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OCTOBER 2017

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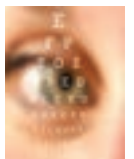
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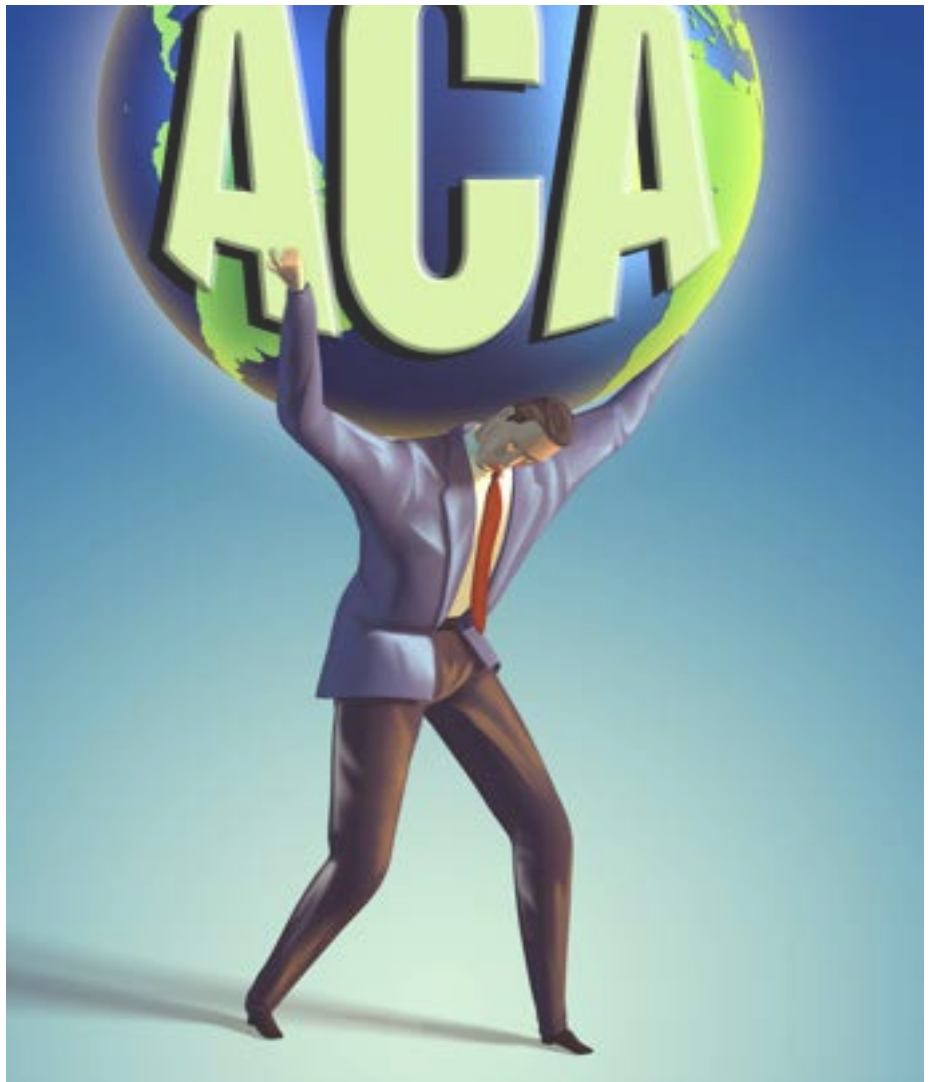
By Bill Winter and Jenny Riley

Are You Ready to Execute the ACA?

The U.S. Senate tried their best to kill it. At first it was repeal and replace the ACA (or “Obamacare” if you prefer). Next came repeal, followed closely by “skinny repeal” (whatever that means). Despite their efforts, the Senate failed to execute the ACA.

With the ACA still alive, where does that leave employers? Like it or not, employers have been left to execute the ACA.

To clarify, we don’t mean employers now have their chance to undo Obamacare. In fact, it’s just the opposite. The responsibilities of employers under the ACA remain unchanged. It’s entirely on the shoulders of ap-



plicable large employers – and their HR departments – to live, breathe, comply with, and execute the requirements of the ACA.

To be fair, we should mention employers aren’t the only ones preparing

to execute. The IRS is still in the mix. In recent days, the IRS has shown signs they too are ready for execution:

- The IRS issued draft versions of the 2017 reporting year forms 1094-C and 1095-C in late July. While re-

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vised instructions for the forms have not yet been released, the updated forms indicate very little change. There are no proposed changes to the 1095-C in the released draft. The 1094-C draft includes removal of Section 4980H Transition Relief. This change is to be expected as the transitional relief was, by its nature, a temporary relief for non-calendar year plans.

- The IRS released a memo recently confirming the business rules and technical requirements for electronic reporting into the AIR system for the

2017 reporting season.

- The IRS updated its Q&A page on the ACA in late April. The page includes the following detail regarding employer shared responsibility payments (i.e. penalties):

The IRS expects to inform employers of their potential liability for 2015 beginning in 2017.

While the notifications for the first year of required reporting took two years, beginning in 2018, the IRS expects it will begin informing employers of their potential liability within months of filing.

Taken together, these signals from the IRS are an important reminder the ACA remains very much alive for the coming reporting season. Everyone must prepare for the ACA reporting season. HR teams must be supported and everyone must deliver on ACA responsibilities. ★

Bill Winter is senior vice president, legal, and Jenny Riley is vice president, project management, for Atlanta-based Hodges-Mace, a provider of employee benefits communication and custom enrollment services to large U.S. employers. More information is available at www.hodgesmace.com.

SEPTEMBER 1, 2017

Company Name	Ratings			Product (Qual./Non-Qual.)	Type SPDA FPDA	Initial Interest	Guar. Period	Bailout Rate	Surrender Charges	Mkt. Val. (y/N)	Min. Contrib.	Comm. Street (May Vary)
	Bests	Fitch	S&P									
American Equity	A-	A-		ICC13 MYGA (Guarantee 5) (Q/NQ)	S	2.30%*	5 yr.	None	9%, 8, 7, 6, 5, 0	Yes	\$10,000 (Q) & \$10,000 (NQ)	3.00%, age 18-75 & 2.10%, age 76-80** 1.50% age 81-85**
				ICC13 MYGA (Guarantee 6) (Q/NQ)	S	2.45%*	6 yr.	None	9%, 8, 7, 6, 5, 4, 0	Yes	\$10,000 (Q) & \$10,000 (NQ)	3.00%, age 0-75 & 2.10% age 76-80** 1.50% age 81-85**
				ICC13 MYGA (Guarantee 7) (Q/NQ)	S	2.60%*	7 yr.	None	9%, 8, 7, 6, 5, 4, 3, 0	Yes	\$10,000 (Q) & \$10,000 (NQ)	3.00%, age 0-75 & 2.10%, age 76-80** 1.50% age 81-85**
*Effective 7/10/17. Current interest rates are subject to change on new issues. **Commission may vary by issue age and state. See Commission Schedule for details												
American General Life Insurance Companies	A	A+	A+	American Pathway Solutions MYG (*Guarantee Return of Premium) (Q/NQ)	S	2.40%* ^a 2.70%* ^b	5 yr.	None	8%, 8, 8, 7, 6, 5, 4, 3, 2, 1, 0	Yes	\$10,000 (Q&N)	1.5% age 0-75 .75% age 76-85
*CA Rates Effective 6/2/17. First year rate includes 1.50% interest bonus. a (less than \$100K) ; b (100K or more)												
American General Life Insurance Companies	A	A+	A+	American Pathway Fixed 5 Annuity	S	1.40%* ^a 2.40%* ^b	5 yr.	None	9%, 8%, 7%, 6%, 5%, 0%	No	\$5,000 (NQ) \$2,000 (Q)	2.00% age 0-85 1.00% age 86-90
*CA Rates Effective 8/7/17 Includes 1.15% 1st year bonus, 1.00% base rate subsequent years. a (less than \$100K) b (100K or more)												
(*Guarantee Return of Premium) (Q/NQ)												
American General Life Insurance Companies	A	A+	A+	American Pathway Fixed 7 Annuity	S	2.40%* ^a 3.40%* ^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 6/2/17. First year rate includes 4.0% bonus 1 st year. a (less than \$100K) b (100K or more)												
Great American Life	A	A+	A+	SecureGain 5 (Q/NQ)	S	2.05%	5 yrs.	N/A	9%, 8, 7, 6, 5	Yes	\$10,000	2.50% 18-80 (Q), 0-80 (NQ) 1.50% 81-89 (Q&NQ)
Effective 8/7/17 Includes .25% first-year bonus and is for purchase payments over \$100,000. Escalating five-year yield is 2.30%. For under \$100,000 first-year rate is 1.90%. Escalating rate five-year yield 2.15%												
Great American Life	A	A+	A+	SecureGain 7 (Q/NQ)	S	1.60%	7 yrs.	N/A	9%, 8, 7, 6, 5, 4, 3	Yes	\$10,000	3.50% 18-80 (Q), 0-80 (NQ) 1.50% 81-85 (Q&NQ)
Effective 8/7/17. Includes 1.00% first-year bonus and is for purchase payments over \$100,000. Escalating seven-year yield is 2.49%. For under \$100,000 first-year rate is 1.50%. Escalating rate seven-year yield 2.39%												
Great American Life	A	A+	A+	Secure American (Q/NQ)	S	1.55%*	1 yr.	N/A	9%, 8, 7, 6, 5, 4, 3	No	\$10,000	5.75% 0-70 4.65% 71-80 *Effective
8/7/17. Eff. yield is 2.57% based on 1.55% first year rate, 1.00% available portion of 10% annuitization bonus (available starting in contract year two) and 0.02% interest on available portion of bonus at the rate of 1.65%. Surrender value interest rate 1.55%. Accepts additional purchase payments in first three contract years. COM12255												
North American Co. for Life and Health	A+	A+	A+	Guarantee Choice II (Q/NQ)	S	2.25%* ^a 2.50%* ^b	5 yr.	None	10, 10, 9, 9, 8	Yes	\$2,000 (Q) \$10,000 (NQ)	2.00% (0-80) 1.50% (81-85) 1.00% (86-90)
*CA rates effective 8/8/17 - a (less than \$200K) b(200K or more)												
Reliance Standard	A+		A	Eleos-MVA	S	3.55%*	1 yr.	None	8%, 7, 6, 5, 4	Yes	\$10,000	3.25%**
*Effective 12/2/16. Includes 1.50% 1st yr. bonus. Min. guarantee is 1.00%. **Reduced 20% ages 76-80, and 40% ages 81-85												
Reliance Standard	A+		A	Apollo MVA (Q/NQ)	S	4.25%*	1 yr.	None	9%, 8, 7, 6, 5, 4, 2	Yes	\$5,000	4.00% to age 75**
Includes 2.00% 1st yr. bonus. Min. guarantee 1.00% **Reduced 20%, ages 76-80, and 40% ages 81-85. Effective 7/17												
Symetra Life, Inc.	A	A	A	Custom 7 (Q/NQ)	S	2.85%*	7 yrs.	N/A	8%, 8, 7, 7, 6, 5, 4, 0	No	\$10,000	Varies
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OPEN ENROLLMENT CHALLENGES

By BARBARA WEAVER LLOYD



Autumn is often seen as a “new beginning” as students, parents and teachers start the school year. For many benefit and HR professionals, these months also mark the launch of the annual benefits open enrollment season. Some 40 percent of California employers follow a calendar year renewal of their benefits with plan year changes effective on January 1. For HR professionals in these companies, September through December are dedicated to preparing and distributing employee notices, educating employees about program changes, and managing the enrollment process. Carefully crafted benefit programs can set an employer apart and attract a talented workforce. Many employees

rely on and appreciate the benefits offered by their employers. At the same time, the open enrollment experience can create angst for benefit managers when their company and employees are face-to-face with yet another increase in medical plan costs.

