In this article, executives give their take on the changing large group market. A consistent theme is that these groups face higher health care costs, which makes high-deductible health plans (HDHPs) more popular. Some groups will see dramatic changes as they become newly classified under the small group market, such as adjusting to how premiums are calculated.

Successful agents will need a more consultative approach when working with large employers.

What Are Some Major Trends Affecting Large Groups?

Rick Coburn, CAHU President: To a great extent, the major trends for large groups mirror the trends for small groups. An aging population with increased medical needs is one factor that influences the

trend of rising health care expenses. This has moderated somewhat in the past few years. But, to a substantial extent, the proliferation of expensive specialty drugs is driving the upward pressure on costs. This trend may accelerate as more effective, but costly, treatments are introduced. Another trend is the expansion of consumer driven health solutions as employers search for ways to mitigate rising premiums. These include voluntary plans that cover the higher deductibles and coinsurance to which employers are increasingly migrating, telemedicine programs to enable employees to connect quickly to medical professionals in non-emergency situations, and technology tools for tracking personal health. A third trend is the application of technology to the insurance industry, including online enrollment, and tools for employees to evaluate plan options.

Tony Lee, CEO of Dickerson Employee Benefits: We are seeing more industries pooling their resources and forming programs that potentially keep large-group rating in place. The Southern California Employee Benefits Program for Charter Schools is an example of one such program that allows small charter schools to benefit from the composite rating traditionally reserved for larger groups.

David L. Fear, Sr., Shepler & Fear General Agency: Large groups are facing two major issues: First, the rising cost of health care services, especially for prescription drugs, has affected large employer plans, especially those that are self-funded. For this reason, we are seeing movement from traditional PPO arrangements to a Medicare based pricing program using third-party entities to negotiate with providers to pay a percentage of Medicare for their claim costs. The key seems to be how much a provider will accept as payment in full and agree not to balance bill the patient. Larger employers who self-fund their medical benefits realize the savings through these kind of pricing schemes, which that has a direct effect on the cost of their benefit plan.

Second, there is increased complexity of offering private coverage due to regulatory requirements enacted at the federal level. Regulators under

the Dept. of Labor and the Dept. of Treasury, including the IRS, are auditing large employer plans to enforce compliance with Federal laws, such as the ACA, COBRA, HIPAA, FMLA, etc. Many large employers are clearly frustrated by the increased rules and regulations. Yet, the government has done nothing to reduce the cost of health care services so that employers, of all sizes, continue to pay more and more for "fringe" benefits. Clearly something is wrong. Some very large employers are looking at the bottom line cost and questioning if it's less expensive to pay the non-compliance fines. Can you blame them?

Kevin Timone, Chief Sales Officer, CHOICE Administrators:




The most obvious issue these groups will experience is the difference in price and rating methodology. The transition from traditional composite rates, to a community/age rated structure,

will take some time for mid-market employers to adapt to and accept. Employers will have to find a strategy that minimizes the premium shock employees are having, and yet still meets the company's health care budget objectives. While large groups have tradi-

tionally enjoyed a certain level of customization and negotiation, that is no longer available as they move. However, many groups will now have the opportunity to offer more options to employees in the small group market.

Rob Carnaroli, Vice President of Sales for Sutter Health Plus: We're likely to see more employers shift costs to employees by selecting high-deductible health plan (HDHP) designs. For employers who already made this move, we'll see increases in plan deductibles, out-of-pocket costs, copays and coinsurance. On the administrative side, more companies are exploring online enrollment vendors to trim human resources expenses. Employers also want simplified connectivity with carriers to exchange electronic data securely and reduce or eliminate paper forms.

Marc McGinnis, vice president of sales, Word & Brown General Agency:

- 
1. Medication utilization is driving costs. Carriers assess renewal increases on medical and prescription utilization. Medical utilization has remained consistently low, but prescription utilization has increased. High prescription prices and utilization have contributed heavily to group renewals.
 2. Overall group increases in the 100+ market have been low. The major increases were seen last year because of ACA, the mandate and affordability. Adjusting employer contributions to adhere to the affordability guidelines in 2014 resulted in larger increases in 2015 as carrier braced for uncertainty.
 3. Renewals YTD for groups 100+ have been modest
 4. Groups that are 101+ FTE with less than 100 benefit eligible employees are having difficulty being written. They are caught between two markets (small and large group) due to FTE counts. A small group carrier may decline to write the group if they have too many FTEs (bringing them to 101+) while a large group carrier

will not quote them since they do not have over 101+ benefit eligible employees listed on the census.

5. The small group market is now defined as 1-100. A group can be written in the small group market because they have 85 eligible employees, but considered applicable large employers (ALEs) by federal law definition (50+ FT and FTE). This is causing much confusion with regard to the employer mandate/penalties. Groups with 50+ FT and FTE are subject to the employer mandate even though they are written under a small group plan.
6. Even though small and large group should both be guaranteed issue, large groups are still being declined. The carrier loophole has been, "We are uncompetitive and will not be re-releasing a proposal."
7. Some industries are loaded or auto declined due to uncompetitive rates.
8. Certain carriers will not quote virgin groups as they are considering participation heavily when vetting their prospects.
9. The rising cost of doing business for employers and carriers has resulted in a reduction of work force.
10. Some employers have considered reducing their workforce to avoid ACA penalties.
11. Minimum wage went up July 2016 – additional cost to employers.
12. An aging population impacts utilization.
13. New technologies, while increasing effectiveness in some areas, are driving up costs in other areas.
14. Pharmacy costs: This is a big one; new specialty drugs are beyond expensive when they are under patent. This happens when a pharmaceutical company's exclusive patent with the FDA expires (usually 7-10 years) and a generic is made available. Once a generic equivalent becomes available, a new drug is already in production; cyclical.

Last year the pharmaceutical companies lost an estimated 32 billion in global sales because of drugs coming off their patent. It's a domino effect: the pharmaceutical companies have to raise prices to recoup the losses, passing rate increases down to the carriers/members.

What Issues Are Brokers Facing With Larger Groups Transitioning Into The Small-Group Market?

Rob Carnaroli, Sutter Health Plus:



The most dramatic change is how premiums are calculated. Premiums for small groups are age rated and this may cause some sticker shock to these groups. In

addition, small group employers face a unique set of complicated rules due to the Affordable Care Act. Employers expect their brokers to be experts on the ACA and all the other ever-changing regulations. They demand a higher level of competency and knowledge.

Rick Coburn, CAHU: With the exception of grandfathered groups, groups in the 50 to 99 range will fall into the ACA range of small groups (two to 99) by the end of this year. There are several issues employer and employees will face, and health insurance professionals will be ready to provide expert advice and service. Among these issues will be moving from composite rates to an individual age based rating system for employees and dependents. The impact on premiums will differ depending on the demographics of each company, but generally this rating change has pushed premiums higher. Another issue is recognizing that carrier service will change to a less personalized mode, with carriers requiring electronic interface for many service issues. Other issues include fewer choices for employers and employees. Some examples are fewer self-funded options, wellness programs, and medical plan choices, as well as some differences in network availability. Small group employers will lose their ability to negotiate premium rates. Underwriting rules will differ, but an advantage in the small group area is the availability of more relaxed participation rules. Another advantage will be the ability to access comprehensive private exchanges. Members of the California Associa-



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tion of Health Underwriters will be actively assisting employers with this complicated transition, offering professional, experienced assistance.

David L. Fear, Sr., Shepler & Fear:



Challenges include going to a member-level rating system compared to composite rates; losing their "risk adjustment factor" and having to purchase a

community rated product; having less flexibility in plan designs (strictly complying with ACA small employer metal plan features); losing alternative funding options (SB-161 limits stop-loss insurance products for small employers); and having restrictions on HRA/FSA programs, which are still enforced by some carriers in the small group market. Also, the small group market does not seem to have as many electronic enrollment options as have been available to large employers (although that is changing). There are a number of workarounds for each one of these six challenges. As time passes, employers will certainly be able to implement (or re-implement) many of these features, but they are still a short term challenge that most employers were not expecting when the ACA first became law.

Kevin Timone, Chief Sales Officer, CHOICE Administrators:

Brokers face several challenges with the transition. The largest, perhaps, is the amount of education their mid-market clients will need as they move into the small group market. There is tremendous pressure to make sure their clients understand all the complexities the ACA brings to the market, including the difference between composite and age-based rates. Other topics that should be addressed are ACA metal tiers and how they work as well as compliance (IRS Forms 1094 and 1095). More than ever, brokers should work closely with partners that offer sales and enrollment support and take advantage of innovative technology tools that streamline the sales and enrollment process.

Tony Lee, Dickerson Employee Benefits:



Groups transitioning from large group to small group have had a major impact on the renewal process as well as on how changes are communicated to the client. The financial impact of going

to age banded rates cannot be understated. We've seen premium swings in both directions depending on the demographic makeup of the group. Some groups have always had tiered rating and unless the concept of age-rating was communicated very early in the process, brokers run the risk of losing long-term clients. Dickerson always advises our broker clients to take their clients through the different scenarios long before renewal so that there is no surprise and contingency plans can be made.

Marc McGinnis, Word & Brown General Agency:

1. Rates! Most groups (51-99) are seeing 20% to 40% rate increases in addition to watered down benefits by transitioning into small group. This is a difficult conversation to have with employers. Account based plans, such as HSAs, HRAs, and FSAs, can be a great strategy to help employers offset the cost increases being passed along to participants.
2. Some groups in the 51+ market had benefit administration systems and some of those systems can no longer support age-rated plans so alternate systems have to be used.
3. There has been additional burden placed on the group administrator because of small group plans and rates complexity.
4. ACA compliant plans have large OOPs, higher copays, and deductibles.
5. SHOP (aka Covered California for Small Businesses) is losing carriers (the individual exchange as well). There are less choices available and less competition due to carrier financial losses in the exchanges
6. Large groups are losing their composite rates and seeing higher costs to

the EE due to member level rating.
7. There is the network versus cost issue.

Of course, we can't call out any carriers by name. The 51-100 segment will be facing sticker shock as they enter the SBM world of rating and rules. The 51-100 groups with previously excellent experience will face higher premiums. The 51-100 groups with less than stellar experience may actually see savings as they enter the GI small group rating world, but all 51-100 groups will see a dramatic improvement in the choices and flexibility suddenly available to them through either the state-SHOP exchange, or the private California Choice exchange -- each with employee choice of multiple plans and a wide range of network options all within the same group with simplified, integrated enrollment and administration.

What are the most effective ways to sell to large groups?

Kevin Timone, CHOICE Administrators:

As always, budget-based approaches are effective when working with an employer who is transitioning out of mid-market and into small group. Today's employers want to get the most value for their dollar while giving their employees more control over their benefits. This approach helps explain why multi-carrier exchanges have seen significant growth. They allow employers to establish their budgets while providing employees broad access to find their doctors at a cost and benefit level they choose.

Rick Coburn, CAHU:

Selling to large groups revolves around the wider needs of large group employers. An effective sales approach recognizes the longer lead times involved in large group and starts with gathering comprehensive benefit and demographic data, and claims data where available. It also includes a conversation with human resources about why they are considering a change, their needs regarding benefits, including compliance issues such as large group penalties, technology to simplify and connect benefit processes, and other aspects
(Continued on Page 41)



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How to Gain a *Competitive Edge* in the Medicare Market Place

by SETH PAUL



The ultimate competitive advantage in business is how hard you work. But even the hardest worker doesn't have all the keys to success. The Medicare sales industry is highly competitive, highly regulated and highly challenging. It's not easy to build a solid, profitable customer base when there are so many agents out there. So, what differentiates you from every other broker, and why should the senior market choose you and your business over the competition?

If you're not so sure, see these five strategic ways to gain a competitive advantage as a Medicare sales broker.

PLACEMENT

Aligning yourself with the right agency is critical for any independent agent's career. Numerous agencies claim to do a lot for the broker, but not many actually do. Remember that you're the talent; your FMO should be a key supporting factor in fostering that talent and setting you up for success.

When it comes to finding the best marketing organization to partner with, look for a full-service FMO that offers more than just a location to submit business. Make sure that you own that business and are being paid the highest allowable by CMS for it. Because a complete product offering is valuable to your prospective clients, the more contracts and products an FMO offers, the better. Look for an agency that has actual departments that specialize in servicing you. From contracting to



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business development, an ideal marketing organization provides opportunities for you to grow your business.

All in all, the best FMO will give you the competitive edge you need to start in this business. You are the expert in the field. The right partnership should be the foundation on which you can depend on and grow.

KNOWLEDGE

You have to know your products and services inside and out. An uneducated Medicare broker is useless to the Medicare consumer and is frustrating for customers. A primary advantage of partnering with an FMO is the education support. The better the FMO, the greater variety in training and higher quality support and tools you'll get.