INCREASING HEALTHCARE COSTS POSE CHALLENGE

Rising healthcare costs are a persistent issue plaguing businesses across the country. In a recent survey of more than 4,000 organizations nationwide conducted by Arthur J. Gallagher & Co., a global insurance brokerage and risk management company, nearly half the respondents ranked increasing healthcare expenses among their top

operational challenges. Although they enjoy a slightly lower average cost of benefits than the national norm, California organizations are not immune to increasing healthcare spend. Employers in the Golden State face the same rate of expanding costs as the national average of 7 percent per year.

Fifty-four percent of California employers reported plans to increase their workforce over the next 24 months, creating conditions for fierce talent competition in a tight labor market. In this heated environment, companies will often entice the skilled workforce they need with richer benefits. For instance, many California companies are paying for a share of their employees’ plans that exceeds the national norm.



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Fully 38 percent cover the total cost of employee-only medical plans. Nationally, less than 25 percent offer this generous fully-paid coverage. As healthcare costs consume an increasing share of total compensation and put a dent in operating revenue, balancing the conflicting priorities of controlling healthcare costs and growing the workforce remains a struggle for many California employers.

RISING MEDICAL COSTS STRESS BUDGETS

As noted earlier, employers in California enjoy a lower than average benefits spend when compared to the U.S. as a whole. Nonetheless, rising medical costs continue to stress budgets and add increasing pressure to mitigate the impact on overall benefit expenses. Employers caught in this bind often resort to passing a portion of their healthcare cost increases on to their workforce in an attempt maintain a modicum of control. These increases can take many forms in California. For example, 61 percent of state employers indicate they have raised deductible and copay amounts, or plan to do so in the next two years. Likewise, 60 percent report they have already resorted to increasing the employee cost of the premium or expect to make this move in the next two years.

Much like the rest of the country, California's health insurance ecosystem is beginning to change as businesses seek enhanced cost controls. Traditionally, health maintenance organization (HMO) plans have been the favored approach to managing costs. However, the prevalence and popularity of these plans may be fading. Among California employers surveyed, 84 percent offer an HMO, versus 29 percent nationally. At the same time, just 61 percent of these organizations identified their HMO as the most popular plan among their workforce.

BEST-IN-CLASS EMPLOYERS EMBRACE INNOVATIVE COST-CONTROL METHODS

In addition to HMOs, other solutions are gaining traction in California. Some employers experience below-average healthcare cost increases and high employee-retention rates. Reviewing

the tactics used by these best-in-class companies reveals promising strategies. Unlike many organizations grappling with rapidly escalating costs, best-in-class employers are less inclined to shift healthcare increases to their employees. Instead, they embrace innovative and preemptive healthcare cost-control methods far more often than the norm. This holds true across industry sectors. For example, these top performers are more likely than most to:

- Introduce wellness and health risk-management programs in the workplace. Key to their success is the support and encouragement of the senior leadership teams.
- Move from fully-insured to self-funding of their health plan. This allows the hands-on management of their expenses versus holding a blanket insurance policy.
- Encourage employees to invest in their own medical spending by offering a consumer-driven health plan that couples a high-deductible plan with a health savings account.
- Offer on-site medical clinics.

As early adopters of benefit innovations, best-in-class employers across the U.S. lead the market with offerings such as onsite medical clinics and telemedicine. They are also at the forefront of providing medical cost-transparency tools, in keeping with the concept of creating smart consumers of medical care. When compared to the rest of the country, California employers lag behind in embracing these newer concepts. Despite the potential cost savings, smaller and midsize companies often do not have the resources or the staff to oversee the implementation of new tools for mitigating healthcare spend. However, with planning, many of these tactics can be implemented with minimal disruption for busy HR and benefit teams.

FINANCIAL WELLBEING AND RETIREMENT BENEFITS ARE ALSO GAINING TRACTION

Financial wellbeing and retirement benefits are also gaining recognition as crucial parts of an employee total wellbeing strategy. In particular, top employers realize that employees' financial stress can dampen their pro-

ductivity. Yet, fully gauging this measure of organizational health remains a challenge for most companies. While some 81 percent of California employers surveyed offer retirement plans, only 38 percent take steps to measure the retirement readiness of their employees.

Today's well-informed employers understand that a total compensation approach involves more than providing medical, dental and retirement plan benefits. Wellness programs, which can help control medical spend, continue to grow. However, only 33 percent of California employers report a company-sponsored wellness program compared to 41 percent in states across the U.S. The majority of local HR professionals recognize that promoting and improving employee health and wellbeing is a top priority for their organization. Yet, more than half say they do not have the staff or time to implement a program.

Today's tight labor market and the ensuing "talent wars," combined with climbing healthcare costs, will continue to lead to innovations in the employee benefits landscape. California employers are wise to create a holistic total compensation approach by researching new tactics, developing long-term benefit goals, and engaging their workforce more closely in the process. Continuing to do things the way they've always done simply won't work anymore. It's time to challenge the status quo. ★



Barbara Weaver Lloyd is area senior vice president, health & welfare consulting at Arthur J. Gallagher & Co. With more than 30 years of health and welfare consulting and brokerage industry experience,

Barbara is a recognized expert in health care benefit design and communication. Her consulting expertise covers a broad range of practices, including health and welfare, human capital, human resources consulting, and international benefits. In addition to her degree in mathematics and physics from the University of Washington, Barbara holds a teaching certificate and has participated and developed several well-known training and client service programs. A resident of Benicia, CA, Barbara also serves as an adjunct instructor of employee benefits at San Francisco State University. Barbara can be reached at: Barbara_WeaverLloyd@ajg.com

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WHAT YOU NEED TO KNOW ABOUT Medicare Supplement Plans

By DAVID GARCIA

Medicare Supplement plans have a reputation for offering seniors the best bang for their buck. At one point or another, many of you have come in contact with someone who is approaching 65 and paying a portion of an employer benefited premium or the full amount of an individual plan with a premium of \$1,000 or more a month. And that includes a deductible, coinsurance, network limitations and a high dollar out-of-pocket maximum. Once they reach 65, they'll have some of the richest medical benefits available today and will gain access to the national Medicare network of doctors and



Demanding clients?
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Narrowing networks?
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hospitals. Once they reach 65, they activate Part A and B of Medicare and can purchase a Medicare Supplement and a Part D plan for an average of \$300 a month

A Medicare Supplement Plan, also known as “Medigap,” fills in some of the gaps in Medicare Part A and Part B coverage, including deductibles, co-payments and coinsurance. All Medicare Supplement policies must follow federal and state laws designed to protect your client. Policies must be clearly identified as “Medicare Supplement insurance.” In most states, including California, Medicare Supplement insurance companies can only sell you a standardized Medicare Supplement policy identified by letters A through N. Each standardized Medicare Supplement policy must offer the same basic benefits, no matter which insurance company sells it.

Every Medicare Supplement policy sold in California by letter, offers the same benefits and shares the same network. A Plan F sold by carrier X in-

cludes the exact same benefits sold by carrier Y. The only difference is the premium amount. We can see that Plan F covers all those gaps when we look closely at the document from Medicare.gov, “2017 Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare.”

A Medicare Supplement plan will not provide coverage for services like vision and hearing care. Dental coverage is also not included with these plans. Prescription drug benefits are not included in Medicare Supplement plans. Beneficiaries who are looking for prescription drug coverage should consider enrolling in a Medicare Part D prescription drug plan.

Important Note: With the passage of H.R. 2 – the Medicare Access and CHIP Reauthorization Act of 2015, Medicare Supplement policies will no longer be able to cover the Part B deductible as part of their benefits beginning January 1, 2020, for newly eligible Medicare beneficiaries. That eliminates first dollar coverage plans. What does this mean to our plan selection?

- Plan F can still be sold after 2020 to individuals who are eligible prior to 2020.
- Prior eligibles can keep their existing policies (even those that include the Part B deductible).
- Newly eligibles will be able to elect Plans D and G in guarantee issue situations.
- Carriers will be able to offer a high deductible Plan G starting in 2020.

Every Medicare Supplement member gains access to the National Medicare network. Your client is no longer required to review the provider search tool on their carriers’ site, but can research Medicare.gov for a list of doctors, specialists and hospitals that accept Medicare in your area. Statistics show that 93 percent of primary care physicians in our nation accept Medicare. When your client accesses

care through a Medicare provider, that provider will submit the claim to Medicare. If the member has a Medicare supplement, Medicare will forward the processed claim to the Medicare supplement carrier to process accordingly. If the care is covered by Medicare, the carrier will pay all or part of the remaining claim based on the benefits of the Medicare supplement member’s plan.

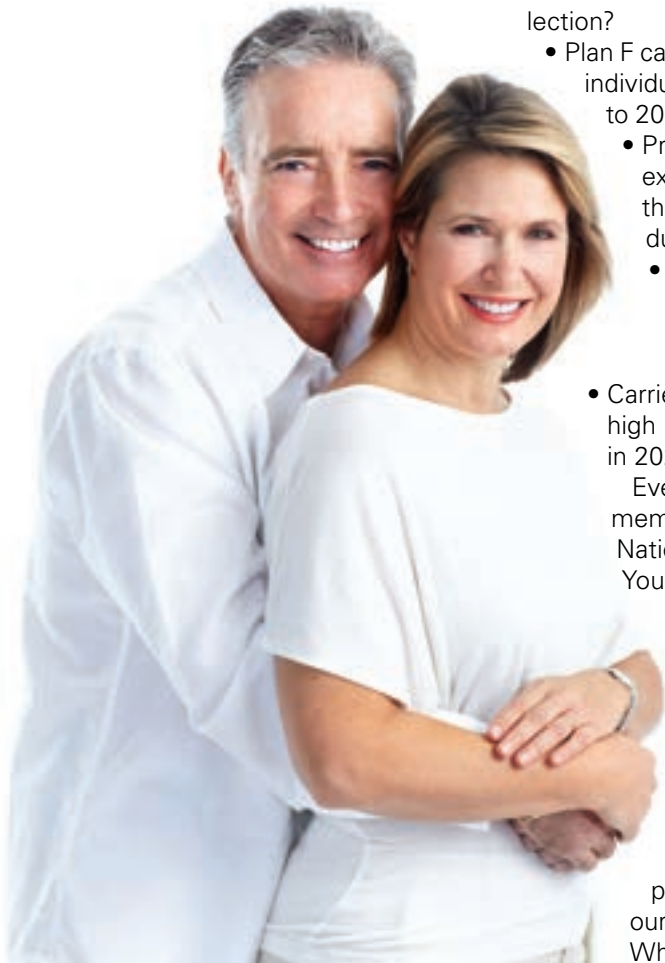
Beneficiaries may enroll in a Medicare Supplement plan in California during their six-month Medigap open enrollment period, beginning on the first day of the month that they are 65 or older and enrolled in Medicare Part B. During this time, beneficiaries aren’t subject to medical underwriting, which means that they can’t be charged higher premiums or denied coverage based solely on medical history or a current medical condition. However, medical underwriting guidelines will generally apply if a beneficiary adds or changes a Medicare Supplement plan at any other time.


One unique feature of a Medicare Supplement plan in California is the “birthday rule.” According to this rule, beneficiaries in the state can buy a new Medicare Supplement plan for 30 days following their birthday each year. The new plan must have equal or lesser coverage than their original plan. During this birthday period, Medicare beneficiaries are not subject to medical underwriting like they would be during other times of the year.

The first step in choosing a Medicare Supplement plan in California is to select the plan type that best meets your client’s medical needs. Once they have selected a plan type, they can choose their specific plan based on premium. This can vary somewhat between individual plans, since Medicare Supplement plans are offered by private insurance companies. ★



David Garcia is the Medicare sales specialist for Warner Pacific. He can be reached at (800) 801-2300 x279 or MedicareProducts@warnerpacific.com. Warner Pacific has secured contracts with top-ranked national Medicare carriers to offer a solution for selling Medicare Supplement, Medicare Advantage and Part D products.





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Are California Voters Ready for Single Payer?

Single Payer Legislation Stumbles Forward: CAHU Pushes Back

By JULI BROYLES

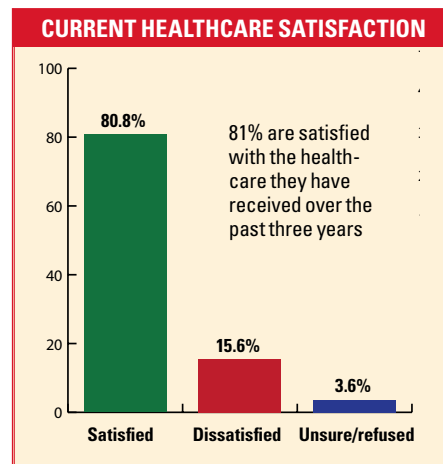
The California Association of Health Underwriters (CAHU), the state's largest association representing licensed health insurance agents, is preparing for action when it comes to proposals for universal single payer programs.

Senate Bill 562 sponsored by two nurse unions and carried by Senators Ricardo Lara (D-Bell Gardens) and Toni Atkins (D-San Diego), proposes a "Healthy California" universal single payer program. The bill mandates a government-run monopoly on all health care services in California. It eliminates all private and public health insurance programs, as well as taking over Medicare, MediCal, Long Term Care and Covered California.

The Senate Appropriations Committee's fiscal analysis indicated SB 562, as currently written, would cost taxpayers approximately \$400 billion per year, more than double the amount of the current \$183 billion state budget. The bill also attempts to take all federal healthcare dollars, including ones earmarked for Medicare and other public health programs. The huge price tag roughly translates to \$9,600 in new taxes per person in California. This doubles what the average California taxpayer pays today in personal income taxes.

CAHU commissioned a poll, performed by JW Wallin Opinion Research, in late April 2017 after universal single

payer language was added to SB 562. The results are very revealing. The poll respondents were more than 1,000 California male and female registered voters, all ethnic backgrounds, aged 18 to 65 and older, across all party lines, and located throughout California's many geographic regions. Polling questions were asked in English and Spanish.



The first question was general: "Thinking about timeliness, cost, quality, availability and accessibility of healthcare coverage to you and your family, how satisfied are you with the healthcare you have received over the past three years?"

The response was that a whopping 81 percent are satisfied with the healthcare they have received since the advent of the ACA (three years).

Sixteen percent were dissatisfied and 4 percent were unsure.

When respondents were asked whether they would support legislation proposing a universal single payer healthcare system, two-thirds of voters would oppose such a plan.

Importantly, when respondents learned of the \$400 billion in annual costs (per the Senate Appropriations Committee analysis) and no cost limits in the legislation, opposition to the universal single payer healthcare system increased to 73 percent.

Overall, the poll clearly showed that a strong majority of Californians oppose universal single payer healthcare when informed of associated costs.

Assembly Speaker Anthony Rendon, after holding SB 562 at the Assembly desk until January 2018 due to so many unanswered questions about funding and undefined scope, announced a series of hearings on health care reform this fall. No doubt that there will be plenty of conversations about universal single payer and other healthcare delivery systems.

Speaker Rendon has appointed a new Assembly Select Committee on Health Care Delivery Systems and Universal Coverage. "The committee's work will help fill the void of due diligence that should have been done on SB 562 or any universal health care bill that so profoundly affects so many Californians," said Rendon.

CAHU President Stephanie Berger has promised that CAHU will be at the hearings to testify and submit comments on the many problems a universal single payer system poses for California and to suggest ways to continue to improve and reduce costs in the current system under the ACA.

"SB 562 has a limitless price tag and no guarantee of better health care for anyone. Californians want the legislature to focus on positive changes to reduce the actual cost of delivering health care and health insurance in a partnership of public and private efforts – not create a gigantic new government-run bureaucracy," Berger said.

The Select Committee will be chaired by Dr. Joaquin Arambula (D-Fresno) and Dr. Jim Wood (D-Healdsburg). Assembly Members Autumn Burke (D-Inglewood), David Chiu (D-San Francisco) and Laura Friedman (D-Glendale), and Republicans Tom Lackey (R-Palmdale) and Marie Waldron (R-Escondido) will also serve on the committee.

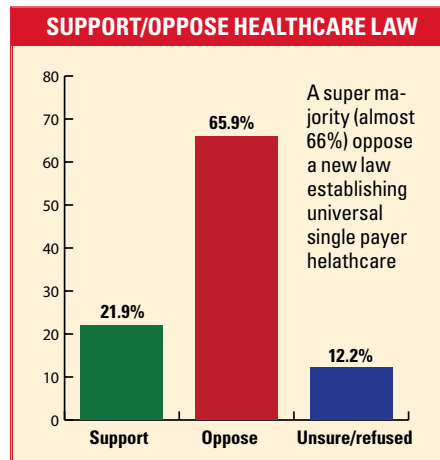
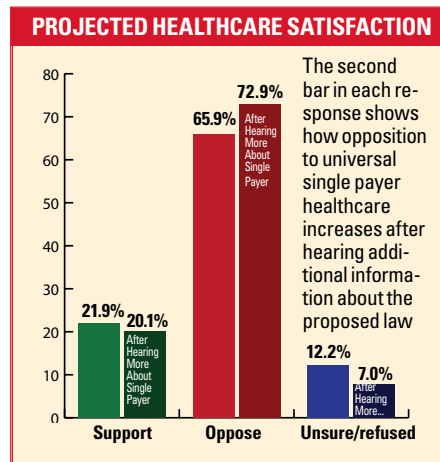
CAHU has communicated agent concerns regarding a universal health care system to the legislature throughout this year's legislative session. CAHU has noted for the record that in government-run health care systems, there is never enough money to provide timely care and the latest technology.

CAHU has also pointed out that all Californians will lose their current health plans, to be replaced by government-run health care, with benefits yet to be determined, to be serviced by a government-run entity populated with political appointees yet to be identified, including multiple appointments from the unions sponsoring the bill, to include provisions yet to be named, at a minimum cost of \$400 billion.

NEW BALLOT INITIATIVE FILED

Proponents for a universal single payer healthcare system are now operating on two fronts: legislation and ballot initiative. On August 18, 2017, a group named Enact Universal Healthcare for CA, Inc. filed for title and summary for a new proposed ballot initiative to amend California's Constitution, called the California Healthcare Roadblock Removal Act.

The initiative proposes to "establish a healthcare trust fund independent of the [state] General Fund." The key provisions of the proposed initiative state, "The purpose of the Healthy California Trust Fund is to fund, promote, support, and improve healthcare and healthcare-related goods, services, outcomes and education. Funds in the Healthy California Trust Fund may not be disbursed or loaned for any other purpose."



The proposed initiative goes on to say, "The State of California may transfer funds in its possession, including federal funds, into the Healthy California Trust Fund (...). Notwithstanding any other section of this Constitution, investment income derived from the Healthy California Trust Fund, and revenue sources dedicated to the Healthy California Trust Fund, including any tax, surtax, or fee, shall not be considered part of the General Fund, nor shall they be counted in or affected by any appropriations limit, revenue limit, or spending formula."

While no economic analysis of the

proposed ballot measure is available, the initiative is an attempt to get voters to override current constitutional limits on use of state and federal funds for activities unrelated to the basis for which the tax dollars are remitted. It also seems to indicate that the proponents have no idea of how taxes work at the state or federal level. On their website, the proponents talk about the estimated annual \$107 billion that SB 562 would have to collect in new gross receipts taxes from business and new sales taxes as "two tiny taxes" on all California businesses, employees and taxpayers of up to \$200 billion annually. For comparison purposes, California's entire state budget for 2017-2018 is \$173 billion.

Once the state Attorney General Xavier Becerra has provided approval to circulate the proposed initiative, proponents will need to collect nearly 600,000 signatures within 180 days to qualify the California Healthcare Roadblock Removal Act for the November 2018 ballot.

There is sure to be a lot more information on this controversial issue in coming months. No matter what, CAHU plans to be at the table presenting reasonable alternatives to ensure competitive public/private marketplace remains where healthcare consumers can purchase quality health coverage at an affordable price. ★



Juli Broyles has over 30 years of legislative and political experience at both the state and federal level. At California Advocates, Broyles uses her experience in labor law, benefits workers' compensation, family

leave, OSHA, unemployment insurance, small business, risk management, sales tax, and many other major public policy issues to aid California Advocates' business and association clients. Before that she was the director of Employee Relations and Small Business for the California Chamber of Commerce. She also served on the staff of a number of Congressional members, including past House Minority Whip Trent Lott. Broyles spent almost five years working for former Assemblyman Tom McClintock as legislative assistant, before joining the Chamber as a legislative advocate. She attended Loyola Marymount University and the University of San Diego, majoring in political science and international economics.

THE GROWTH AND EVOLUTION OF PRE-PAID LEGAL PLANS

By EMILY B. ROSE

Voluntary group legal plans, an innovative concept that became popular in the U.S. in the mid-1970s, have grown substantially over the last 45 years and are now one of the most sought-after voluntary benefits by large employer groups and employees alike.



According to a 2016 Willis Towers Watson Voluntary Benefits and Services Survey, employer-sponsored voluntary legal plans are offered by nearly 60 percent of employers. Employers seek to strike the balance between what employees want from their benefits and what employers can afford to offer. Employers are now better understanding what a legal plan is and how offering one can be a beneficial addition to their suite of benefits, for both them

and their employees.