In the ever-changing world that is Medicare, make sure that you stay up-to-date with Medicare rules and regulations as well as the annual health plan benefit changes. If you don't know something, at least know how to find it. Medicare.gov is a very useful tool. You should also be able to get answers from your FMO sales support team (assuming you chose a good one).

To maintain a competitive advantage in the Medicare market place, always look for ways to expand your knowledge and choose an agency that will give you the best tools to do so. The more you know, the more value you can provide. Providing value to your customers will guarantee success.

POSITIONING VERSUS PROSPECTING

Now that you have the right partnership and the necessary industry knowledge, you can focus on positioning yourself in the Medicare marketplace. Prospecting clients and customers is a never-ending cycle. Plus, with the Medicare space being extremely regulated, compliance is a must (so make sure the organization you choose has an outstanding compliance department that has your back).

Because of these prospecting challenges, the best approach is to position yourself as the leading authority, specialist or trusted advisor in the Medicare world. When you're perceived as the expert, clients will approach you as



opposed to you having to chase them down.

Look for opportunities to showcase your knowledge and value as the local Medicare expert. Put yourself where the Medicare consumer is already at instead of trying to make them come to you. Whether it's a doctor's office, hospital, medical clinic, community event booth, or senior center, make yourself available to be the educational resource that the Medicare community needs. This proper positioning of your business will give you the advantage over the broker that's chasing down prospects and leads.

CONSISTENCY

Consistency is the key to success. Be consistent in every way and in everything you do. This includes the look of your marketing materials, the message you deliver, the level of customer service, and the quality of service you provide to each and every customer. Your marketing organization can deliver consistency with uniform marketing materials, but it's up to you to be consistent with the rest.

From direct mail campaigns to visiting your doctor office partners, it's your ongoing efforts that will set you apart from the competition. A single community event or one visit to a physician's office might produce some business for you, but it's your continued participation and effort that will build credibility. And establishing yourself as a credible resource in the Medicare market place will absolutely

give you an advantage over the competition.

CREATE ADVOCATES

Best business practices revolve around what you promise to your customer, and how often you actually follow through on that promise. By being consistent on the value promise you provide to your customers, you won't just satisfy your customer's wants and needs, you'll exceed them.

And when you exceed customer expectations, you create advocates for your brand.

The desire of all businesses is to create a pool of fans and advocates who will go out of their way to promote what you do. A satisfied client will get you referral business by endorsing you, not because you asked them, but because they want to. Whether it's your Medicare clients promoting you and referring friends and family, or physicians referring other physicians to utilize your services, this business is all about creating fans.

By partnering with the right FMO, contributing valuable knowledge to the Medicare population, positioning yourself as the expert in opportune situations, and consistently providing unparalleled service, you'll have precisely what it takes to gain a competitive advantage as an independent agent, and thrive as a Medicare sales broker. ★

Seth Paul is regional Sales Manager for AGA Inc. For more information, call 800-498-6880.

JUST THE FACTS

Marketing & Selling Your Services to Baby Boomers

by BRENT HITCHINGS and DAVID GARCIA



Let's start off with a Boomer Mantra when it comes to aging, "I am not a senior" (as defined in years past). Now this is not to take away from the Greatest Generation. That group that preceded Baby Boomers. Take note of the word "greatest." Our purpose is to help you understand that one size does not fit all when it comes to generational marketing and to stress the importance of making adjustments when marketing to Boomers.

It is primarily a belief by Boomers that, as they did growing up, they will also be changing the country when it comes to growing older or reaching "middle-essence" as they like to call it. The oldest Boomers are 70 this year, and the youngest 52. That is a big marketing opportunity for you.

They will live and work longer than their predecessors did. Colleagues will have to get used to energetic gray-haired coworkers. Surveys tell us those turning 70 this year, and over the next several years, are much more inclined to stay on the job than were previous

generations, out of necessity or desire.

By 2022 nearly a quarter of people 70 to 74 will be working — double the figure in 1992.

For many Boomers the feeling is that "I have a lot more to contribute." The golden years will truly become that as far as Boomers reshaping life.

Despite all the talk of their not saving enough money for the next chapter of their lives, they still own the largest discretionary income out of all of the generations in the workplace today. Once again, a big marketing opportunity for you to consider as you look at ways to grow your business moving forward.

So here are the facts:

- In 2015 approximately 5.25 million Boomers in California were 65+.
- Approximately 1,000 Boomers in California turn 65 each day.
- If you do the math that is 365,000 sales opportunities a year.
- Medicare Supplement compensation is upwards of 20% first year 10% renewal.

- Medicare Advantage compensation is upwards of \$400 first year \$200 renewal.
- It is a year round selling opportunity.
- Fastest growing insurance industry.
- Compensation not impacted by ACA.

We know what you are thinking, "From what I have heard it is too regulated or takes too much time to sell and service." We would suggest you contact your favorite GA or FMO to learn how they can take away the alleged pain. By the way, once you include these products in your portfolio we believe you are going to be asking yourself, "Why didn't we do this sooner?"

So in closing, understanding Medicare eligibility along with the other needs of the Boomer Market is more important than ever before whether you sell individual or small group products.

Now is a great time to jump on board the Boomer wave. ★

Brent Hitchings is director of Sales for Warner Pacific. David Garcia is Medicare Sales Specialist for Warner Pacific.

OCAHU/IEAHU HEALTH UNDERWRITERS

Senior Market Conference Coverage

By LEILA MORRIS

It was a packed house at OCAHU/IEAHU's Senior Products & Marketing Summit at the Pala Casino in August.

Keynote speaker, Rusty Rice, vice president of the National Assn. of Health Underwriters (NAHU) gave a run down of the organization's changing focus. First of all, NAHU is expanding its senior product line to unpack market opportunity and is looking for chapter leaders. NAHU is also doing the following:

- Restructuring the legislative council to include a chair, a vice chair, and a legislative manager who is an expert in senior products.
- Reviewing whether classes are too expensive.
- Offering a new certification.

Rice then turned to the election. He didn't spend too much time discussing Hillary Clinton's health insurance platform except to say that her initiatives would be difficult to pay for. Rice said that Donald Trump has called for repeal of the ACA, but it can't happen. "You can't take away something that has already been given to somebody. The Republican party is so fractured right now. They will tell you that people need to be able to buy insurance across state lines. What is interesting is that none of them will tell you that this will work. They all know that it won't work, but they are going to continue to tell you because

they need the backing of the Republican Party. Donald Trump is also calling for individual tax relief, but he has bordered on some really crazy ideas including doing away with employer based coverage."

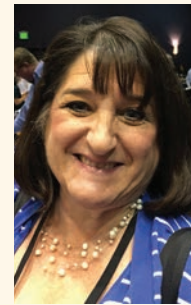
Legislators on both sides of the aisle are calling for a repeal of the Cadillac tax, said Rice. "When you look at the Affordable Care Act, some parts don't make sense. Portions of it were put in to give the other side a win. Enrollment is a good example. Tell me how much sense it makes to tell people that, if you have two or more employees, you have to automatically enroll somebody in your health insurance. You have to go ask if they want to stay in or not and if they don't, you have to dis-enroll them. I believe that this was put in there as something that was easy to take out."

Rice said that, in the Senate, Republicans are defending 24 seats while Democrats are defending 10; it could go either way. On the House side, all seats are up for election so there is no telling how it could go. Sixty-six districts are considered to be in the competitive area. "This could change Washington politics," he said. He noted that the single payer issue is coming up in Colorado with Proposition 69; and a single-payer initiative passed the New York assembly in May.

ADVISOR ON THE STREET



Professionals at the conference told us how rewarding it is to sell Medicare, not just financially, but also personally.



Linda Seltzer, Teague financial insurance services in La Mesa, CA:

I have been selling Medicare for at least 12 years. Today, there is more to know. It's getting harder and harder for an individual to know what's going

on. A consumer might choose their employer plan and find out that they are paying \$400 a month for the same coverage they could have had for free. I had a San Diego judge who didn't understand his benefits. Even smart people don't know how their benefits work. Certain benefit plans are more expensive for the same coverage. Drug plans are not equal. I get most of my clients through word-of-mouth referral and our property & casualty sister company that brings in a steady stream of new clients. With groups, we start educating employees who are nearing the Medicare age. Many times, the employer and the employee don't know about the penalty for enrolling late into Medicare. My method of selling is through education. I have very loyal clients who refer me, and it is wonderful. I love my clients. I also offer a great cancer plan that a lot of people don't even know exists.



Mindy Chris, Global Health Insurance in Murrieta:

We focus on small and large group benefits and Medicare. The more we get into small group, the more referrals we get, and the more it's growing. We track when people are aging into Medicare. We also get a lot of employers contacting us when employees are aging into Medicare. Keeping up with Medicare training and knowledge is the challenge. Sitting down with people is the easy part. We love helping the seniors and simplifying it. People love going from individual health insurance into Medicare. They always seem happy and relieved. We use a field-marketing organization (FMO), which has been helpful. Anyone at the FMO who answers the phone can answer any question that I have. That is a huge stress reliever. They are in your

back pocket. It is something that you need have to have going through this because it is so overwhelming.

Luz Guzman and Vanessa Lim, Infinity of Health Consultancy Ser-



vices in Perris: Guzman: Selling Medicare is very rewarding because you get to really help people and give them something that they didn't know they could have. I love what we are doing and want to help as many of the 10,000 Baby Boomers as I can who are turning 65 every day. I speak Spanish, so people love it when you explain things that they could not understand before. When you gain their trust,

they refer you. We find many clients through relationships with doctors.

Lim: We get referrals from the doctors and the patients themselves. We gain relationships with doctors by knocking on doors. We explain how we can help educate patients and doctors about Medicare.



Ted Holloway, LA Care Health Plan:

We have been getting a lot of requests for agencies to contract with LA Care. We contract with four general agencies now and over a thousand brokers.

We have a training specialist and offer extensive training to new reps and brokers. We deal mainly with the low-income beneficiaries who are dual-eligibles. ★

Leila Morris is senior editor of California Broker Magazine.

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WORKING WITH HEALTH BENEFIT CHALLENGES

by ED WALKER

Rethinking Supplemental Options

As we all know, the passage of the national Healthcare Reform, more commonly known as the Affordable Care Act (ACA), has had a substantial impact on the healthcare insurance market. Most significant is the decreasing number of primary plans available and the rising cost of healthcare premiums, which is forcing employers to cut costs by limiting the amount and types of benefits they are able to offer employees.

Such changes are presenting challenges for your clients and limiting your ability to serve as their broker. To make matters worse, you are working harder to keep up with the multitude of changes caused by ACA but receiving decreased revenue due to the reorganization of carrier-broker compensation structures.

Your role remains the same: Think strategically and help your clients put benefits in place that will meet the diverse needs of their employees and provide access to the care they need while also keeping costs in check. So how can you accomplish this with new challenges at every turn? Brokers today need to rethink the strategic use of an established tool — supplemental health products.

Long considered an optional add-

on, supplemental solutions are now necessary to achieve the customization that clients seek. Today, it's critical that brokers think of health plans and supplemental plans in one cohesive tool box. A broker must first understand the overarching challenges and needs of the client, then reach into his or her tool box to thoughtfully select the products that work together to meet each client's needs.

ple, according to the Devenir Group, the number of HSA accounts rose to 16.7 million in 2015, a 22% increase from the previous year.

The percentage of employers that expect supplemental benefits to be vital to their total rewards strategy also is on the rise. According to a report issued in early 2016 by the Healthcare Trends Institute, about 40% of employers offer three or more health plan options, which include supplemental tools.

What is fueling this growth? The supplemental market takes a holistic approach to meeting client needs by identifying gaps and providing options to fill them. Clients are seeking these types of solutions to improve overall coverage, and as the demand continues to increase, new supplemental products and options are being introduced to the market.

There are several different types of supplemental solutions, which generally fall into three categories:

- Health Accounts, such as a health spending account (HSA), an employee-owned and contributed tax-exempt account to pay for qualified medical expenses; a health reimbursement arrangement (HRA),



NO LONGER AN AFTERTHOUGHT

In spite of the changing market, supplemental solutions have continued to grow. The supplemental insurance market is currently valued at more than \$7.1 billion, up 3.6% since 2014.1 Though it was unclear how ACA would affect this market, reform has evidently helped spur this growth. For exam-



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an employer-owned and contributed benefit plan that reimburses for qualified medical expenses and must be integrated with other group health plan coverage; and a flex spending account (FSA), an employer-owned, employee-contributed account that allows eligible employees to be reimbursed for qualified medical expenses.

- Voluntary Insured Benefits, which can be offered by the employer and opted into by the employee. Generally employee funded, these benefits offer flexibility by allowing employees to self-select coverage and help fill some gaps that primary plans do not cover. Voluntary insured plans are typically “event-driven” and limited in coverage to the defined scope. These include critical care insurance, hospital indemnity plans, dental, vision, etc.
- Expense Reimbursed Insured Plans, typically employer-paid, can be carved out by employee class (as an Excepted Benefit) and offered to those usually not eligible for other types of tax-efficient health accounts, like shareholders and partners. These plans offer different levels of healthcare reimbursement, can be added onto a variety of primary plans and offer a broad range of coverage to fill primary plan gaps, such as co-pays, deductibles and balance bills.