Nearly 60 million Americans experience at least one legal event each year. Research conducted by Decision Analyst, Inc. for LegalShield in 2015 found that two out of three employees had to take off at least one day of work to deal with these legal issues. Unfortunately, employees who do not have access to a group legal plan through the workplace are more than likely dealing with legal issues on their own. In fact, 76 percent

of employees were hesitant to call a lawyer. Most employees find asking a friend, family member or colleague to recommend an attorney far more off-putting than asking for a doctor or dentist recommendation. Legal issues are private matters that people often resist sharing with others. As a result, employees rely on search engines or advertisements to find legal representation. This leads employees down an overwhelming path of choices, where

finding a qualified, affordable attorney is like finding a needle in a well-intentioned haystack.

On average, the hourly cost of an attorney is just under \$300. The Federal Reserve Report on Economic Well-being of U.S. Households in 2015 found that nearly half of the population say they either could not cover an emergency expense costing \$400, or would cover it by selling something or borrowing money. It's clear that in many cases an average U.S. employee can't afford to hire an attorney. Overwhelmed with choice and fear of legal fees, employees tend to ignore their legal issues entirely and choose not to stand up for their legal rights—or, worse, try to handle the matter on their own. In fact, a lot of common legal issues are reactive in nature and could be avoided with proper legal guidance.

In the past year, the most common legal matters that LegalShield's Provider Law Firms have handled include landlord/tenant issues, consumer/finance, estate planning, traffic and real estate matters. With voluntary group legal plans, participants become educated on their legal rights and feel empowered to take proactive steps toward protecting themselves and their families by getting their estate in order or having their lease or home purchase agreement reviewed before signing. This helps avoid any unforeseen pitfalls in the future.

When recommending a group legal plan to clients, it is important to remember that like other voluntary benefits, legal plans are not a commodity product. Asking the right questions to get to the core of the benefit value is paramount when brokers are reviewing benefits to ensure their client's employees are receiving a comprehensive solution for their needs.

A main component of any legal plan is the provider network of law firms and attorneys. Traditional legal plans have a large provider network, and these don't solve the overwhelming issue of choice or the requirement for a participant to first understand their legal matter be-



fore being able to determine the best lawyer for their unique needs. More modern network models provide a high-tech, white-gloved approach to service, taking the guesswork out of the process. The modern approach assigns a provider law firm to each participant, providing them a single point of contact, and allowing the carrier's provider management team to proactively manage the service provided to the participant.

Another improvement, found in the modern approach to providing legal service, is the recognition that legal matters do not arise solely between the hours of 9 and 5. Participants need the comfort and reassurance of knowing who to call and how to quickly access an attorney anytime they are faced with a legal matter. We have found that employees value a robust mobile app that provides a direct connection to their assigned law firm, including 24/7 emergency support and access to commonly used legal forms. This further informs and empowers them in exercising their legal rights. Having a law firm literally in the palm of their hand provides peace of mind and eliminates hesitation when facing a legal matter.

Technology is truly changing the way employees use their benefits, and participants are coming to expect mobile apps as a necessary product feature. As brokers continue to expand their business, voluntary benefit carriers continue to evolve their products to meet the growing demand and need.

As a company, LegalShield is seeing the demand for mobile access continue to grow, and our mobile accessibility is a common question brokers ask about our service capabilities. There is no doubt that brokers have contributed to the growth of voluntary benefits, especially legal plans, and clients continue to rely on them for guidance in the benefit decision making process. ★

Emily B. Rose is vice president of sales for LegalShield's business solutions division. She is responsible for strategic sales development, as well as strategy and sales growth, for LegalShield's broker and national accounts divisions. Emily has



nearly 15 years of experience in the group voluntary benefit space, specifically with group legal and identity theft protection plans, and is an industry expert in the worksite voluntary benefits arena.

ONE SIZE DOESN'T FIT ALL

By RODNEY MATTOS, VP, National Commercial Group

A SAVINGS OPPORTUNITY FOR COMPANIES BIG AND SMALL.

In a post-reform employee benefits world, it makes sense for companies to keep a close eye on benefits costs. There was a time when smaller employers had limited choices in the marketplace; they searched for the best insurance premiums and hoped their employees would be satisfied with the coverage.

Times have changed. It's now possible for companies to enjoy significant savings by choosing self-funded benefits plans. In some cases, self-funded dental insurance can save employers thousands of dollars a year, but there are some factors to consider before making the decision.

FULLY-INSURED VERSUS SELF-FUNDED: WHAT'S THE RIGHT CHOICE?

We're all familiar with the fully insured plan. An employer contracts with an insurance carrier to cover the dental benefits of its employees and their dependents, then pays the insurance premiums—regardless of whether the plan is used—in addition to premium taxes and other state-mandated fees.

By contrast, in a self-funded plan, the employer collects a premium from its employees and is responsible for paying their claims. Typically, the company hires a third party, like Premier Access, as their Administrative Services Only (ASO) partner to provide claims management, offer customer service to employees, and maintain the provider network. Self-insuring dental benefits may help a company create greater cash flow each month—money that can be invested in other areas of the business to foster growth.

Large corporations have provided self-funded benefits to their employees for years because they have the cash reserves to pay for claims. But more recently, health-care legislation has triggered fully insured premiums to increase to a level that smaller employers struggle to cover. As a result, more companies than ever before are choosing to self-fund their benefits.

WHAT ARE THE ADVANTAGES OF SELF-FUNDED DENTAL INSURANCE?

Self-funded dental insurance plans allow the employer a level of transparency they

won't find with fully insured benefits. When a company contracts with Premier Access to manage its self-funded plan, the employer receives detailed reports on claims (retaining their employees' privacy according to law), which allows the company to monitor costs and adjust funding levels where necessary. Knowing the true costs of dental benefits also gives an employer the freedom to design benefits plans that are best suited to its workforce.

Self-funded insurance plans are exempt from most state insurance regulations, which makes them a good option

Don't forget that Premier is, once again, number one in Ruark's report for the California and Nevada markets for Effective Network Discounts. That means our members pay less on average than members of other dental plans.¹

(For details, visit <http://bit.ly/Ruark-CA> and <http://bit.ly/Ruark-NV>.) "

for companies with employees in multiple states. And since the company only pays for claims that are filed, there's no cost to the employer if benefits aren't used.

WHAT BUSINESSES SHOULD CONSIDER SELF-FUNDED INSURANCE?

Companies with sufficient cash flow to pay out claims and a workforce with a good health risk profile can benefit the most from self-funded dental plans. Ideally, an employer should be comfortable with a certain amount of risk and be willing to implement a self-funded plan for at least a few years. This gives the company a comprehensive view of costs, savings, and overall effectiveness of the program.

WHY IS PREMIER ACCESS YOUR ASO PARTNER OF CHOICE?

As an ASO partner, Premier Access provides the same unparalleled service and attention to detail as we offer our fully-insured customers. All members benefit from our large national network, which includes dental providers that offer dis-

counts averaging 45.1 percent¹. Our in-network effective discount, which is the savings on each claim paid based on network discounts and member utilization, is greater than the industry average². This means that we recruit the dentists our members want to see, and our innovative plan designs continue to meet the needs of our customers.

ASO plans can be confusing, but we're here to guide you and your clients through the paperwork and plans. We work with each customer to create a custom benefits program, and we provide detailed claims reports on a schedule the customer sets—at a rate that's competitive.

Premier is recognized as a market-leading carrier of self-insured dental plans. Why? Because we save our customers 15 percent to 20 percent on dental costs each year by offering three key features: multi-year savings in administration fee, a more cost-efficient PPO network with deeper discounts, and additional savings with our Premier Choice Network.

We're excited about being on the leading edge of ancillary and self-funded employee benefits, and we're passionate about increasing value. Whether we're serving the State's largest employer or helping a small-business owner navigate the world of dental and vision benefits, Premier Access is dedicated to helping working Americans get the most value for their hard-earned money.

YOUR ASO PARTNER OF CHOICE.

Rodney Mattos has been with Premier Access Insurance Company since 1998, where he uses his 25 years of industry experience to integrate the operational efficiencies of parent company Guardian with the entrepreneurial spirit of Premier Access and Avēsis. For additional information, contact Rodney Mattos at rodney@premierlife.com.

¹ Based on all benefit designs sold in California and Nevada. Effective discounts are not normalized for differences in benefit mix among companies.
² Ibid.

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DISABILITY SURVEY'S IN: *DISABILITY MANAGEMENT PROGRAMS AND EMPLOYEE PRODUCTIVITY ARE LINKED*

By BRIAN KOST



Finding and onboarding new talent can be one of the most expensive and time-consuming tasks a company will undertake. Once an employer has onboarded an employee, the goal is that the person is productive. But what if that person has a health condition that is limiting them in the workplace?

Unfortunately, if the employee doesn't work with a manager or HR

representative on this issue, he or she may struggle to be productive and could eventually require a disability leave. This may seem unavoidable or just part of doing business, but it can be prevented with a simple solution: good disability management. Employers can work to keep their treasured employees and help them be more productive with effective disability management. And you can help.

HELPING EMPLOYEES STAY PRODUCTIVE

Recently, a survey conducted by The Standard examined the link between disability management and employee productivity. The results suggest that employees who receive support from their employer related to physical injuries, chronic conditions, mental health conditions or other similar disabilities are more likely to resume productive

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roles in the workplace. In fact, 93 percent of employees surveyed who received support for their health conditions stated they could do their job effectively.

As a broker, you can be the trusted advisor your clients need as they put together an effective disability management program. By providing important insights that help employers understand the need for disability management, best practices for implementing a successful program, and showcasing the resources available to provide support, you can help make sure your clients are doing everything possible to help their employees.

HOW ARE EMPLOYEES ASKING FOR HELP?

Before an employer can enact their disability management program, they must first understand how employees are asking for help — or why they aren't asking at all.

An employee with a health condition may be nervous about bringing it up at work. The Standard's survey found that 53 percent of employees were too scared to bring up their health condition with a supervisor, while 49 percent felt they were treated differently after speaking with their supervisor.

These findings highlight two important challenges: employees often feel they can't talk to their managers about their health conditions, and if they do, they feel labeled by their condition afterward. Feeling labeled by a medical condition is common for employees in a workplace, as they can feel that others — whether it's fellow coworkers or managers — believe they are unproductive or that accommodating them could be too costly.

Adding to the challenge, managers often are afraid to approach employees about potential disabling conditions. Compliance regulations have been developed to keep employees safe and their information private, but adversely, these important regulations can cause fear in HR and managers alike. This fear often leads employers to think they aren't supposed to know the details about an employee's condition, or that knowing certain things will cause them to be noncompliant. However, with appropriate manager training, regarding

the privacy protections of the Americans with Disabilities Amendments Act (ADA), asking questions is a vital first step for helping an employee with a medical condition at work.

As a broker, you can help your clients by recommending training and resources on disabilities in the workplace. Manager training, for example, can provide managers with the confidence to approach employees who may be struggling with a disability, while making them more approachable. Sharing resources and best practices related to having these tough conversations can help employers and employees better understand and feel comfortable with an employee's health situation, breaking down any fear-related barriers.

As a broker, you can help your clients by recommending training and resources on disabilities in the workplace.

HOW CAN EMPLOYERS PROVIDE SUPPORT?

Maybe the most surprising aspect of disability management is that accommodations don't have to be elaborate to help employees who are working through health conditions. Sometimes, simple adjustments are exactly what employees need to help boost productivity and mitigate their illness or injury.

The survey conducted by The Standard showed that, of the accommodations provided to help support employees' health conditions or disabilities at work, many were simple adjustments:

- 62 percent said they were provided with flexibility to attend appointments
- 58 percent were provided with schedule modifications
- 40 percent noted they received workstation modifications

Overall, these accommodations and support can help increase employee productivity. Forty two percent of employees surveyed felt they could perform their jobs extremely effectively after receiving support from their employer, while 50 percent of respondents agreed with the statement that they felt

more productive after receiving accommodations.

As a broker, you can remind employers of these accommodations for employees. You can also connect them with the valuable resources. For example, even with the simplest or most complex of workplace accommodations, disability carriers can help. Seventy seven percent of employees surveyed were helped by their employer's disability carrier.

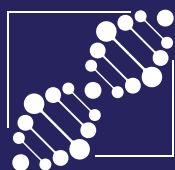
Some disability carriers have consultants who can work alongside an employer to coordinate an employee's return to work, including any accommodations. Consultants can also connect with the employee's medical team to discuss restrictions or limitations, and collaborate with the employer on a return-to-work plan and potential accommodation ideas. Disability consultants can rely on their own expertise and years of helping other employers with reasonable accommodations under the ADA Amendments Act to help guide an employer.

Help is available — to both an employee and employer. Your clients may not realize that one of the key ways to keep valuable employees productive is through an effective disability management program, and they don't have to execute on a disability management program alone. By providing resources, insights and best practices, you can be the trusted advisor that your clients need to put together a successful program. ★



Brian Kost is the senior program director for Standard Insurance Company's Workplace Possibilities program. He has been with The Standard since 2007 and was instrumental in creating the program that exists today. Brian implements and coordinates several on-site programs that allow employees to get back to work more quickly and maintain productivity, and he develops and maintains the metrics that monitor companies' success. With more than 30 years of experience, Brian is a results-driven manager with a successful track record of innovative program design in reducing absence, improving return-to-work outcomes and helping employees become more productive. He holds a master's degree in career and guidance counseling. He also is a certified rehabilitation counselor and ergonomist.

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Question and Answer with Producers at the Senior Products and Marketing Summit

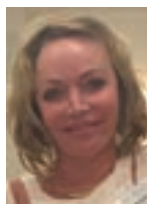
OPEN ENROLLMENT TIPS

California Broker recently had the honor of meeting up with some fantastic readers and producers at the Los Angeles and Ventura County Association of Health Underwriters Senior Products and Marketing Summit at Sportsmen's Lodge in Studio City. We asked producers to share their best tips and strategies for handling open enrollment. We heard about customer relationship management (CRM) systems and much more...



"Right now I think we handle about 1,200 PDP clients. When you have that many clients it could take an hour to manually go through and find someone's information should they call you and have a question. So what's saved us is our CRM. We do a mailing in mid-September. On the mailing, our clients get a form that's all prepopulated. Attached to it is a list of their drugs as we last knew with instructions to make corrections and send back. But our forms have bar codes! As soon as the info comes back, it's beeeep! This way we always know where a client is in the process. Once we have the info and update it, we make recommendations starting October 1."

Harry Thal, Harry P. Thal Insurance Agency, Kernville.



"To relieve stress during open enrollment, it's important to work with great partners! Your partners are always paramount to success. Also, start planning further in advance than you think you need. Lay out a road map with target dates. We typically start our roadmap in August."

Bobbi Kaelin, president of Los Angeles Association of Health Underwriters and vice president, PayPro Administrators, Riverside.



"Ido all Medicare. Timeliness is important because we only have seven weeks. So what we do is organize really well. We send out

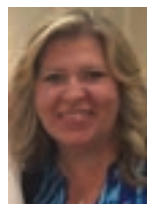
letters in the beginning of September so by October we're ready to see all of our clients. We need to touch every client. We get a letter to them, call them and touch base to make sure everything is okay. But the idea is to be organized and see which plan they're on and whether or not we really need to look at them. So we organize by the client and by the plan. We know all the benefit changes, we know the drug changes and we focus on letting those clients that are impacted know immediately. Because we're so organized and we start early, we'll be ready for October 15!"

Maggie Stedt, president, Orange County Association of Health Underwriters and owner of Stedt Insurance Services, San Clemente.



"I've been in the health insurance business for 30 years, but I've only been selling Medicare Advantage for about two years. Right now, I'm looking for the right CRM so I'm in better contact with my clients. Being in contact is a very big thing. There's a lot of competition out there. If you don't stick with your clients and be consistent, they will jump to another agent. Clients aren't as loyal as they used to be 15 or 20 years ago."

Andre Woods, Woods Insurance Services, Pasadena.



"Our industry has been slower to embrace technology and slower to adapt. But a CRM is key for anyone in our industry. It's not one-product-fits-all either. Which CRM

is for you depends on your individual needs. But there are many good ones out there and it pays to find one!"

Dawn McFarland, VP of communications for CAHU and president, M&M Benefits Solutions, Reseda.



"Keep in touch with your clients! You really need to reach out. There's a lot of changes going on. And within the MediCare market some of the carriers have changed plans and you may have clients who need to switch plans. Brokers have to be on top of this to protect their business. It's best to protect what's already in the door rather than chasing to replace that. If you think you can sell them and move on, you're not in it for the long run."

Denise Grudin, external account executive, Premier Senior Markets, Sacramento.



"The advice we give our brokers is to definitely start early. Make sure that they follow up with their clients before the renewals start. That way once the

renewals start, they've already had contact with their clients and they're very familiar with what's going on. They also can see if the pricing has changed for their clients. That's very important. We also recommend brokers do email blasting and now the new thing is text blasting. Email blasting has worked well for our brokers. Follow-up text blasts are something new we're trying this year."

Luis Sanchez, Dickerson Employee Benefits and Insurance Services, Los Angeles.

Life Insurance Controversy

Legal marijuana industry and associates may have trouble gaining coverage

By VICTORIA ALEXANDER

In August, *California Broker* was contacted by a representative for a woman in Las Vegas who applied for life insurance and was declined because she was the owner of an advertising and social media company that specialized in handling clients in the legal marijuana industry.

I interviewed the woman over the phone and she supplied back up documentation, including a letter from a major life insurance company that stated she was being denied coverage because her occupation is "associated with marijuana sales, distribution or production."

California Broker has decided to withhold the name of the woman, her insurance agent and the name of the insurance company that declined her. We've decided to do this because her insurance agent has voiced concern over

"It's crazy, absolutely crazy," the woman said. "If [company name withheld] would've denied me because I'm a little bit chubby, well that would make a little more sense to me. I'd probably start eating more salad and reapply. But I just don't understand this."

the woman's ability to gain coverage should her name become public. He's helped her apply to several other insurance providers and they are awaiting

news of approval – or not.

The 37-year-old married mother of two daughters said she was seeking a \$1 million term life policy. "I'm a mom, I have a business, I have a home and I'm the primary breadwinner," she told me. The woman's husband, who is one of her employees, applied for a lesser life insurance policy and was granted the policy in a timely and usual fashion.

"It's crazy, absolutely crazy," the woman said. "If [company name withheld] would've denied me because I'm a little bit chubby, well that would make a little more sense to me. I'd probably start eating more salad and reapply. But I just don't understand this."

We contacted Mark J. Neuberger, an attorney at Foley & Lardner LLP in Miami, Florida, who has written about and researched benefits and health insurance issues related to the use of legal marijuana.

Neuberger and his associates are not aware of any lawsuits yet involving people associated with the medical marijuana industry getting declined for life insurance.

"All I can do is speculate why this woman might have been declined," said Neuberger, who is not affiliated in any manner with the case. "Life and annuities are subject to federal anti-money laundering provisions. Marijuana may be legal in many states, but according to the federal government it's still a Schedule 1 narcotic – the same as heroin." Insurers may not want to take the woman's premium, speculated Neuberger. "They may be thinking, 'I don't know where this cash is coming from and I don't want to get involved.'"

California Broker reached out to at least half a dozen major life insurers to get comment or clarity on this issue. All insurance providers declined to comment. We'll continue to follow this issue and offer updates as we have them. ★



THE RISE OF THE PET PARENT

HOW GENERATIONAL PRIORITIES AND ENHANCED VETERINARY CARE ARE IMPACTING CLIENT NEED

By SCOTT TAYLOR



Do a search for “millennial” and “workforce,” and you’ll certainly be overwhelmed by the sheer number of articles, reports and infographics dissecting the topic. Headlines like “Communicating with Millennials” and “How to Motivate

Millennials” have become commonplace. I recently read an article about employment service anniversary awards losing their impact because this generation’s tenure at a company is on average less than three years.

The impact of millennials in the work-

place is having a profound effect. Good companies are adapting things like work-life balance and offering customized benefits to accommodate these younger employees. One of the areas experiencing growing popularity is pet health insurance. It’s become one of

the most requested voluntary benefits by employees, right up there with identity theft protection, student loan debt programs and renters insurance.

This is happening for two reasons. First, they have a greater tendency to become pet parents and view their dogs and cats as part of the family. In fact, the North American Pet Health Insurance Association (NAPHIA) reports that 82 percent of pet parents place a very high value on the human-animal bond and treat their four-legged companions as part of the household.

Second, technology has pushed the envelope in the veterinary industry, resulting in enhanced treatment options, but often at an increased cost. In fact, according to research by the American Pet Products Association (APPA), nearly \$16 billion was spent in the U.S. for veterinary services in 2016.

Combine these two, and you come up with a simple formula: an increase in the number of people who consider pets to be part of the family, who at the same time are experiencing an increase in health care costs for these family members. The result is an increased demand for pet health insurance.

Before I continue, I'd be remiss if I didn't point out that it's not only younger adults who value their four-legged companions. Consider another statistic provided by the APPA from their 2017-2018 National Pet Owners Survey: 68 percent of households in the U.S. have a pet and it's obvious to see the popularity of pet ownership across all generations.