Prior to ACA, these supplemental solutions were often an afterthought because there were more primary plan options that could offer different levels of coverage. But in today’s environment, supplemental offerings have become more necessary than ever before because they can solve challenges for both clients and brokers.

PROVIDING CLIENTS WITH A CUSTOMIZED SOLUTION IS CRITICAL

The homogenized primary plans currently saturating the market are unable to meet the vast and varying needs of clients. One-size-fits-all plans don’t truly fit anyone, leaving clients unhappy with their levels of coverage and unmet business goals.

The strategic use of supplemental products takes a holistic approach by

first understanding the client’s goals and challenges, then considering the primary plan options alongside supplemental plans. A broker can identify gaps in the primary plan, and provide options to fill them. Think of it as a cost-efficient way to battle shrinking coverage.

For example, to combat rising premiums, the employer can choose a high deductible primary plan to lower premium cost. Then, they can back fill coverage with varying types of insured supplemental plans based on the objectives for different employee constituencies. This will help offset some, if not all, of the increased deductible and close the coverage gap. Of course, it’s in the best interest of the company to protect their most valuable employees, their key leaders, by providing them with a more robust expense reimbursed insured plan that will follow more closely to the 213(d) guidelines, covering items such as preventive executive physicals. By providing these different levels of employer-paid or voluntary insured plans, the employer can better meet their cost and coverage objectives even in a world of fewer primary plan choices. (See illustration.)

SUPPLEMENTAL IN ACTION: MEETING COST AND COVERAGE OBJECTIVES

- Step 4** Add on Healthcare Expense Reimbursed Insured Plan (*Medical, 213(d), Dental, Vision, Executive Physicals Coverage for Leaders*)
- Step 3** Offer Critical Illness or Accident Voluntary Insured Plans (*Payroll Deducted with No Cost to Employer*)
- Step 2** Layer on Medical Expense Reimbursed Insured Plan (*Additional Medical Coverage for Employees*)
- Step 1** Switch to High Deductible Primary Health Plan (*Meeting Client Cost and Coverage Goals*)

In addition to achieving cost-efficiency, supplemental solutions allow you to help your clients create customized benefit structures that will best meet their other goals too, such as recruitment, retention or total re-

wards. Achieving this flexibility would be impossible with the one-size-fits-all plans, but utilizing supplemental tools in conjunction with primary plans gives you the ability to structure the overall benefits package in countless ways in order to effectively meet the goals of each client.

A KEY TO YOUR SUCCESS

Leveraging these supplemental solutions won’t just help solve your clients’ problems. There are substantial wins for you as well. Incorporating and becoming an expert in supplemental solutions will diversify your portfolio, making you stand out from your competitors who are only offering homogenized plans. The ability to offer clients strategic solutions that incorporate supplemental plans will make you an asset to current clients (who will more than likely thank you by sending new clients your way).

Additionally, when you expand your portfolio options, you also grow your revenue streams. Keep in mind, these avenues don’t fall under the same compensation pressures as primary plans do, since they don’t have ACA MLR and other requirements to deal with in regards to compensation. In addition, some supplemental plans compensate for selling the plan the first year and every renewal year, thus creating a sustainable stream of revenue.

A POWERFUL TOOL IN DEMAND

In today’s healthcare climate, you can no longer afford to treat supplemental solutions as an afterthought. The ability to customize healthcare coverage is a valuable skill that is in demand. With supplemental solutions in your portfolio, you’ll have the power to meet clients’ needs, as well as the flexibility to evolve in today’s healthcare insurance market. ★

Ed Walker is a 25-year veteran of the healthcare insurance industry, and an expert on supplemental insurance and emerging healthcare solutions. Walker currently serves as President of Armada-Global, a supplemental insurance and healthcare technology company. Ultimate Health is Armada-Global’s market-leading supplemental expense reimbursed insured plan. For more information, visit UltimateHealth.com.

401(k) AND HSA DEFERRALS

Perspective Partners, LLC launched NestUp Managed Deferrals, which educates employees, offers personalized 401(k) and HSA deferral recommendations, and implements choices with just two clicks. When appropriate, NestUp also recommends directing HSA deferrals to retirement-oriented investments and lets employees opt for an HSA investment based on their 401(k) QDIA. "The significant tax advantages HSAs have over 401(k)s means they can have a big impact on long-term retirement savings," says David Snyder, CEO of Perspective Partners. NestUp takes an integrated approach that optimizes employer matching and tax benefits. By helping employees save for near-term out of pocket costs, it can lead to greater acceptance of high deductible health plans. Perspective Partners works with employers, record keepers, retirement plan advisors, benefit brokers and such partners as HSA administrators, benefit technology companies, payroll companies, and insurance exchanges. Importantly, NestUp can be used with any 401(k) or HSA provider. For more information, visit Managed-Deferrals.com, or contact Laura Benotti at laura@perspectivepartners.com.

DISABILITY

Guardian Life introduced individual disability insurance with enhanced customization options. Provider Choice offers three simple policy packages. Each package includes a base policy with hospice care and provisions for serious illnesses such as cancer, stroke, and heart attack. Policies can be customized with riders, or options, that address customers' needs. Provider Choice offers riders that can cover retirement plan contributions, partial disability, and options to help keep pace with inflation. A student loan benefit rider covers repayment of student loan debt, which is typically a significant financial commitment for professionals with advanced degrees. Professionals, such as physicians and dentists, can select the "true own-occupation" option. Provider Choice also offers an enhancement just for physicians. Policies are non-cancellable and guaranteed renewable. For more information, visit

guardianlife.com/disability-income-insurance/enhanced-disability-income-protection.

GROUP CRITICAL ILLNESS & ACCIDENT COVERAGE

MassMutual introduced group critical illness and accident policies through employers, directly or through MassMutual's BeneClick! integrated benefit exchange. The coverage is voluntary or on an employer-paid basis. The policies cover employees and, where available, spouses and children. For more information, visit massmutual.com.

WELLNESS

Humana is offering a well-being rider with its voluntary benefit product portfolio. The rider pays a cash incentive for getting standard screening tests. If a screening test yields a diagnosis of one of six covered conditions, the employee gets a cash incentive to enroll in a covered lifestyle program and another cash incentive to complete the program. The incentive also applies if the employee has already been diagnosed with a covered condition. For more information, visit humana.com.

DIGITAL BUSINESS CARD

Agent Review teamed up with Inigo to offer a digital business card app. It sends designed contact information to anyone you meet while importing contact info about your new acquaintance. Agent Review is an online platform that allows consumers to search and review local agents. All members get unlimited custom business cards, tracking of who clicks and views their cards, and downloadable data. For more information, visit agentreview.net.

ONLINE HOSPITAL-SHOPPING PLATFORM

DoctorGlobe offers an online U.S. domestic hospital-shopping interactive platform for self insured employers. DoctorGlobe's bonus-incentive strategy replaces the traditional approach by waiving out-of-pocket costs for the plan participant, and providing a cash award as a part of the corporate savings. DoctorGlobe ranks hospitals on distance, cost, and quality, offering plan sponsors the choice to work within their provider network, with out-of-

network providers, or both. For more information, visit doctorglobe.com.

PET INSURANCE

Figo Pet Insurance created the Pet Cloud App. You can keep all of your pet's records, locate dog parks, or find your pet with their pet tag. Figo offers pet insurance plans averaging less than a \$1.50 a day. It covers all non-pre-existing illnesses or injuries with no limits on claim payouts. It reimburses up to 100% of the vet bill; is accepted at any licensed veterinary practice, emergency hospital, or specialist; and has a yearly deductible instead of the traditional (and more expensive) per-condition deductible. For more information, visit <https://figopetinsurance.com>. Whole Life

Colonial Life's improved whole life product provides guaranteed rates and coverage, so policyholders know how much their policies will cost and what they'll be worth when needed the most – regardless of the interest rate. And while Colonial Life products are sold through the workplace, employees are guaranteed the right to take their policies with them when they change jobs or retire through portability, with no increase in cost. The coverage options allow policyholders to change their coverage as their needs, and those of their families, change. These options include riders for accidental death benefits, waiver of premium, and spousal and child term coverage. There are also separate whole life policies available for spousal and child coverage. For more information, visit coloniallife.com

JUVENILE LIFE INSURANCE PLAN

Colonial life is offering a new juvenile whole life insurance plan. It is offered as a voluntary benefit through the workplace. Employees can select this coverage for their children, grandchildren, step-children or adopted children as a separate policy, whether or not they buy coverage for themselves. They can choose coverage amounts from \$10,000 to \$300,000, with options to increase the amount when the child turns 18, 21 and 24 without any health questions. Ownership of the policy may transfer to the child at age 18. For more information, visit coloniallife.com. ★

Why People Miss Out on Their Disability Benefits

by ART FRIES

Here are eight reasons why disability policyholders miss out on benefits:

1. They fail to have someone review their disability policy for many years so that they get past crucial dates: They have a policy that pays lifetime disability benefits. However, benefits aren't paid for lifetime if they claim total disability too late. So if
4. They don't tell their attending physician that they may have to reduce hours or stop working because of medical symptoms.
5. They work an additional job or do too many management duties that cause the insurance company to say they have a dual occupation. For example, a dentist client spends too many hours doing management du-
6. They fail to provide documents to the insurance company that are nec-
7. They overly engage in social networking, which gives the insurance company excessive data about them while they are on a disability claim.
8. They fail to provide documents to the insurance company that are nec-



sickness must start before age 60 and they claim benefits after that date they get paid to age 65, not for life. I can't tell you how many calls I've received in which the policyholder did not know the timing of when they had to claim total disability.

2. They assume that a partial disability claim will pay for life when almost all insurance companies pay to age 65, 67, or 70 on a partial claim.
3. They fail to get appropriate medical advice (if required in the policy) and have it properly documented in medical records.
6. They work at another occupation after going on total disability that is in conflict with their medical symp-

ties. The dentist stops working and claims total disability. The insurance company says, "You have a dual occupation. In order to collect on the claim, you must be working; even though you cannot do your clinical dental duties, you can continue to work at your management duties." They collect nothing since their claimed medical symptoms only apply to clinical dentistry, but not the management duties and they are not working.

essary to pay the claim. This may include (but not limited to) tax returns, P&L statements, procedure codes and purchase agreements.

These are just some of the things that cause disability claimants to lose out on benefits. Getting the proper advice from one who has expertise in disability claim practices can go a long way to securing benefits in a timely fashion. ★

Art Fries is a disability claim consultant providing advice on a national basis in the U.S. He is located in Nipomo, Calif. He can be reached at 800-567-1911 or email friesart@hotmail.com The web address is www.afries.com.

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The New California Gold Rush



Expansion of Small Group to 100 Should Make You Bullish on New Sales!

by Ron Goldstein, CLU

California's revolutionary expansion of the small group employer category has greatly increased new business opportunities for brokers who adapt to the healthcare reform-driven marketplace. As it played out, this year, the Golden State is one of only four (including Colorado, New York and Vermont) that moved forward with the Affordable Care Act's (ACA) expanded definition of a "small employer" to one with 100 employees (up from 50 or fewer). In late 2015, federal legislation gave states the option to stay with the pre-ACA definition, but California continued forward since the provision had already been incorporated into state law.

THE MARKETPLACE SHIFT

The expanded small group classification is a game-changer. The market once consisted of independent grocers, auto repair garages, local restaurants, dry cleaners, beauty salons, and other small businesses – many with only a handful of workers. Now it has grown to encompass companies, such as financial services firms, car dealerships, retail, food and service franchises, as well as many others that have a larger, more diverse group of workers.

The result is profound for the small group segment. Employers are seeking to identify, select, and manage health benefits for an increasingly disparate workforce while managing costs and financial risks. They are also trying to navigate a web of ACA mandates to ensure compliance with regulatory requirements and avoid penalties.

Despite these challenges, the expanded small employer market creates exciting opportunities for brokers to expand their business by serving as insurance experts and skilled curators of plan benefits and options.

THE NEW SMALL GROUP

While data varies between sources, such as the U.S. Census Bureau and the U.S. Small Business Administration (SBA), the number of private-sector businesses statewide that fit the new small group criteria is estimated to be about 500,000 small businesses. All told, these firms employ some five million people, according to the SBA.

According to the latest California labor market data, newly added companies and employees in this small group category include around 33,000 employers and about 2.3 million employees. Note the math here. The expansion has nearly doubled the number of affected employees. This represents a lot of businesses and workers who must navigate unfamiliar insurance territory and a multitude of new compliance requirements. They need industry experts to make the best choices possible.

More small employers are grappling with the vast array of choices and plan options to address a complex, challenging, and diverse employee base. This is no easy task. For exam-

ple, a 22-year-old single woman who is starting her first job out of college will probably want a different plan than would a 59-year-old financial services manager who has a spouse, three children, and plans to retire in the near future. Brokers and benefit advisors have the know-how to manage the complexity for these new employers.

THE EVOLVING BROKER RELATIONSHIP

The days when it was simply about enrolling people in coverage are quickly fading. Brokers need to help small employers and workers understand the intricacies of public marketplace, private exchange, and small business carrier options. Savvy agents play an even larger role in providing invaluable services after enrollment.

To address small group demands, successful agents will focus on six key roles that now define the broker-small business relationship:

1. Consumerism Guru: Businesses need a reliable guide, given the increase of many new exchanges, technology platforms, and online services. Also many have recently entered the small group category. They need a specialist, an advocate, and a problem solver to negotiate the changing health exchange and marketplace options – options that are becoming increasingly comparable to how the financial services industry provides 401k offerings. Employers need a trusted resource and counselor who clearly understands the new market environment.
2. Advisor to Small Groups: Small businesses rely on health benefits to attract and retain the best workers. Restaurateurs, hair stylists, and machinists are skilled in their respective industries, not health and employee benefits. They face the daunting task of finding the right coverage options at the right price to meet a wide range of needs and requirements for their diverse group of workers. Without the steady hand of a professional advisor, it can be difficult to target optimal coverage options.
3. Service Provider: The ACA has been a catalyst in automating a variety of traditional broker functions, such

as plan comparisons, enrollment, physician selection, and more. This trend actually deepens the value of skilled agents. There are a number of reasons why, but they all track back to one vital factor – service. Brokers who help small businesses navigate healthcare reform offer tremendous value. They can help manage health care costs, keep up to date on regulatory requirements and changes, and assist with benefit administration and employee benefit education. They listen to the needs of each business, match those needs to the best marketplace options, provide quotes for coverage, and place the business with the pro-

The days when it was simply about enrolling people in coverage are quickly fading. Brokers need to help small employers and workers understand the intricacies of public marketplace, private exchange, and small business carrier options.

- gram that offers the best options.
4. Human Interface: Several years ago, IBM commissioned a poll of 1,000 U.S. consumers and found that, when it comes to insurance providers, there is an overwhelming preference for personalized service and human interaction. Technology has enabled the seemingly overnight explosion of online insurance marketplaces. But brokers who can deliver outstanding service support to their customers will win in the long term. Nothing beats face-to-face interaction that is timely, personalized, and valuable to clients.
5. Single-Point Expert: A benefit specialist must be a go-to expert to solve their clients' problems, meet their needs, vet and recommend coverage options, and guide workers through benefit claims processes. The value of a single-source expert cannot be overstated. A good broker satisfies all of a small business' needs, whether it's health, life, dental, payroll, or other benefit services. Not having to deal with multiple vendors and contacts saves time, money, and the sanity

of employers and workers.

6. Problem Solver: Brokers should also be entrusted problem solvers. Few benefits are as important to employers and their workers as health coverage. Small businesses are perhaps more acutely attuned to this as they must try to compete cost-effectively with their larger counterparts for talent. Health coverage is a primary trigger for recruitment. It is critical to put this very important benefit in the hands of a professional who can be trusted to make informed decisions.

Moreover, brokers today must solve some of the trickiest benefit coverage puzzles. Since they do not directly represent a carrier, exchange, or marketplace, they should focus on serving client needs rather than selling to a specific (and often narrower) selection of plans. Brokers must sift through options and present the best, unbiased choices that match their clients' employer-worker needs. Their primary motivation is to serve, not sell.

THE FUTURE FOR SMALL GROUPS

The bottom line is that the expansion of the small group has created more options, flexibility, and opportunity. But pitfalls are everywhere for employers attempting to go it alone, especially those that are new to the category.

There is a greater demand for benefit professionals who offer service and ongoing, customized support that goes far beyond initial enrollment. In the small business community, there is a greater demand for advisors who can target the best range of options while identifying health plans that fit an employee's individual needs and stage in life. Small business owners need professionals who offer health-care coverage expertise and deliver service with a personal touch. This is where smart, knowledgeable, and service-oriented brokers and professionals have the most to gain. ★

Ron Goldstein, CLU, serves as president and CEO of CHOICE Administrators, which provides health insurance options and provider access to small businesses and their employees. He also created and manages America's longest-standing, state-approved exchange, CaliforniaChoice. For more information, please visit www.calchoice.com.

How Brokers Are Key To Transforming Health Insurance and Benefits



by COURTNEY NICHOLSON

The Affordable Care Act transformed the American healthcare system by introducing public health insurance exchanges. That said, about 150 million Americans, or ten times as many people on public exchanges, still access health insurance and benefits through their employers. Transforming the employer-sponsored benefit market is what will truly create a profound impact on how employers and employees choose and use health insurance and benefits.

RISE OF BENEFIT MARKETPLACES

Healthcare costs are sky-high in the U.S. and continue to rise. They have more than doubled over the past decade and outpace inflation. Spiraling health insurance and benefits costs are a top concern for businesses, according to a pulse survey of employers in the Northeast and Mid-Atlantic from hCentive, a healthcare software company that serves insurance brokers and agencies, health insurers and state agencies.

Businesses are also struggling to navigate the complex regulatory landscape, and these challenges are more pronounced for small and mid-sized businesses. While large corporations have entire teams dedicated to dealing with compliance, coverage changes, and taxes, smaller companies have fewer resources available to untangle the ins-and-outs of benefits enrollment, administration, and compliance.

Despite the high costs and compliance, offering employee benefits is still a priority for many small and mid-sized employers. These companies are going head-to-head for a limited pool of qualified employees and have to offer compelling benefits if they hope to attract and retain the best employees. However, to do so cost-effectively, employers need better transparency and choice of

benefit plans and products to select and configure contribution strategies that fit with their business, employees and budget. For example, they can change a carrier due to premium spike or select high deductible health plan paired with a health savings account (HSA).

For all these reasons and more, benefit marketplaces are emerging as a crucial tool. Benefit marketplaces are online platforms that connect brokers with carriers to offer a variety of health insurance and benefit products along with a seamless and intuitive experience to shop, enroll, and manage. These online marketplaces are more flexible and customizable because they enable employers to adapt health insurance and benefit offerings from a wider array of choices to their business model and unique set of needs. Employers can pick and choose what options are available to employees rather than swallowing a one-size-fits-all package. This marketplace model offers a multitude of advantages to employees as well. They give employees more control over their health insurance, as well as a growing list of other insurance and non-insurance products (e.g. financial and wellness) and enable them to make smarter decisions and maximize their benefit dollars with the right benefit product/plan option combinations.

WHAT BENEFIT MARKETPLACES MEAN FOR BROKERS AND AGENTS

Employers rely on brokers and agents to provide better choices that are easy to understand and offer tools and advice to help guide the decisions. Some smaller employers who bypassed their brokers and turned to self-service technology solutions promising free or “freemium” HR/payroll/benefit offerings realize they still need broker guidance and robust support for enrollment and compliance.

Benefit marketplaces are gaining momentum by bridging the gap: smaller employers have a level playing field to access benefits, and brokers are better equipped – not displaced – with digital technology to serve and support small and mid-sized employers.

By adopting benefit marketplaces, brokers can help employers build benefit packages with quotes, select insurance and non-insurance ancillary and voluntary products, manage choices, ensure compliance, assist with enrollment, and provide ongoing support – all transparently and conveniently with a single technology platform. Brokers also have better tools to help employers manage change and increase the engagement of employees in their benefits, which companies in hCentive’s survey indicated is a challenge. Effective methods of engagement depend on demographics and communications. Agents can help educate employees on coverage, out-of-pocket expenses, tax implications, and other critical plan features with more intuitive technology tools built into benefit marketplaces.

The employee benefit landscape is changing rapidly. Brokers have an opportunity to thrive – not just survive – by getting ahead of the curve and investing in the right benefit marketplace technology to offer clients better value and service on benefits and ancillaries, decision-support, enrollment, and administration in one integrated experience. Employers and employees are eager to embrace the new health insurance and benefit paradigm that means more control, choice and flexibility at a lower cost. ★

Courtney Nicholson is director of Relationship Management for hCentive Inc. For more information, email courtney.nicholson@hcentive.com.

The Private Exchange Market: Will Employees Demand More Choices in Benefits?

by ERIC HELMAN

Recently, McKinsey and Avalere Health have released studies forecasting the decline in the number of insurance carrier options on the public exchanges. What are the implications for the growth rate of private exchanges? At first glance, the answer is pretty simple. Public exchanges and private exchanges have very little in common. Public exchanges are composed of individual insurance products and include access to government subsidies for 85% of the enrollees. Private exchanges are composed of group insurance products and include access to government subsidies (in the form of pre-tax premiums) for 100% of the enrollees.

THE VALUE OF PRIVATE EXCHANGES

As has been widely reported, many insurance carriers are racking up significant losses on the public exchanges. As a result, many carriers have announced exiting markets for 2017. According to a recent study conducted by McKinsey, up to 17% of Americans will only have one choice of health carrier in the public exchanges in 2017. Luckily, California citizens will still have access to multiple carriers in most ar-

reas, but the year-over-year comparison shows a significant reduction in choice, even for Californians.

Choice is one of the key features of the exchange concept – whether public or private. Some have said that the magic of private exchanges is that when you give employees more choice and increased visibility of what their employers are spending, they are happier with their benefit choices even if they buy fewer benefits. So, in a sense, private exchanges may be enabling greater cost shifting to employees while mitigating employee dissatisfaction. Industries that are rapidly moving to private exchanges are heavily populated by employers who are struggling to control their compensation costs in the post Obamacare era. Industries such as multi-site retail, staffing, and non-union manufacturing are dominating.

BALANCING COST AND CHOICE

So what does negative press about the public exchanges have to do with private exchanges? One could argue that the public exchanges have never been very popular. When healthcare.gov was first launched, there was negative press associated with the website and its

inability to handle the large number of visitors. Now, three years after the launch of the federal government's public exchange, the negative press seems to be centered around excessive price increases and reduced carrier participation. From year to year, employers must balance cost containment, regulatory compliance, and employee retention as they direct their benefit strategies. If the exchange concept fails to deliver on the cost containment front, will it deter employers from considering a private exchange strategy? If reduced choice is the inevitable outcome of the exchange concept, will employers shy away from private exchanges because of their inability to consistently deliver the right balance of employee satisfaction and cost containment?

It has been said that we are in the third inning of the development of private exchanges and there is a bright and long future ahead. But, as many veterans of the benefits industry know, this industry has a long history of shiny penny solutions that fade as rapidly as they appear. For now, it appears that private and public exchanges will continue to co-exist, peacefully or not. In the end, the market will dictate what choices employees have about their benefit options. Given the forecast for healthcare inflation, we can ill afford to lose any solution that promises to control costs and improve employee satisfaction. ★

Eric Helman is chief strategy officer for Hodges-Mace, where he is responsible for creating, communicating, executing, and sustaining strategic initiatives. He brings a vast background in innovative employee benefits administration and enrollment processes to the thriving Atlanta-based employee benefits firm. For more information, visit erichelman@hodgesmace.com.



Managing the Dark Side of Customization With Technology

by JOE DONLAN



Most people say that customization is a good thing. Who wouldn't choose to get exactly what they want instead of settling for close enough? But in the post-Affordable Care Act era, brokers, employers, and employees have to contend with many variables. Take the growth of private exchanges. More than 6 million employees enrolled in health plans through private exchanges last year, and as many as 40 million will enroll in private exchange plans by 2018.

With a private exchange, workers can purchase medical, dental, and vision coverage from several participating insurance companies. Private health exchanges are more flexible and customizable than are public exchanges. They are the latest expression of healthcare consumerism, allowing employees to address health and financial security needs holistically.

Employers and brokers need to view offering benefits as a way to provide a custom-made portfolio of products with many options to suit many needs. The portfolio approach allows employees to customize the products that

You can add immeasurable value by offering technology that helps an employee make not just a choice, but the best choice for their situation and their family.

are best for them and their families. Voluntary and other types of non-traditional benefits can help employees enhance their health and financial security. These benefits may include gym memberships, wellness programs, tuition reimbursement, transit benefits, and flex time or telecommuting.

AUTOMATING BENEFIT ADMINISTRATION

It begins with a solid foundation that helps employers manage benefit administration more effectively. For some employers, it means managing benefits for the current, active, full-time employee roster. For others, it includes part-timers, retirees, or other groups. They may have different benefit requirements as mandated by the government or the employer's preferences.

Regardless of the number of separate groups, it has to be easy for employers to add, delete, and move members if they go from one group to another. Employers need tools that help them do the following:

- Manage ACA compliance.
- Track eligibility and enrollment.
- Get alerts to changes that could affect coverage including life events,

such as a wedding or birth.