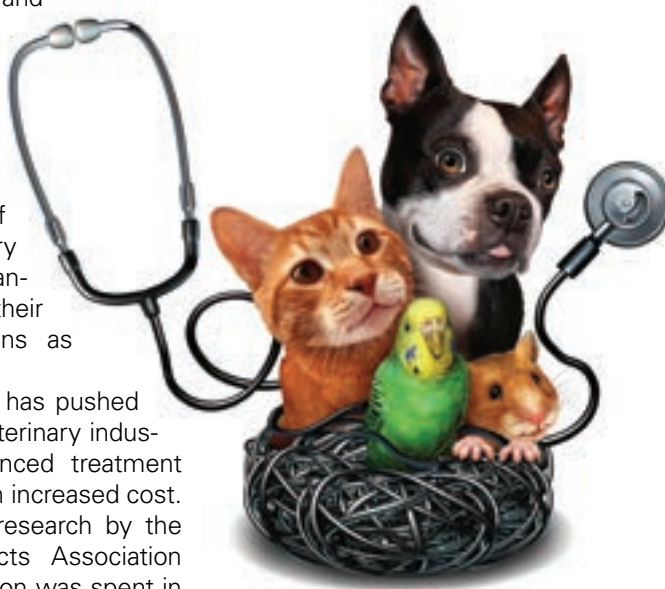
WHAT IS PET HEALTH INSURANCE AND HOW DOES IT WORK?

The definitions and mechanics of pet health insurance vary from provider to provider, but generally speaking, it reimburses pet parents for veterinary costs. The amount of reimbursement can be impacted by things like deductible, coinsurance, annual limits and whether or not the procedure or condition is covered.

As a general rule, most policies won't cover pre-existing conditions. This is

why it's so important to get insurance when the animal is young.

Also, pet health insurance is primarily a product for dogs and cats. However, some companies cover a wide range of animals, like horses and exotics.



THREE CONSIDERATIONS FOR CHOOSING A PET INSURANCE PROVIDER: LICENSING, EXPERIENCE AND TECHNOLOGY

Pet health insurance is a great way to broaden your existing portfolio of product offerings. Simply based on the number of U.S. households with a pet, it's very likely you'll have clients who find it valuable.

Choosing the right company to partner with is of obvious importance. But it could be a challenging endeavor. According to NAPHIA, there are more than 20 different pet insurance brands marketed across the U.S. and Canada.

Here are three tips to keep in mind as you evaluate which pet health insurance company with which to partner.

1. Licensing – From an insurance structure standpoint, pet health insurance, while it “looks” like human health, is actually a property and casualty product. Thus, selling it requires a Property and Casualty license. This won't necessarily impact which provider you choose to work with, however it's something you need to know up front.

2. Experience – Reputation. Industry experience. Trust. These aren't new terms or factors along the insurance partnership journey. Yet, it's important to have some perspective of the nuances you'll find in pet health insurance.

- a. First, the industry is rather young. In fact, the U.S. market traces its history to the early 1980s. (Interesting side note: globally, the first dog received insurance coverage in Sweden in 1924, soon followed by the United Kingdom in 1947.)
- b. Second, new entrants are still coming into the market. In fact, three of the companies are less than 10 years old.
- c. Finally, like most industries, pet health insurance has witnessed its share of mergers and acquisitions. I mention this not as a bad thing, but simply to point out that changes are occurring.

3. Technology – This is one of the big differentiators in the marketplace. Compared to typical insurance products, the pet health insurance industry has successfully leveraged the benefits of technology. Online shopping has simplified the experience for consumers. In fact, the entire experience can be done in the digital space, which further appeals to millennials. From the seller's standpoint, this enables products to be marketed with a lower cost and effort.

POTENTIAL, POTENTIAL, POTENTIAL

NAPHIA says that since 2009 the average annual growth rate of pet insurance in North America has been 13.2 percent. And, still, industry estimates put the penetration rate for pet insurance in the U.S. only somewhere between 1 to 2 percent. Of course, this means there's great potential out there. If the popularity of pet parenting exhibited by millennials continues, the potential shows even greater signs of more growth to come. ★



Scott Taylor, is AVP, strategic partnerships, with Crum & Forster Pet Insurance Group™.

HEALTH SAVINGS ACCOUNTS CAN HELP YOUR CLIENTS - AND YOU

By DOUG DUBITSKY

There are many ways to engage a client in the financial planning process. Among the tactics less taken is an approach focused on medical expenses in retirement.

Most financial advisors don't discuss the value of a health savings account (HSA) with their clients – whether due to lack of knowledge or because it's outside their direct purview. But discussions about the benefits of HSAs—many of which are not commonly understood—can be part of a larger conversation about retirement planning and allow you to gain additional trust with your client.



HSAs AS CONVERSATIONAL DOOR OPENERS

Conversations about financial planning typically focus—as they should—on the accumulation of wealth. Clients may feel they're in a strong position for retirement by pointing to sizable 401K balances along with expected social security payments.

However, as you begin to identify and tie down specific expenses and needs



in retirement, especially when your client is nearing retirement, it's natural to ask the question: "Do you feel you're properly covered for healthcare expenses in retirement?"

As you talk through what portion of their assets they expect to leverage to help cover healthcare expenses, you'll be able to inform them of the benefits of an HSA. You can paint the picture of how they help people pay their out-of-pocket healthcare costs, in a form of debit/credit card. And while information about HSAs may be available to your client through their workplace, bringing it up in the context of retirement planning is more meaningful and timely to you in building a deeper connection with your client. Encouraging your client to participate in their employee-sponsored HSA may not be something that directly benefits you financially, but it's the right thing to do.



HEALTHCARE EXPENSES ARE SIGNIFICANT—AND ONLY GROWING

If your clients aren't concerned about health care expenses in retirement, they should be. For men retiring in 2015 at the age of 65, health care expenses are estimated to be \$115,000. Women retiring at the same age will need approximately \$130,000 given that their life expectancy is two years longer.

This means the average couple will need approximately \$250,000 to cover healthcare expenses after retirement. These expenses are increasing each year and tend to be larger for higher net worth clients, who are more likely to seek out additional and higher quality health services.



HOW AN HSA ADDRESSES HEALTHCARE EXPENDITURES

HSAs were introduced in 2004 to help workers cover their healthcare expenses. They have become more popular with the proliferation of high-deductible health plans as employers seek to shift more healthcare costs to their workers.

More and more, however, HSAs are seen as a way to build savings to fund

medical expenses for retirement years rather than being used to fund current medical expenses if they don't need to be used. This is because of the three tax benefits offered by HSAs: tax-deductible contributions, tax-free growth and tax-free withdrawals for qualified medical expenses.



EDUCATE YOUR CLIENTS ABOUT HSAs

There are many misconceptions and little known advantages of HSAs that you'll want to emphasize to your client. One area that's not well understood is what constitutes "qualified medical expenses." Most people are aware that they can use HSAs to pay for visits to doctors and hospitals as well as prescription drug costs, but there are other expenses they're likely to encounter in retirement that also qualify. For ex-

"Most people are aware that they can use HSAs to pay for visits to doctors and hospitals as well as prescription drug costs, but there are other expenses they're likely to encounter in retirement that also qualify."

ample, the cost related to adapting a residence so that it can accommodate someone with disabilities or medical conditions, such as installing special handrails or rebuilding steps, may be paid for with HSA funds.

Your client may also confuse HSAs with flexible spending accounts that are offered through their workplace. You'll want to emphasize that unlike flexible spending accounts, HSAs do not have a "use it or lose it" requirement nor do they have a maximum carryover. The money in HSAs belongs to the account owner even when it's opened through an employer-sponsored program.

With HSAs, account owners can

choose to invest the dollars in their accounts, giving them the opportunity to benefit from potential growth. They should, of course, be reminded that investments have risks and that growth is not guaranteed.

Your clients always have the option to withdraw money from their HSA at any time. However, if money is used for

"By encouraging your client to take advantage of them (HSAs) as part of a saving strategy for today or for retirement planning, you'll help them gain greater control over their financial future."

nonqualified medical expenses, such as for cosmetic surgery or hair transplants, before the age of 65, they must pay a 20 percent penalty. Beginning at age 65, account owners can withdraw money from their HSAs for any reason without penalty. However, if the money is not used for qualifying medical expenses, they must pay tax on the distribution.



HSAs ARE THE WAY OF THE FUTURE

There's nothing less predictable than one's future healthcare expenses. The ability to meet these uncertain expenses in retirement is a primary and increasing concern for employees.

HSAs are a great way to address this need, yet they remain sorely underutilized. By encouraging your client to take advantage of them as part of a saving strategy for today or for retirement planning, you'll help them gain greater control over their financial future. You'll also establish yourself as a trusted resource who can be counted on to dispense invaluable financial advice. ★



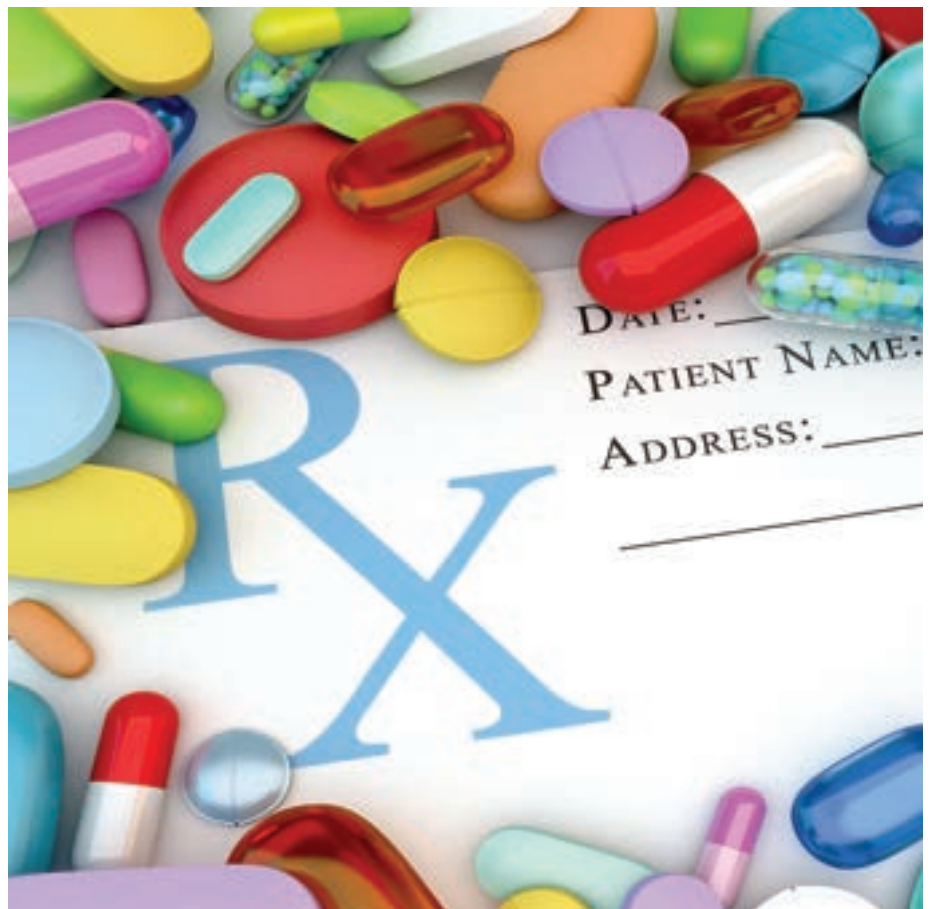
Doug Dubitsky is vice president of product management & development at The Guardian Life Insurance Company of America® in New York City.