- Integrate their payroll system.
- Handle the thousands of other tasks associated with offering health and financial benefits.

You will gain a very distinct competitive advantage by offering clients the technology to simplify and automate a mountain of benefit administration tasks in the face of dozens of insurance options. Employers have a lot at stake in terms of health insurance, and the landscape has become exponentially more complex. You can be a partner who shifts most of that burden off of the employer and turns the conversation from cost to service.

HELPING MEMBERS MAKE INFORMED CHOICES

The good news in the post-ACA world is that consumers don't have to settle for health plans for the masses. With private exchanges, they can choose a plan that suits their needs. While a plan may not be tailor-made, it's not off the rack either. The downside is that most people have little understanding of the nuances of health insurance so it may be difficult to find that perfect plan. That can lead to a lot of employee dissatisfaction, whether it's having a huge out-of-pocket expense for an emergency department visit or discovering that a doctor's visit wasn't covered.

One of the most important services you can offer is to help employees make the right choice from among dozens of health and ancillary options, which is not really feasible with the traditional call center. That's where consumer-facing technology can create a huge competitive advantage – the kind that keeps accounts happy and secure.

Rather than laying out the options with a static comparison chart, you can offer technology that walks employees through the decision-making process. The technology should tell employees which options are available, and what those options mean in simple language or even in multiple languages.

The technology should help lead the employee to an informed decision based on the answers to questions, such as age, family status, health history, risk tolerance, etc. It should take a holistic look at the employee's situ-



ation and make recommendations for additional products when appropriate.

For example, if the employee selects a high deductible health plan to keep premium costs down, the technology should recommend accident and/or catastrophic illness coverage to guard against an unforeseen event that could bring financial ruin. The technology can recommend adding vision care if the employee wears glasses or works in a job where eye strain is common. A life event, such as a wedding or birth might prompt a recommendation for life insurance.

You can add immeasurable value by offering technology that helps an employee make not just a choice, but the best choice for their situation and their family. After all, happy, healthy employees make for a stable and productive workforce.

Of course, the technology must also make it easier for employees to manage their benefits throughout the year. The technology should be able to answer most questions so employees can manage the bulk of their benefits themselves, and only need to contact the call center for particularly complex issues. Helpful tools win member praise while making you harder to replace. These tools include assistance with searching for the lowest-cost option for prescription medications or approved money-

saving alternative therapies.

The key is to make these tools as easy to use as shopping online. Consumer expectations for information availability, ease-of-use, and service have been set by their experiences with online retailers. If the technology you offer doesn't match that experience, it will be dismissed. With the right technology, you can distinguish your organization while increasing client acquisition and retention.

END THE CONFUSION

Health insurance is already complex and intimidating for most people. Offering the right technology can help your clients do a better job of delivering benefits to employees, and helping them find the health plan and other benefits that suit them best. You can also help them take full advantage of the benefits they do select, creating greater satisfaction and goodwill between employers and their employees. It is important for brokers to transform their benefit offerings to align better with what employees value – benefits that reflect the interconnections among their careers, their employers, and their personal lives. ★

Joe Donlan is senior vice president of the Broker Segment at Connecture Inc. For more information, visit www.connecture.com.

In California

WHAT'S AHEAD IN CALIFORNIA'S HEALTH INSURANCE MARKET

Don't wait to start working with your groups to enroll in a health plan. This was a central message of the recent Warner Fest event in Woodland Hills, Calif. John Nelson, CEO of Warner Pacific said, "Do as much as you can early on even though they [your clients] are waiting until December. Take their information. Put it on our system. You may not have complete data, but at least you have done 90% of the work." An estimated 80% of group plans renew coverage beginning December 1 or January 1. Brent Hitchings Warner Pacific director of Sales for Northern California said, "Get your cases in as soon as you can. Last year, the business that came in prior to the effective date was done far sooner with less pain than business that came in after the effective date. It is not too early to get business in. In fact, we expect to start getting business for December 1 in September. Larger groups are not going to tolerate waiting until January for approval on a case. Prepare them that this is a unique time for the industry and this is what they are facing." This sentiment is echoed by Chris Patton vice president of Sales for Covered California for Small Business. In his upcoming article in the September issue of California Broker magazine, he says, "Blue Shield is touting lower rates for small groups renewing prior to the fourth quarter, which could save them up to 10%. Insurance providers, such as Health Net, are offering incentives to agents who conduct client renewals from July through October. Moving up open enrollment might allow companies with 50 or more full-time equivalent employees a chance to secure third quarter 2016 rates prior to 2017 increases."

The New Small Groups

Neil Crosby, director of sales for Warner Pacific said that the new definition of small groups as one to 100 last January has been terrifying for employers. "There are so many employers in the mid market/large group segment that are now considered small group. They are not sure what to do, which creates a huge opportunity for you. There are 33,000 mid market/large group em-

ployers that have to move to small group. That represents 33 million employees. Fourteen percent of California's entire workforce has to move from their large group/mid market plan into a small group plan. The average group is 70 employees and the average premium is \$600 monthly. If you multiply that by 2.3 million employees, about \$1.4 billion of monthly premium has to move to small group. That is \$69 million in agent compensation that has to move from large group to small group. When those mid market/large groups were classified as large groups, you may not have been able to use a general agent or sometimes you had to share your commission. You don't have to do that anymore. You get full compensation."

Crosby added that these groups will no longer enjoy flexible plan designs or be able to negotiate their rates to soften rate increases. Also, some carriers are no longer offering a dedicated account manager for these groups. But the biggest issue is with composite rates. Nelson said that these larger groups have completely different expectations. "They have a sense of entitlement, which is deserved. They are larger cases and pay a lot of premium. They are used to calling us on the same number for claims and billing issues and getting an answer right away. To take this block of business and move them over to small group, which is very much cookie cutter, will be a culture shock in addition to the rating methodology changes."

Medicare

Speakers also outlined the benefits of selling to the senior market and unveiled Warner Pacific's new services to brokers who sell Medicare. Nelson outlined how Medicare products could offer a lifeline to brokers who sell in the problematic individual market. In some states, carriers are withdrawing from individual markets or not paying commissions for new business. Outside of California, there have been huge rate increases. "That will get fixed and our customers will be fine, but it is going to take some time and some regulation. In the meantime, if you are used to selling individual, I would look into the senior

products because that is very important for insurance companies."

Hitchings said, "When you have a market like seniors that insurance companies deem very important, and very much of a profitable business line, it is really great for agents. They are in competition for your time and services." Hitchings gave the following reasons to get into Medicare product sales:

Demographics: "California is the number one state with people who are 65 or older. About 1,000 people age into Medicare each day. The is a huge opportunity for all of us."

The retention rate: "You will, on average, retain 85% of your clients in the senior marketplace. The average policy life is six years."

The commissions: "Carriers need us to get market share. They are competing for your business." "Medical supplement commissions are upwards of 20% the first year with a 10% renewal. Medicare Advantage compensation for a new entrant is \$400 for the first year and \$200 per renewal on a per-member basis."

Your book of business: "You need to be a resource for your group customer. You want to retain clients who are aging out of individual, small group, and large group plans. Protect your book of business." "The 51 to 100 market is moving to member-level rating. Who is the most impacted? Those about to turn 65. When they get this big of a rate increase, they are likely to turn to their employers for solutions. Employers will ask you to help with solutions for their employees."

As part of its senior product launch, Warner Pacific will be introducing a portfolio of carriers in California and nationwide with a full complement of senior products along with support and training.

The ACA

As for a repeal or replacement of the ACA, Crosby said, "The ACA is here to stay. There is just too many positive provisions in the law that have helped your clients to the point that there is no way that it will be repealed and replaced." Nelson added that agencies keep adding provisions and requirements to the ACA.

The Small Group Market

Nelson said that competition in the small group market is alive and well. "The Small group market is solid. It is not going the same way as the individual market. It is a great market to be involved in. Competition is alive and well," he said.

PETERSEN HIRES REGIONAL VP

Valencia-based Petersen International Underwriters hired Lori Boggs as a regional vice president of the firm. Boggs was previously the national account management vice president of MetLife Insurance Co., and she is one of the country's foremost disability insurance experts. Boggs will be home-based on the East Coast. For more information, call 800-345-8816, email piu@piu.org, or visit piu.org.

PROFITS PLUMMET FOR LEADING HEALTH PLANS

The majority of leading health plans saw reduced profitability in the first the quarter of 2016 compared to the first quarter of 2015. On one hand, health plans saw increased enrollment in their exchange business. But the ACA also brought financial losses. Affecting profitability was the volatility in financial markets, investment losses, costs associated with pending acquisitions, and health reform regulations, according to a report by Mark Farrah Associates (MFA). MFA reviewed enrollment and financial trends of Aetna, Cigna, Health Care Service Corporation (HCSC), Humana, Kaiser Permanente, UnitedHealth Group, and Anthem. Membership increased 1.3% for the leading U.S. health insurance plans from the first quarter of 2015 to the first quarter of 2016. Enrollment increased 1.4% in administrative services only (ASO) funding arrangements and 1.2% in fully insured business.

In the first quarter of 2016, four of the seven companies had enrollment gains in the fully insured business, ASO, government segments, and commercial markets. However, several top health plans had membership losses and less than favorable profit margins. As of March 31, 2016, enrollment figures were mixed in risk-based and self-funded medical membership.

UnitedHealth, Aetna, Humana, Anthem and Cigna will be pulling back

exchange business for 2017. An inadequate risk-pool program is one reason why many health plans are withdrawing from the exchanges. UnitedHealth maintained its leading position with 39.4 million members, a 1.73 million increase from 37.7 million in first quarter 2015. United's risk-based enrollment increased 7.5% to 17.6 million members, compared to 16.4 million in first quarter prior year. UnitedHealth earned \$1.8 billion on total revenues of \$35.9 billion. The company's profit margin declined 11%. A reason for the decline is public exchange performance.

The company says that enrollment increases are due to growth in services to mid-sized employers, small groups, and individuals. Exchange participation contributed to membership growth for UnitedHealth in the first quarter of 2016. But the company reported financial losses from exchange business and announced that it will exit nearly all exchanges in 2017.

Anthem reported a 3.5% profit margin in the first quarter of 2016, down from 4.5% a year ago. The company cited increased losses from investment activities, costs incurred associated with the pending acquisition of Cigna, and higher interest expense. Anthem had the second largest gains in the first quarter of 2016 with an increased enrollment of about 1.07 million medical members. As of March 31, 2016, Anthem's medical membership grew 3%, from the first quarter of 2015. Much of Anthem's membership growth was due to increases in its Medicaid, Blue Card, and National Accounts businesses. Anthem included about 5.6 million BlueCard members in enrollment reporting. (There may be some double counting due to sharing national accounts across Blue plans).

Cigna had a 3% increase in medical members in the first quarter of 2016. Cigna attributes its enrollment increase to strong sales in the middle market, select segments, and government business. Kaiser Permanente's revenues increased over 5% from the first quarter of 2015. It had the most significant decrease in profit. Operating margin declined to 3.1%, from 6.8% in the first quarter of 2015. Kai-

ser had a decrease in net income, partly due to volatility in financial markets and investment losses. But the company remains confident with growing operating revenues and enrollment. Kaiser had 5.6% enrollment growth in the first quarter of 2016, reflecting a 5.7% increase in risk-based membership. The company attributes much of that enrollment growth to its individual, group, and government segments. Kaiser remains focused on acquisitions and key business investments to sustain customer retention and grow membership.

Humana, Aetna, and HCSC saw membership declines. Humana had a 4.1% decline in total risk-based membership and 4.3% decline in ASO enrollment. This was due, partly, to the loss of individual commercial members. There has been lower membership in non-ACA compliant business. Membership losses can also be blamed on discontinued ACA-compliant plans and the loss of some large group ASO accounts. In the first quarter 2016, Aetna's medical membership was about 22.4 million, reflecting a decrease of 805,000 members from the prior year. The company attributed its membership losses to its commercial insured products, which were offset partially by growth in government business. Aetna had a 4.3% decline in profit margin, from 5.3% in first quarter 2015 to 5.1% in the first quarter of 2016, also partially attributed to pressure on its exchange business. For more information, visit www.markfarrah.com.

PROPOSED SILVER EXCHANGE PREMIUMS JUMP

An analysis from Avalere finds that 2017 premium increases vary significantly by geography, but they are going up for the most part. Likely contributors to premium growth are lower-than-expected exchange enrollment, higher enrollee healthcare costs, and the end of the reinsurance and risk corridor programs, according to the report. Proposed premium increases average 11%, but consumers can select lower cost Silver plans, which are set to increase only 8%. "Exchange consumers have been active shoppers who tend to re-shop

each year and gravitate toward lower premium plans. As in previous years, many enrollees will limit their premium increases by selecting plans with smaller premium increases and taking advantage of premium subsidies," said Caroline Pearson, senior vice president at Avalere.