GET THE MOST FROM YOUR PBM

FIVE THINGS BROKERS SHOULD CONSIDER

By MICHAEL PERRY

Prescription benefits managers (PBMs) have been under increased scrutiny in recent years. With drug prices rising, and consumers concerned about a lack of pricing transparency, prescription drug benefits have a significant impact on the bottom line for both clients and their members. Reuters reports that U.S. annual spending on prescription medications is projected to increase to \$400 billion (based on net price) by 2020. Many PBMs claim to offer cost savings and superior service to combat growing healthcare expenses, but do they really? Here are five questions you should ask when you evaluate a PBM.



1 **WHAT IS THE PRICING MODEL?**

PBMs today offer traditional and pass-through pricing models, as well as combinations of each. In the traditional model, a PBM does not charge an administrative fee, but typically generates undisclosed revenue by retaining a portion of the drug costs billed to clients. They may also retain a portion of any rebates received. PBMs offering a pass-through model charge the client the same amount billed by the pharmacy for the medication, pass through 100 percent of rebates, and generate revenue through predetermined and contracted administrative fees. Other pricing models may incorporate elements from both traditional and pass-through pricing models, which allows the PBM to disclose

the amount of spread and charge a smaller administrative fee. However, any amount the PBM retains in spread or rebates should be disclosed as revenue.

Clients need to understand the type of financial model offered and its impact. It is nearly impossible to compare pricing from PBMs because the discount rates never represent an apples to apples comparison, which prevents clients from see-

ing the entire picture. If a PBM does not disclose what portion of prescription fees it retains, how does a client know they're getting the best price?

2 **IS PRICING TRANSPARENT?**

No matter what finan-

cial model a PBM client chooses, the pricing should always be transparent. Look for one that fully discloses their revenue streams. Even in a traditional model, the PBM should be prepared to share details such as what portion, if any, of rebates they retain and what types of profits are rolled into medication costs billed to clients in the form of spread. There should be no hidden fees or incentives that detract from working in the client's and member's best interest.

Fair pricing comes from PBMs that do not inflate drug costs with hidden fees, reclassification of drugs to define their own brands or manipulation of the average wholesale price. Look for PBMs that pass along the mail order and specialty pharmacy's actual acquisition costs to clients. Other fair pricing initiatives include total pass through of rebates.

In addition, ask how a PBM calculates guaranteed discounts. Numerous factors, such as the inclusion of zero balance claims, compounds and single source brands in guarantee calculations, can inflate the promised discount. PBMs may also retain additional revenue if they are able to negotiate a better discount or improved rebates before the end of the contract. To ensure the best drug prices year-round, work with a PBM that passes along pricing improvements as soon as they go into effect, not at contract renewal.

DOES THE PBM FOCUS ON QUALITY CLINICAL CARE OVER REBATES?

It may be tempting to think only in terms of prescription discounts and rebates when considering PBMs, but this view leaves clients and members vulnerable to higher overall expenses over time. In the long run, more effective treatment will have a greater impact not only on client and member satisfaction, but on drug spending. The Institute of Medicine estimates the U.S. healthcare system is wasting well over \$750 billion per year—roughly 30 percent of current U.S. healthcare costs. Factors that contribute to the wasted healthcare dollars include

unnecessary care or inappropriate medications, tests and procedures; fraudulent claims; overpriced products and services; inefficient care; and the failure to prevent problems that require expensive intervention. Patient non-compliance and patient safety issues add to the waste. These are often the result of inappropriate treatment, as well as a lack of guidance, support, and coordination of care support from industry professionals. Each of these problems represents a missed opportunity to control the escalation of healthcare costs.

PBMs can help reduce this trend by focusing on patient care and improving outcomes, rather than on the promotion of medications with the biggest rebates—options that may in fact lead to the highest net cost. Making sure the member is on the right medication, that there are no contraindications to medications or other diagnoses, and ensuring that members use the medication appropriately improves overall member health. This reduces expensive hospital stays. Members should have easy access to nurses and pharmacists who can provide quality advice and explain their drug options to help them remain compliant with treatment plans. Innovations such as pharmacogenetic testing, which identifies how a patient will metabolize certain medications, can help members and their healthcare providers immediately identify the right treatment eliminating the trial and error process that often occurs.

WHAT STEPS DOES THE PBM TAKE TO FOCUS ON UNIQUE CLIENT NEEDS?

No two clients are the same. In an increasingly complicated healthcare system, PBMs must be flexible in order to best meet their clients' needs. To do this, PBMs must be prepared to invest in their clients, not simply as another account, but as valued partners. Personalized care that extends beyond board rooms to individual member experiences, customizable service and superior client satisfaction are all hallmarks of a PBM that works hard to

focus on their clients. Even something as simple as how quickly a client or member can get hold of a live human being, not a computerized phone tree, makes a difference in how effectively a PBM serves a client's needs.

HOW STRONG IS THE PBM'S COMMITMENT TO ETHICS?

Faced with public demand for better control of drug price increases, state and federal legislators have placed both PBMs and pharmaceutical manufacturers on notice. Consumers want fair and ethical treatment from their pharmacy benefit providers. Proposed legislation at the state and federal level targets issues such as full pricing transparency and increased scrutiny of how well prescription medications actually work. However, PBMs can act now to ensure that clients and their members are treated with respect and fairness. Quite simply, they should:

- Put members and clients first.
- Focus on the best overall outcome and the lowest net price.
- Commit to client and member education.
- Conduct voluntary checks and balances evaluated by independent third parties.
- Be transparent and honest in their business practices.

A good PBM is as focused on the client and on quality clinical care for members as they are on costs. A great PBM continues to innovate to address the growing complexities of the health care system. When a PBM promises savings, don't simply take them at their word. Ask them how. Review their pricing models, clinical programs and ability to adapt to each client's unique situation. Look for proof of fair and transparent pricing. Ask how they take their commitment to ethics

beyond words and into practice. ★



Michael Perry is president and CEO of BeneCard PBF. He can be reached at Michael.Perry@benecardpbf.com.

IICF Women in Insurance Conference

Diversity, inclusion, innovation, great food and spectacular views of Los Angeles from the 51st floor of the City Club were all on the menu for the Insurance Industry Charitable Foundation's recent Women in Insurance luncheon. More than 200 leaders in the Southern California insurance industry attended. Speakers included CNA's Riki Nieman and Joyce Trimuel, Farmers' Rehan Ashroff and Jon Axel from The Liberty Company Insurance Brokers. This event is just one of many hosted each year by the IICF Western Divi-



sion, which comprises philanthropically minded insurance professionals organized by boards of directors throughout California along with Arizona, Colorado and Washington Chapters, who give back generously to their local communities through grants, volunteer service and leadership. The IICF Western Division has awarded a record amount of community grants in 2017, nearly \$450,000, to an array of nonprofit organizations addressing critical needs in the areas of education, child abuse prevention, disaster preparedness, and health and human services. IICF will host its next Women in Insurance Conference Series events in June 2018, with day-long regional forums in Chicago, Dallas, London (March), Los Angeles and New York. The events are intended to allow those in the insurance community to continue exploring today's most relevant and important challenges and solutions with respect to diversity, inclusion and innovation in the workplace. Earlier this year, IICF held its Women in Insurance Global Conference in New York, with nearly 600 speakers and dozens of leading speakers and panelists in their fields of expertise. For more info, please visit www.iicf.org.

L.A. Care Asks to Go Digital with Medi-Cal Directory

It looks like the Medi-Cal directory may be on the way to going digital. L.A. Care, a Medi-Cal provider, submitted a proposal in June to go digital with its behemoth paper directory. The company says the switch would save at least \$1 million. A recent Los Angeles Times editorial supported the notion that all Medi-Cal directories should be digital. California has yet to approve the switch, however.

Insurance Industry Embraces Blockchain

The Institutes, a risk and insurance knowledge group, and LIMRA (Life Insurance and Market Research Association) announced a partnership to advance the adoption of blockchain solutions across the insurance industry through The Institutes RiskBlock™ Alliance, the industry's first enterprise-level blockchain consortium.

This announcement follows the inaugural meeting of LIMRA's Blockchain Advisory Council on September 7 at the Massachusetts Institute of Technology. Attendees not only discussed high-value opportunities to leverage blockchain technology but also how the industry can align around practical, collaborative solutions that are designed, developed and implemented efficiently.

LIMRA and The Institutes contend that industry alignment is the most important factor in unlocking the potential of blockchain. "The key to making blockchain work is to bring together the entire industry—insurance providers, trade associations, educators, technology partners—to solve this challenge together," said Peter L. Miller, CPCU, president and CEO of The Institutes. "With the combined expertise of The Institutes and LIMRA, RiskBlock will advance blockchain beyond proof of concept and toward practical application of this game-changing technology across every spectrum of the insurance industry. For more information about blockchain technology and to receive updates on The Institutes RiskBlock Alliance, visit TheInstitutes.org/Blockchain.

Covered CA for Small Biz Announces Rates and Plans

Covered California for Small Business (CCSB) recently unveiled the health plan choices and rates for small-business employers and their employees for the 2018 plan year. The state-wide weighted average rate change will be 5.6 percent for employers and their employees, which is down from the 5.9 percent change in 2017.

- Among the five plans CCSB will offer in 2018:
- PPOs – Blue Shield of California and Health Net
- HMOs – Kaiser Permanente and Sharp Health Plan
- Community health plan – Chinese Community Health Plan in San Francisco.

CCSB will not offer Western Health Advantage in 2018, a change that will affect approximately 350 consumers. CCSB has experienced double-digit membership growth for the third consecutive year. Currently, more than 35,000 individuals have insurance through CCSB, representing a growth of approximately 7,600 individuals for a 27 percent gain in membership over this time last year. This makes CCSB one of the largest small-business health option programs in the nation. CCSB spokespeople say that similar to the individual market, consumers may be able to limit increases in their rates or perhaps even save money on their premiums by shopping and switching to the lowest-cost plan in the same metal tier. Businesses with one to 100 employees can apply for coverage. Federal tax credits may be available to employers with 25 or fewer employees. Get more info at www.covered-ca.com/forsmallbusiness/

RAND Study Says ACA Repeal Will Hurt Vets

A new study by the nonprofit, nonpartisan RAND research organization concludes that proposals to repeal or replace the federal Affordable Care Act would likely increase the demand for service in the Veterans Affairs medical system, while also increasing the number of veterans who have no insurance coverage. Under legislation passed by the U.S. House of Representatives, health coverage losses among non-elderly veterans would be concen-

trated among older, low-income and less-healthy veterans, according to the study. These groups of veterans are more likely than other nonelderly veterans to obtain care from the VA medical system, magnifying the potential impact of ACA repeal on demand for VA care. "Repealing or significantly scaling back the Affordable Care Act is likely to increase the number of uninsured veterans," said Michael Dworsky, the study's lead author and an economist at RAND. "Some veterans who lose health insurance coverage as a result of ACA repeal will become more likely to seek care from the VA health system, leading to additional strain on a health care system that already faces challenges in ensuring adequate capacity." The report "Veterans' Health Insurance Coverage Under the Affordable Care Act and Implications of Repeal for the Department of Veterans Affairs" is available at www.rand.org.