While rates can come down dramatically between proposed and final filings, Avalere analysts say premium increases in 2017 appear to be higher than in 2016. An Avalere analysis conducted at a similar point in the rate filing process in 2016 found much smaller proposed premium increases.

Proposed premiums for the lowest cost Silver plans in Connecticut, D.C., and Oregon are up more than 15%. But proposed premiums are down for the lowest cost Silver plans in Washington State and Rhode Island. Rhode Island is the only state with lower average proposed Silver premiums for 2017. Rhode Island's highest cost issuers are exiting the market for 2017, and one of the remaining issuers is offering lower cost options.

ERS AFTER OBAMACARE: MORE PATIENTS, FEWER ON-CALL SPECIALISTS

The average monthly emergency department visit increased 5.7% in Illinois after the implementation of the Affordable Care Act (ACA) while population numbers remained flat. While visits to emergency departments in Massachusetts climbed steadily from 2005 to 2014, the availability of on-call specialists declined significantly (surgeons, psychiatrists and other specialists). The results of two state studies were published online in *Annals of Emergency Medicine*. A large post-ACA increase in Medicaid visits and a modest increase in privately insured visits outpaced a large reduction in emergency department visits by uninsured patients. "We still don't know if these results represent longer-term changes in health services use or a temporary spike in emergency department use due to pent up demand," said Scott Dresden, MD, MS, of Northwestern University Feinberg School of Medicine. "During the studied period, the burden of increasing patient volume was clear. The proportion of

emergency departments reporting any patients primarily cared for in the hallway climbed from 70% to 89%. That is obviously far from ideal and is indicative of an increasingly taxed emergency medical care system," said Jason Sanders, MD, PhD, of the Department of Emergency Medicine at Massachusetts General Hospital in Boston.

Financial Planning

CLOSING THE GAP BETWEEN 401(K) OFFERINGS AND WORKERS' NEEDS



A study by Transamerica identifies opportunities to increase retirement security through the workplace. For example, offering automatic enrollment is one of the most effective ways to increase plan participation. Seventy-one percent of workers like the idea of automatic enrollment, but only 21% of 401(k) plan sponsors offer it. Forty-one percent of large companies offer automatic enrollment as do 28% of small companies, and 18% of micro companies. Automatic escalation increases a participant's contributions to the plan, typically by 1%, annually or when they get a pay raise. Sixty-seven percent of workers like the idea of auto escalation, but only 28% of plan sponsors offer it.

The study calls for more education on the consequences of taking loans and hardship withdrawals from 401(k)s and IRAs. Limiting the number of allowable loans may also help. Twenty-three percent of workers have taken a loan and/or early withdrawal from their plan. The most common reasons are that the employee doesn't have emergency savings, lacks insurance coverage, or needs to pay off debt.

Two out of three workers say they don't know as much as they should about retirement investing. But many would be motivated to learn more if it

was easier to understand. Personalizing retirement tools and education can get more people engaged. For example, workers in their 20s are almost twice as likely as workers in their 60s to find mobile apps to be helpful in managing their retirement accounts.

The survey illustrates a tremendous opportunity for employers to help employees balance work and care giving responsibilities. Just 58% of employers offer flexible work schedules to accommodate care giving. Only 47% allow their employees to take unpaid leave under the Family and Medical Leave Act (FMLA), which suggests that they are unfamiliar with the law. Given increases in longevity and the high cost of assisted living and long-term care, many workers will become unpaid family caregivers while balancing their careers, raising children, and saving for retirement. Lost work hours can limit the caregivers' retirement security.

Many workers envision a transition into retirement starting with part-time work. But only 25% of employers give pre-retirees the option of shifting to part-time work. Eighty-nine percent of workers say that a retirement plan is an important workplace benefit. Ninety percent of workers who are offered a 401(k) or similar plan are saving for retirement compared to just 48% of workers who are not offered a plan. Plan sponsorship rates are relatively high with room to grow. Seventy-four percent of companies offer a 401(k) or similar employee-funded plan (SEP, SIMPLE). That includes 92% of large companies (500+ employees), 89% of small companies (100 to 499 employees), and 72% of micro companies (10 to 99 employees).

Only 38% of employers extend plan eligibility to part-time workers. "By addressing the coverage gap among part-time workers, policymakers can help improve the retirement outlook of women and lower-income workers who are more likely than other demographic segments to work part-time," said Catherine Collinson, president of TCRS and Transamerica Institute. Collinson said that the solutions are well within reach, yet some may require public policy reforms, assistance from employers, and industry innovations. ★

HSA's: An Overlooked Retirement Benefit

by BARBARA DELANEY

In 2003, health savings accounts (HSA) were created as part of the Medicare Prescription Drug, Improvement, and Modernization Act. This act provides a tax-free program for the funding of medical expenses that are not covered by health insurance. An HSA is a savings account in which the funds are exclusively used to pay for qualified medical expenses. Over time the funds grow, with no time limit on when they must be used. In contrast, with a flexible spending account, the funds must be used or lost at the end of each 12 month period. Theoretically, the funds could accumulate for decades and be used during retirement when medical expenses tend to soar.

Since 2003, HSAs have steadily become part of the mainstream in two distinct ways. As an employer, an HSA can be a health insurance benefit in combination with offering employees a high deductible health insurance plan (HDHP). Individuals and/or families can also purchase high deductible insurance plans to save on medical insurance premiums. They can then open their own HSA account. In fact, within the next year or two, a majority of large companies, as well as many small businesses, are likely to offer an HSA. Unlike traditional health insurance plans, HSAs require full funding

of medical expenses by the insured via the HDHP until the deductible is met. Once that limit is met, the HDHP usu-

"Medicare, as it stands today, leaves many financial gaps that must be absorbed by the patient, which can be challenging if living on a fixed income. Adding more potential stress is the trend of rapidly rising medical costs for senior citizens."

ally covers 100% of eligible medical expenses. Deductibles can range from \$2,600 to \$13,100 for a family and \$1,300 to \$6,550 for an individual (single). At first glance, that level of out-of-pocket seems pretty scary to the average person versus paying a small co-pay, but there is so much more to HSAs.

Before we share the retirement benefits of an HSA, let's quickly explore how they operate. Employees contribute to the health savings account; that contribution is tax exempt up to an annual predefined limit. The current tax-free employee contribution limit is \$6,750 for a family and \$3,400 for an individual, plus an additional \$1,000 for employees over 55 to help them catch up. Moreover, many employers contribute to each employee's account. The average annual employer contribution is approximately \$900 for a family or \$500 for an individual. However, some companies contribute as much as \$2,000 to their employee's account.

Once an HSA is established, like a 401k, the account remains with the employee regardless of job changes. Employees and employers also enjoy the immediate benefit of significantly lower monthly premiums. Another instantaneous financial advantage is that most HDHPs cover preventative care at 100%, no copay is required; due to this, more people are receiving preventative care than those using traditional insurance.

At this point, everything we've covered is fairly common knowledge regarding the health coverage HSAs provide. But a really important benefit of an HSA, which often goes unnoticed, is the retirement benefit. Yes, HSAs

offer a tremendous retirement benefit; now let's examine why. Traditional health insurance premiums can be expensive. By offering an HDHP, premiums are decreased – often drastically. This allows employees to divert the money they are saving on the lower premium into their HSA (and businesses can redirect their portion of the premium savings to other areas that may be in need of funding). The funds' employees contribute to their HSA are exempt from taxes up to the limit established by the Internal Revenue Service (IRS). Investment gains made from the HSA are also tax-free. If you are lucky enough to live in a state that follows the IRS guidelines, additional savings are made against state income tax liability. All of this is a great opportunity to save and build funds, but there is still more. Because most HDHPs will pay 100% for preventative care, money is saved on copayments for things like immunizations, screenings, and routine physical exams, which provide another source for HSA contributions. Finally, many employers will contribute to money their employee's account, that contribution is tax-free for both entities.

Our example family of four doesn't have any serious health issues, but has a baby and young child. Immunizations and routine physicals are covered at 100%. In theory, they would have zero out-of-pocket medical expenses over the course of a year. There will be enough in the HSA to cover the maximum family deductible in two years. Five years after establishment, the HSA is worth over \$30,000 and in 10 years over \$62,000. After 30 years, when it's time to retire, the account

could have grown to \$185,000+.

Unfortunately, Medicare, as it stands today, leaves many financial gaps that must be absorbed by the patient, which can be challenging if living on a fixed income. Adding more potential stress is the trend of rapidly rising medical costs for senior citizens. With the financial backing of an HSA, the high cost of health care for the elderly is dramatically mitigated. This allows those seniors to use their other

welfare benefits consultants on health insurance options, thus aren't always presented with the entire picture. The retirement benefit isn't discussed because health insurance consultants typically aren't experts on the investment side and are not licensed to discuss them, so the conversation never is brought up. Since C-level executives don't think of HSAs as an investment, they are not using as much investment strategy, unlike pension plans or 401ks.

Lastly, but of equal importance, is the introduction to employees. When employees are introduced to an HSA, the focus is often solely on the health insurance portion. This means that the average employee has no idea about the retirement benefit, thus is less likely to actively participate in growing the account. However, as HSAs continue to make their way into mainstream health insurance offerings, and more educational materials are created, there

is no doubt, the retirement benefits will no longer be overlooked. ★

Barbara Delaney is principal & founder of Stone-Street Advisor Group

FAMILY OF FOUR WITH AN ANNUAL INCOME OF \$120,000

- \$1,200 – annual savings on lower premium
- \$300 – savings on preventative care
- \$1,687 – savings on federal income tax
- \$500 – FICA
- \$2,000 – employer contribution
- \$558 – gain on investment – 10%
- \$6,245 – saved and/or made in one year

retirement income for living expenses and life enrichment experiences, such as travel or lavishly spending on grandchildren. Based on this data, there is no doubt that an HSA can be a bonanza for retirees.

Once the data is crunched, it's fair to wonder why such an outstanding retirement benefit is so often ignored. There are a few probable reasons. To begin with, even though HSAs are over a decade old they've just recently begun to become inclusive of mainstream employer-based health insurance offerings. Benefit professionals and human resource executives tend to work with health and

CAN YOUR HEALTH SAVINGS ACCOUNT (HSA) DOUBLE AS A RETIREMENT PLAN?

Health Savings Accounts Offer Account Holders Tax Benefits 401(k)s Cannot

by MORGAN ANTHONY AND PETER RYAN

When people begin to think about building their nest eggs for retirement, many do not think of their health plan as the first place to look. According to a survey of middle-class American's conducted in 2014, second to paying for monthly bills and expenses, their top two concerns are paying off medical expenses and saving for retirement. However, 34% of Americans don't contribute to a traditional retirement savings plan at all – a trend that is leading to many Americans not properly preparing for retirement.

The average available retirement funds for households with people 65-74 years old is \$148,000, which is shocking considering that a 65-year-old couple retiring in 2015 are estimated to need nearly \$245,000 to cover medical bills alone. This evidence supports that people are trying their best to save for these costs, yet are falling short of their goals when only contributing to a 401(k), which begs the question, are their other alternative to your average retirement savings vehicle?

For many the answer to that question is a health savings account (HSA). A dollar placed in a health savings account to be used for eligible medical expenses goes much further than one placed in a 401(k), due to the triple tax benefit of an HSA. Money goes into an HSA free of federal, state and FICA taxes and accrues tax-free interest. However, unlike a 401(k), account

holders can use and withdraw HSA funds tax-free as well, as long as the funds are used for eligible medical expenses.

Unlike the use-it-or-lose-it nature of a Flexible Spending Account, HSA funds roll over year after year. This allows account holders to accumulate interest and invest their HSA funds to grow their balances tax-free, benefiting from the advantage of dividends from competitive interest rates and mutual fund options. On top of this, an HSA comes with far fewer distribution restrictions than a 401(k).

MAKING YOUR HSA DOLLARS WORK FOR YOU

The main advantage of an HSA is that it offers people the flexibility to follow a strategy that can help save a substantial amount of money. Although an HSA must be paired with a high-deductible health plan, which some people may say is a drawback and not a feature, this actually provides people with more savings opportunities than traditional plans.

When operating under an HDHP, health insurance premiums are drastically lower than other health insurance options, while the deductible is high, studies show that the average out-of-pocket cost for an individual is \$810 a year, proving that most people don't ever reach their out-of-pocket maximum.

When you are hands on with your health savings strategy, you can begin to experience some very real savings

on health care expenses, which you can then contribute tax-free up to the maximum contribution limit every year to your HSA, to grow inside of your account and connected investment account. Depending on rate of return, someone saving the maximum for 20 years with an HSA with no withdrawals could expect to accumulate between \$118,000 and \$193,000.

When it comes to preparing for the future, an HSA allows people the flexibility that many other retirement vehicles do not, making an HSA an integral part of any person's retirement strategy. ★

Morgan Anthony is well versed in all aspects of the HSA, Morgan has toured the country speaking publicly on the benefits of Consumer Directed Health Plans (CDHP). A NAHU ACA Healthcare Reform Certified Professional, CDHP Specialist and carrier of a life and health license, Morgan has spent the past 8 years managing a successful sales team and client base in the industry throughout Southern California, Arizona and sections of the North East. This included but was not limited to large group sales, mid-market, GA business, municipalities, small group, direct sales and a variety of manufacturing firms.

Peter Ryan is an HSA expert certified Marketing Writer at SelectAccount, a top 10 HSA administrator. Peter covers industry trends, account holder education, and consumer engagement. A Graduate of the University of Minnesota-Duluth with a degree in Marketing Communications, he previously worked as a freelance copy writer in the health care field. <https://www.selectaccount.com/contact-us/>

WHAT WORKERS WANT FROM THEIR Vision Benefits



by JOHN THORP

Times have probably never been tougher on the eyes – and better for vision benefits. With nonstop use of digital device and longer work hours, employees are feeling the strain on their eyes, which translates to more interest in their vision coverage. For the first time in seven year history of Transitions Optical's Employee Perceptions of Vision Benefits survey, the vision benefit is now the second-most popular election in terms of enrollment, tied with dental. Eight out of 10 employees who are offered the vision benefit choose to enroll. This trend is likely to continue since Millennials use vision benefits more than any other demographic group.

Benefit brokers need to recommend the right vision benefit package to keep interest and enrollment high. This means understanding what employees want in a vision plan and showing how their vision offering delivers.

We've found that employees prioritize three main areas when evaluating the vision benefit.

1. Does it cover my eye health needs?
2. Does it allow me to select the doctor and eye wear I want?
3. Does it meet the needs of my entire family (if dependent coverage is involved)?

Let's take a deeper look at employee needs in these three areas.

KEEPING EYE HEALTH COVERED

Employees know that their vision is important and they want to protect it. In fact, Americans rank blindness among the top four "worst things that could happen to you" alongside cancer, Alzheimer's disease and HIV/AIDS, according to a recent poll by Prevent Blindness America. Because of this fear, employees want to know that they are getting the eye care they need to safeguard their vision.

There's a common misconception that the main purpose of a routine eye exam is to provide an eyeglass prescription. While checking vision certainly is important and plays a critical role in an employee's day-to-day productivity, there is more to an eye exam than what meets the eye. Comprehensive eye exams allow the eye doctor to see inside the eye to watch for signs of eye disease. Early detection can help avoid vision loss, or at least reduce its severity. Glaucoma is a good example. According to Prevent Blindness America, 2.7 million people had glaucoma in 2010, with 5.5 million projected to suffer

from the eye ailment by 2050. The disease starts gradually by reducing side vision. Most people don't notice it right away because they simply turn their heads to see better. By the time they notice on their own, significant vision is often lost, and they can't get it back. Simple tests conducted during an eye exam can catch this disease early, and an eye drop treatment regimen can keep it from getting worse.

The eyes are also an important window to health. Eye doctors can detect chronic diseases through a comprehensive eye exam, such as diabetes and other health conditions, including high blood pressure, high cholesterol, multiple sclerosis and arthritis. With chronic diseases like diabetes, early detection by the eye doctor can prompt employees to work with their primary care physicians to get their disease under control sooner. This can create better long-term health and huge long-term health care cost savings for the employer. Average medical expenditures for people with diagnosed diabetes are 2.3 times higher than they would be without diabetes, according to the American Diabetes Assn.

PROVIDING NETWORK AND EYEWEAR OPTIONS EMPLOYEES NEED AND WANT

It is extremely important to make sure that employees have access to a wide range of network doctors and eyewear choices like frame styles and premium lens options. It can help your vision benefit offering stand out from the rest. Nine out of 10 employees say that, when selecting their vision plans, premium lens options are important, such as anti-reflective lenses, photochromic lenses and impact-resistant lenses, according to the Transitions Optical survey. This makes sense given added the visual stresses on today’s workers, and the need for lens features that help alleviate eyestrain and fatigue.

Today’s employees live in an increasingly fast-paced and digital world. They’re spending more time in front of computers, laptops, and digital devices. While taking breaks to rest their eyes can help, the vast majority of employees admit that they spend at least part of their work breaks on their digital devices!

Employees are feeling the effects and they’re interested in solutions. The majority of employees complain about light or glare at work. One in three is bothered by light or glare reflected off of a computer screen or digital device.

The silver lining is that the right lens options can address vision problems, such as eyestrain and fatigue. Anti-reflective lenses can help to decrease glare, especially when reflected off of digital surfaces indoors. Photochromic lenses automatically darken and adjust their level of tint to help people see better and more comfortably outdoors. Transitions photochromic lenses also offer 100% UV protection outdoors and help protect from harmful blue light indoors and out. Recommending vision plans that offer these kinds of network choices and lens options is a great way to stand out and show that you are in tune with the visual needs of today’s workers.

FOCUS ON FAMILY: SPOTLIGHT ON THE VISUAL NEEDS OF CHILDREN

Parents make up a large portion of the workforce – and many parents put their children’s needs ahead of their

own. In fact, more parents saved for their children’s college education than for their own retirement, according to a 2016 survey by T.RowePrice. Because of this, kids’ coverage should be highlighted within vision packages.

It’s important for eye care to begin early since children have unique eye health needs. Undiagnosed vision problems can hurt a child’s school performance. Kids with vision problems can have trouble playing sports, and can suffer from low self-esteem. Kids may not know that they’re having trouble seeing or may not be able to communicate that they are having issues. To avoid these problems, it’s important for all kids to get regular eye exams, especially before they start a new school year.

The right eyewear is also important for children. Kids need even more eyewear protection since they are more active than adults. The majority of vision plans cover impact-resistant lenses for children so their lenses don’t shatter if they are dropped or hit. Brokers should also talk about why sun protection is so important since kids spend more time outdoors and their eyes are more vulnerable to damage from UV rays. Over time, cumulative UV exposure can contribute to serious eye diseases, like cataract and macular degeneration.

Many parents are concerned about protection from harmful blue light. They know it is emitted from digital devices, which their kids are using at higher rates than ever. But the sun emits 100 times the intensity of electronic devices and screens, so a product like Transitions lenses, which filters harmful blue light indoors and out, can help address parents’ concerns on this topic as well. Most importantly, by highlighting a feature like this and by providing education, brokers help raise awareness of the importance of sun protection. This will help encourage more kids to protect their eyes now – and for the future.

PRESENTING THE BEST PACKAGE

Recommending the right vision package to meet employee interest is only half of the equation. Brokers also need to present these options smartly to employers and provide education and

tools to sell in the benefit to employees. Below are some tips for presenting vision benefits to your clients.

1. Reinforce the return-on-investment (ROI). It never hurts to highlight value. Two Healthy Sight Calculators are available through the Transitions Healthy Sight Working for You program – a version you can share with HR professionals (HealthySightWorkingForYou.org/Calculator) so they can learn how much they can save through a premium vision plan, and one they can share with their employees to get them thinking more about their vision (HealthySightCalculator.org).
2. Provide Education. Many companies and vision plans have resources for brokers to educate clients on the importance of the vision benefit.
3. Follow Up. Education should go beyond the enrollment period. Providing year-round education to employees on what’s covered in their vision benefit helps remind them of the value the their employer is offering. This reminder also increases the chance that they’ll take advantage of their plans and get the eye care and eyewear they need to feel their best and do their best on the job.

Benefit brokers can maintain employer and employee satisfaction with their vision plans by staying in tune with employees’ visual needs and interests, recommending vision benefits that address these needs, and providing education along the way. ★

John Thorp is president of Anthem Blue Cross’ Vision business. Previously, Thorp worked at EyeMed Vision Care, from finance and underwriting to account Management. He also held finance and acquisition positions at Omnicare and Philips Medical Systems. Thorp earned his Bachelor of Arts degree in Economics from Denison University, and his Master of Business Administration degree from Xavier University.

The Anthem Whole Health Connection initiative promotes early detection, prevention, management of chronic conditions. When an eye doctor diagnoses a member with an illness, the member and their primary care doctor get alerts when they miss vital maintenance and preventative care. In addition, Anthem’s Blue View Vision plans fully cover Transitions lenses for kids under 19. Anthem offers a number of educational fliers for brokers on eye health and ways to avoid certain eye conditions.

LARGE GROUP HEALTH: View from the Top

(Continued from Page 12)

of human resources that touch benefits, and a further conversation regarding risk tolerance to determine if the employer is a candidate for forms of self-insurance. An agent needs to be well versed in technology tools, and have good knowledge of the differences in carrier benefits and administrative options.

Tony Lee, Dickerson Employee Benefits: Many successful agents are re-branding themselves as business consultants offering total solutions that affect the client's bottom line in a more direct way. In addition, more agents are structuring their businesses to consult on specific products and/or industries. They are making effective use of technology, including marketing automation and social media, which helps them focus on personalized, targeted messaging. Channels, such as blogging and online video marketing, provide platforms for agents to share their expertise and position themselves as sought-after authoritative resources in specific business sectors. This, in turn, leads to more qualified referrals from business leaders seeking consultants who truly understand their industries and the challenges they face.

David L. Fear, Sr., Shepler & Fear: Most large employers use the services of consultants or very sophisticated brokers to address short-term and long-term trends. Successful agents should prepare to provide more of a consultative approach to how they work with large employers. Since a high percentage of large employers self-fund their health care benefits, producers must understand stop loss insurers, third party administrators, and a host of plan design issues including consumer directed, wellness, and flexible benefit programs. Demonstrating knowledge is not enough to gain a large employer's business. Successful producers have a strong background in the regulatory area (both state and federal) and are very versed in human resource issues. What

worked 10 years ago is not enough to gain their business today. A producer must be one step ahead. The consultative approach takes a great deal of fact finding, survey reviews, and an understanding of the employer's short and long term employee benefit objectives. Don't assume that there is one simple answer to their challenges. Clearly identify each employer's concerns and challenges, and then develop a game plan that will result in their buy-in.

"A producer must be one step ahead. The consultative approach takes a great deal of fact finding, survey reviews, and an understanding of the employer's short and long term employee benefit objectives. Don't assume that there is one simple answer to their challenges."

Rob Carnaroli, Sutter Health Plus: To be successful, carriers will need to keep pace with market demands. As HDHPs become more popular, consumers want robust transparency tools to understand the underlying costs of health care. Carriers that can deliver these tools and other convenient, online solutions will be attractive options to large groups that are shopping for coverage.

Marc McGinnis, Word & Brown General Agency:

1. Provide additional options, such as trusts that only certain brokers have access to.
2. Present alternate carrier options, such as broker-friendly PEOs, self-funding, medical-bridge plans.
3. Present trusts all brokers have access

to, such as ACEC.

4. Tweak plan benefits in a way in which it saves the group money without impacting the plans overall. For example adding higher prescription deductibles etc.
5. Assist with compliance resources; compliance is at the center of everything we do in healthcare (ERISA, Section 125, COBRA, ACA, HIPAA)
6. Ask what is the group's story. What are their pain points and needs as well as their network, their pharmacy, and their costs?
7. Work closely with your GA rep or carrier rep; they are the local experts.
8. Some large groups are adding cross-border healthcare to their health benefit offering to support their Spanish-speaking employees and as a cost-saving strategy. Some brokers are leading with cross-border as a strategy to counter continued premium inflation of the traditional U.S. carriers and show added value to their clients.
9. The employer saves when the employees select lower cost options.
10. Choices! Know your carrier options:
 - a. Certain carriers have been very successful with their HMO deductible products lately as employers are looking to save on premium costs while not compromising the network size or flat copays for doctor's visits, urgent care, pharmacy, etc.
 - b. Eighty-five percent of Health Net's groups are buying Enhanced Choice where a large group can choose up to six plans (similar to popular Choice models in the market) – with defined contribution. They are also finding success with their HSA plans since integrating with Health Equity. Most groups are offering multiple HMO network. Health Net is working on a 51-100 benefit eligible but 101+ FTE product – no one else has this – for groups caught between the two markets. More to follow on this as HN finalizes their product. ★

Leila Morris is senior editor of California Broker Magazine.

An Urgent Need for Change in Long-Term Care Options

(Continued from Page 6)

consider, such as offering subsidized premiums, or establishing more generous Medicaid eligibility standards. It could include a sliding scale cost-sharing option for Medicaid covered long-term care services for those who are most likely to spend down to Medicaid. A study done for the SCAN Foundation shows no connection between those who might spend down to Medicaid and the ability to pay a long-term care insurance premiums. Since the beginning of the Partnership program in California, the majority of people who exhausted their long-term care insurance benefits (598) did not access Medicaid benefits – most likely because they were not eligible.

Work should also be done to determine how various income groups can fund long-term care insurance coverage and premiums over their lifetime, similar to the way that gaps in retirement needs are used to plan for retirement income.

The old saying is that, “Something is better than nothing.” But, that’s not true if the “something” is not meaningful. Paying premiums for a small amount of benefits or for short durations is a waste of scarce resources for a person who would otherwise become eligible for Medicaid. It also takes advantage of a near poor individual’s lack of knowledge about the social safety net.

If people are buying small amounts of coverage because they can’t qualify for larger amounts, it may be because the premiums for the “something” they are buying are underfunded and unsustainable. With only a few months of coverage a person might pay almost as much in premiums as they could collect in benefits. In addition, compared to 360 days of coverage, 365 days of coverage must meet with much more stringent requirements and have far more consumer protections. Premiums and coverage should be consistent with a person’s ability to pay premiums over time, and the resources that would be at risk when long-term care expenses occur. Benefits and premiums should be tailored to a buyer’s needs and resources.

Reducing regulatory barriers should not mean stripped down or inferior coverage, less consumer protection, or less regulatory oversight. Inflation protection, for instance, is critical in a benefit that’s not expected to be used for decades. It is indefensible to sell someone a benefit that loses value every year premiums are paid.

Disclosures are important for consumers to understand what they are buying and how a product works. A disclosure shouldn’t only contain information that protects the insurer. A disclosure shouldn’t replace regulatory requirements and relieve a regulator of prohibiting or preventing some future action by the insurer or its agent.

Long-term care benefits require careful regulatory scrutiny and oversight, particularly when multiple types of benefits are combined, when benefits have different values or payouts depending on how they are used, or when there are different options for using coverage.

Pricing assumptions and large rate increases in legacy products offer a clear example of the need for careful review and understanding of products. Unlike death, the need for care is not clear-cut, which lends itself to interpretation and disputes.

Adding a long-term care benefit to a Medigap policy would add cost to an existing premium and put two benefits at risk when premiums increase. A long-term care benefit would drive up a Medigap premium in direct proportion to the claims experience. In the past, some Medigaps contained a mandatory home care benefit, which was seldom used and later removed. People didn’t understand how to use the benefit. They confused it with Medicare’s very strict benefit for care delivered at home. Considerable caution is warranted when considering adding cost to existing coverage.

Consumer education cannot become a marketing stream for insurers. Consumers need information about services, providers, local resources, and how to utilize their financial resources to pay for care and benefits.

They need to know that Area Agencies on Aging can provide information about local resources and services, including the new federal Independence at Home Demonstration and the State Health Insurance Assistance Program (SHIP) for help with understanding long-term care insurance.

The type of long-term care and the cost of care are usually not known before needing care. With some advance knowledge and planning, families could be better prepared for a long-term care event, even when they can’t afford to buy insurance to cover that cost.

Public benefits could be retooled to help with the need for care. Also important public and private market ideas could be combined to fashion national approaches to financing care.

Changing or removing existing requirements or prohibitions will require careful examination. Regulatory requirements are usually the result of something that needed to be changed or prohibited. For example, marketing standards and disclosures came about because of consumer complaints and press reports. Rate increases have been a once-a-decade problem for the past 30 years – each one worse than the last.

New products must have sound economic value while not pricing people out of coverage as they age. They must provide a meaningful benefit at the time of claim. It must be clearly explained to consumers when products are allowed to use attained age rates, restrict coverage to a defined term, increase rates on a scheduled basis, impose vesting periods, or include a cash value. New product issuers must explain how consumers or their benefits will be affected by whatever combination of choices they make for coverage now or in the future. ★

Bonnie Burns is a training and policy specialist and consultant for California Health Advocates and a NAIC Consumer Representative. California Health Advocates provides training and education on Medicare and long-term care. For more information, visit <http://cahealthadvocates.org/bonnie-burns-speaks-to-long-term-care-innovations-naic-public-hearing>.

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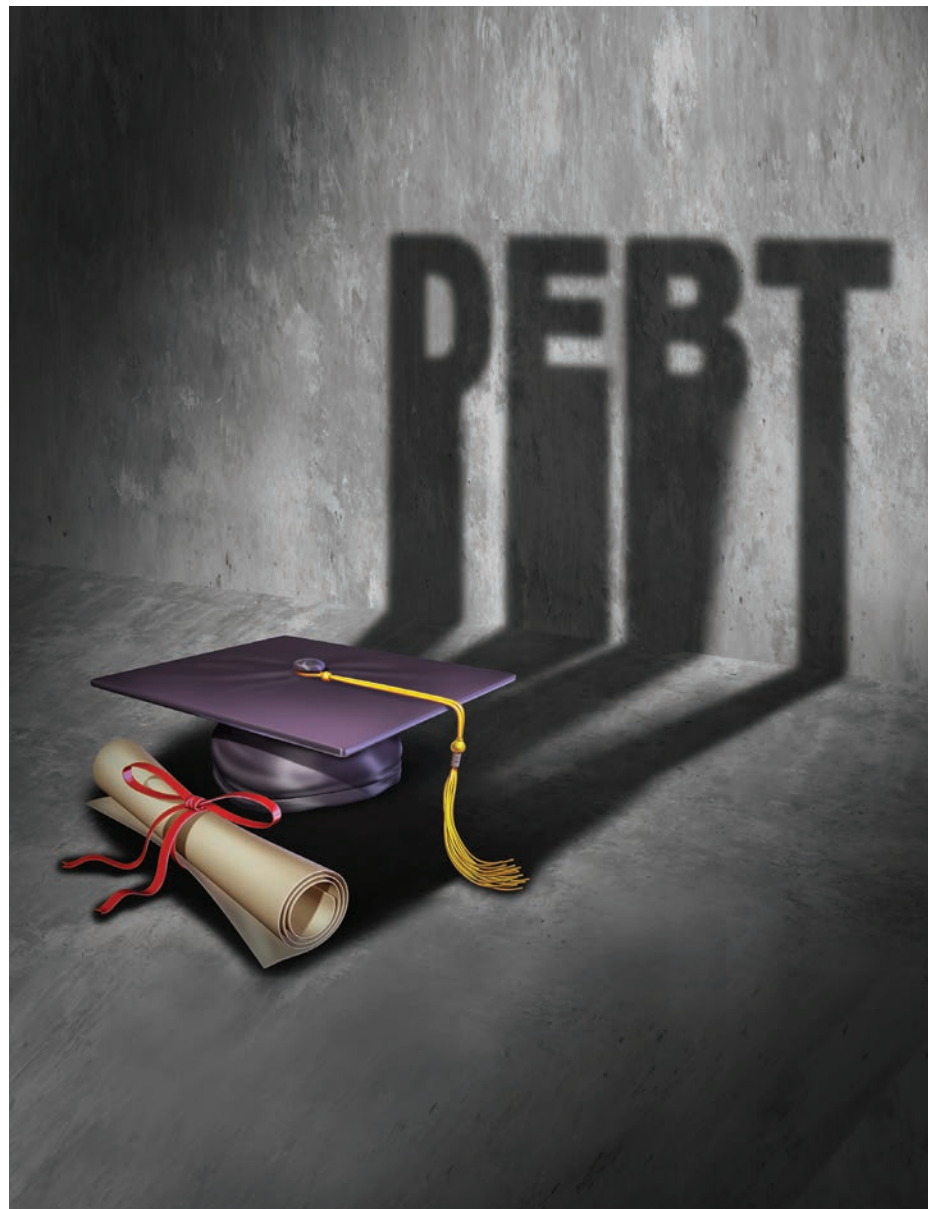
Protecting Your Family From Student Loan Debt with Life Insurance

by BRENDAN FARRELLY

There's nothing quite as exciting as getting accepted to college, but funding that education with a student loan is a much less enjoyable experience. Taking out a student loan is a huge decision and comes with potentially devastating consequences if the proper precautions are not taken before signing on the dotted line. Have you ever thought about who might be responsible for your debt should the unspeakable occur?

Take the story of the Mason family, who were thrust into the news in 2014. Five years earlier, Steve and Darnelle Mason's 27-year-old daughter Lisa died suddenly of liver failure, according to a CNN Money report. Steve and Darnelle immediately took Lisa's three children into their home, but quickly realized that the financial burden stemming from Lisa's passing would be difficult. Lisa had left behind roughly \$100,000 in private student loan debt, which Steve and Darnelle were now responsible for repaying. Saddled with extra expenses of taking care of Lisa's kids, the couple immediately fell behind on their payments, and the balance on the loans doubled to more than \$200,000 after accounting for late penalties and interest.

With the help of hundreds of micro donors through a GoFundMe page, the Mason family was able to reach their funding goal and has gotten their financial lives on track. But the years of financial heartache could have been avoided had Lisa taken out a life insurance policy.



Life insurance is usually the last thing on your mind when sending a loved one to college. But if you are co-signing on their student loan, life insurance could bail you out of financial devastation should you unexpectedly take responsibility for a mountain of debt. "I absolutely wish we had [a life insurance] policy," Steve Mason told CNN Money. "We would not have struggled financially for the past four years with these private student loans, and our credit would not have been ruined."

THE EVER GROWING MOUNTAIN OF STUDENT DEBT

The Masons were not the first, and surely will not be the last family to be financially burdened with the student debt left behind by a loved one. The national student loan debt today is at a frightening level of about \$1.3 trillion. College tuition is rising, and total student loan debt is growing at a rate of \$2,726 every second, according to MarketWatch. In the second quarter of 2015, the average monthly student loan payment was \$351 for those between 20 and 30 years of age, according to the Federal Reserve Bank of New York's Consumer Credit Panel data. Would you be able to seamlessly cover such a monthly payment if the unspeakable happened tomorrow?

The good news is that student loans from government programs, which represent a majority of total outstanding student debt in the U.S., are forgivable in the event of an unexpected death. But for loans from a bank or other private lender, the outstanding balance must be repaid in full by the loan's co-signers under the agreed upon terms.

LIFE INSURANCE TO THE RESCUE

This is where a life insurance policy can come to the rescue. With the co-signer of a student loan as the beneficiary of the child's life insurance policy, the payout can be used to repay the debt in the event of an unexpected death. After the sudden passing of a loved one, relieving yourself of the financial burden they leave behind can be an enormous help. It may mean you won't have to deal with pesky debt collectors, your credit will not be ruined,

and your retirement funds will remain intact. Not only can you potentially rely on the policy to provide coverage for payments, but also, life insurance is very affordable.

There are financial advisors that specialize in setting up appropriate life insurance policies for college graduates who are saddled with student debt. Advisors typically look at the outstanding balance on the loan, the student's assets, and projected future income to determine the adequate amount of necessary coverage. If you are interested in finding out for yourself, there are countless life insurance calculators to help figure out what policy is best for you. If all goes according to plan, and the student is able to repay their student loan, they'll also be left with a nice cash value supplemental whole life insurance plan, which is a great asset to have.

COVER ALL THE BASES WITH DISABILITY INSURANCE

Another overlooked scenario – and one that is usually more common than a young adult dying – is a debilitating injury that forces you to step away from the workforce. A life insurance benefit will not kick in unless a policyholder has died, so what do you do when you are injured or too sick to work and thus repay your student loans? Disability insurance is a viable option to protect your assets and credit against such an unfortunate situation. Depending on your profession, financial advisors can help find discounts or guaranteed standard issue programs to help mitigate the costs when purchasing a disability insurance policy.

A TOUGH CONVERSATION

At such an exciting time in your child's life, discussing a topic as grim as life or disability insurance is probably the last thing on your mind. But the unexpected happens every day. It is better to be prepared for a rainy day. If you are a student headed to college or graduate school, think about who might take on your financial burden should something happen to you. If you are a parent sending you child away for the first time, protect yourself from potential financial ruin should the unspeakable happen to your loved one. ★

Brendan Farrelly is vice president of Trew Financial & Benefits Group. He is affiliated with Penn Mutual, locally known as Sterling Wealth Strategies, in La Jolla, CA. Brendan helps clients with prudent risk management techniques, and uses innovative software tools, including eMoney Advisor and LEAP. He graduated from San Diego State University with a degree in Economics with an emphasis in Finance in 2002. As a Certified Fund Specialist, he provides continuing education in several communities. He serves on the Board of Directors of ElderHelp of San Diego. He is also active in several national and local organizations. His personal interests include spending time with his family, playing soccer, and going snowboarding, surfing, golfing, and traveling. To reach him, email brendan_farrelly@trewgroup.com, or call 858-248-0319.

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A close-up, profile view of Nick Bavaro, a middle-aged man with dark hair, wearing a white shirt and a dark tie. The background is dark and out of focus.

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Nick Bavaro lives by his own advice: be a student of the industry, develop a strong work ethic, and be honest. This approach and his creativity create a sense of loyalty between Nick and his clients. It's a similar loyalty he's developed with Word & Brown, who he calls a "five tool player," a baseball term for someone who excels in all areas.

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