WIFS Recognizes Circle of Excellence Qualifiers

Women in Insurance & Financial Services (WIFS) announced its 2017 Circle of Excellence qualifiers. WIFS Circle of Excellence is a recognition program for members who achieve significant income levels. The recognition is based on annual production for the previous year. This year, 178 members qualified for the distinction with a reported combined income of \$53.1 million. Qualifiers will be recognized for their achievements on October 26 during the 2017 WIFS National Conference in Minneapolis, Minnesota. More info can be found at WIFSnational.org.

EBN: Macy's Case Means Wellness Plans May Face More DOL Scrutiny

The Department of Labor recently brought suit against Macy's Inc., as well as the third-party administrators of the retailer's health plan, for various violations under the Employment Retirement Income Security Act of 1974. At issue is a tobacco surcharge. The suit alleges that the Macy's wellness plan doesn't meet the applicable wellness plan non-discrimination requirements because the plan failed to provide a reasonable alternative standard for participants to avoid the tobacco

surcharge levied by the plan. It also alleges the plan continued to charge participants a tobacco surcharge even while participants were enrolled in the wellness plan's smoking cessation program. Bottomline: if the wellness plan is an outcome-based, health-contingent plan that contains a tobacco surcharge, plan sponsors and administrators should ensure that participants who satisfy any plan requirements for avoiding the surcharge are excused from the surcharge for the entire period of coverage.



Products

MassMutual has launched Advisor-Advantage+, a website and tools to help financial advisors sharpen their capabilities to support retirement plan sponsors and participants. AdvisorAdvantage+ features a web-based tool to help advisors create a value proposition to differentiate themselves in the marketplace, a web-based prospecting tool created by Larkspur Data Resources to help advisors market their capabilities to local employers, and other tools and information dedicated to the success of employer-sponsored retirement plans. More information can be found at www.massmutualatwork/advisor-advantage/

Hixme Launches Employer Health Cost Simulation Tool, Invites Broker Inquiry. Agoura Hills-based Hixme and design collaborator Axene Health Partners (AHP) has launched BundleMe™, a high-tech, big data tool that finds the best core benefits and wraparound plans for each insured in groups 500 to 5,000. Companies routinely end up saving 10 to 20 percent on health benefits, according to Denny Weinberg, Hixme's CEO and a former senior executive at Wellpoint. "Hixme's platform delivers a very different and attractive model for large insurers, particularly those who may be starting to think about self funding," says Weinberg. The two-year-old company is open to creating relationships and training opportunities for large group brokers. Contact the company through hixme.com.

Events

World Medical Tourism & Global Health Conference – Oct 2-4 Los Angeles. The fast growing field of medical tourism is creating a need for trained and knowledgeable professionals. Visit the World Medical Tourism & Global Health Conference for workshops and classes to become a Certified Medical Tourism Professional (CMTP). More info at medicaltourismcongress.com.

Women in Insurance and Financial Services 30th Annual National Conference - October 25-27 Minneapolis. This year's conference, Dream It Achieve It, will celebrate the impact that women are making in the insurance and financial services industry. The conference focuses on empowering women through dynamic educational workshops, networking events and inspirational sessions that help women invest in their futures. An additional element of this year's conference is a featured session that provides attendees the opportunity to earn continuing education (CE) credits. The exhibit hall will host 50 vendors with products and services aimed at elevating the businesses of those in the industry. Workshop topics include marketing strategies, sustainable investing, Department of Labor policy, best practices, team building and more. Learn more and register at www.wifsnational.org/conference.

NAILBA 36 – November 16-18, Hollywood, Florida. Registration is now open for the National Association of Independent Life Brokerage Agencies (NAILBA) 36th Annual Meeting, NAILBA 36. Scheduled November 16-18, 2017, at the Diplomat Beach Resort in Hollywood, Florida, the meeting will attract high level representatives from brokerage general agencies, life insurance carriers and insurance industry vendors. This year's agenda has been expanded to deliver four keynote experiences over three general sessions and more than 15 workshops. Go to NAILBA.org for a complete schedule of events.

WHEN WHOLE LIFE MAKES THE MOST SENSE

By RICHARD M. WEBER

“Buy term and invest the difference” is probably the most iconic slogan for misdirecting and potentially mismatching a client’s needs and purposes for life insurance—and the types of policies we might otherwise suggest to them.

Of course, there’s a legitimate place for term insurance. We don’t sell enough and our clients don’t buy enough for the real protection needs they have. But what about universal life (UL) or indexed universal life (IUL) or guaranteed universal life (GUL) or even variable universal life (VUL) for longer-term needs? There’s an extensive list of new policy styles and many design variations for each that were supposed to render whole life obsolete.

To the contrary, there’s been a resurgence in the “permanent” life insurance marketplace in the last 10 years for which whole Life has regained some of the market share UL and its subsequent generations of design had penetrated since UL was first introduced in the late 1970s.

As a fee-only insurance fiduciary, consumers hire me to assess, in part, “what kind of life insurance is in my best interest?” We start by talking about their general risk tolerance for long-term investing. How they prefer to manage their long-term money (often investing for eventual retirement) is a great clue to help objectify a recommendation for a policy or portfolio of policies. We also have a brief discussion about the two major concept designs of life insurance intended for a lifetime, which includes policies with comprehensive guaran-

“Taking a longer view of how a life insurance policy can evolve into different valuable uses over time – first as protection and later as an uncorrelated asset uniquely offsetting an untimely problem with sequence of returns – is the best way to demonstrate our value as professional life insurance agents...”

tees, and those without them. These other policies translate into assumed but non-guaranteed planned premium designs since they may contain nominal guarantees but primarily anticipate future favorable experience with portfolio gains/losses, the trend of claims, and other expenses.

With an appreciation for these different insurance design concepts, few consumers with a conservative risk tolerance (“I’m intolerant of volatility and seek guarantees over return”) will be drawn to variable policies. An expression like, “I’m tolerant of volatility and willing to do without guarantees in favor of premium investment opportunity,” may seek a policy style in which inherent volatility is acceptable because of an appetite for upside potential. This

isn’t a matter of right or wrong types of policy, but matching consumers with a policy type that’s compatible with inherent risk tolerance.

Having defined a logical decision path for a risk-tolerant policy, there are additional questions to pursue with clients:

- How important is access to cash value?
- Should cash values be guaranteed to lock in, or be subject to fluctuation based on uncertain stock and/or bond market movements?
- Should there be naturally occurring increases in death benefit to help offset the long-term effect of inflation?
- What are the resources from which policy premiums will be paid – out of your prospect’s cash flow or out of other assets on their balance sheet?

While the responses are important to our ultimate recommendation and answer to “what’s the best kind of policy for me?” it makes sense to explore one of the most valuable aspects of permanent life insurance: Life insurance as an asset class.

Traditional asset classes include cash, fixed returns and equity. In the last 10 years, and in my firm’s advocacy on behalf of The Guardian Life Insurance Company of America®, we have successfully won over non-insurance financial professionals to recognize death benefits, the most important part of a policy, as a cash asset to be paid at precisely the point it is needed and for which it was designed. The underlying cash value of a policy, designed to be affordable for a lifetime, has a similar relationship to an



asset class consistent with the type of policy. For example, whole life has fixed return reserves supporting the cash value and is therefore associated with a fixed return asset class. The account value of VUL, by contrast, would map to an equity asset class.

Permanent life insurance addresses permanent needs, so in theory if we're matching risk tolerance to provide direction for a recommended policy type, it shouldn't matter whether it's whole life or well-funded IUL. But before the final recommendation, there's a critical last question: Not withstanding risk tolerance and its inference of compatible policy styles, how valuable is it to have life insurance as an uncorrelated asset class? In consideration of retirement, the major hazard is drawing down equities at the outset of a downward-spiraling stock market – or in the face of rapidly rising interest rates and the devaluation of bond values. Either move of the natural undulations of equities and interest rates can improve or devastate a retirement income distribution plan.

This consideration may ultimately be the deciding factor for whole life, even if a more aggressive style of policy such as IUL could be indicated from risk tolerance, to the extent that whole life is an asset uncorrelated to the fluctua-

tions of interest rates and equity markets. With whole life's locked-in cash values and previously applied dividends¹ (typically to paid-up additions), participating whole life is unique in its ability to protect what otherwise could be a permanent loss of value when forced to take income from a declining stock market. Yet, some risk tolerant clients may wonder if there is a middle-ground to have whole life's solid guarantees² while at the same time having some upside potential. Guardian has been able to create a product that embeds an index feature on a whole life chassis as a means to create more flexibility and potential upside opportunity.

Consider this: retiring on January 1, 2000, might have seemed like a good idea for a 65-year-old client who wanted to enjoy the benefit of her disciplined savings. She invested diligently and accumulated \$1 million in her retirement plans from which she planned to withdraw an aggressive \$75,000 a year. Had she been of an age to retire in 1985, the strategy would have worked wonderfully considering favorable sequence of returns for the next 16 years. But starting retirement at the outset of 2000 would devastate her portfolio, and she would run out of principal by 2011.

Had she separately begun providing protection for her family in a whole life policy while she was in her 30s, a well-matured policy would have given her the option to withdraw/borrow³ \$50,000 a year between 2000 - 2002 and again in 2008 (remember, because policy loans aren't subject to income tax,⁴ she can withdraw/borrow less) - her draw-down will last 6 years longer than if she hadn't had the foresight to include an uncorrelated asset from which to provide income while allowing time for "the markets" to recover.

Answering "what's the best kind of policy for me?" can be more complicated than an offhanded recommendation. Taking a longer view of how a life insurance policy can evolve into different valuable uses over time – first as protection and later as an uncorrelated asset uniquely offsetting an untimely problem with sequence of returns – is the best way to demonstrate our value as professional life insurance agents with our clients. ★



Richard M. Weber, MBA, CLU, AEP (Distinguished) is a Managing Member of Ethical Insurance Solutions, LLC, and consultant for Guardian Life Insurance Company of America. Weber was the 2012-2013

President of the 10,000-member Society of Financial Service Professionals. With 50 years of experience in sales, training, product design, senior management and compliance, Ethical Insurance Solutions provides training and consulting services empowering life insurance agents, financial planners, advisors and their clients to explore and view life insurance in the broader context of financial planning.

Footnotes:

1 Dividends are not guaranteed. They are declared annually by Guardian's Board of Directors.

2 All whole life insurance policy guarantees are subject to the timely payment of all required premiums and the claims paying ability of the issuing insurance company. Policy loans and withdrawals affect the guarantees by reducing the policy's death benefit and cash values.

3 Policy benefits are reduced by any outstanding loan or loan interest and/or withdrawals. Dividends, if any, are affected by policy loans and loan interest. Withdrawals above the cost basis may result in taxable ordinary income. If the policy lapses, or is surrendered, any outstanding loans considered gain in the policy may be subject to ordinary income taxes. If the policy is a Modified Endowment Contract (MEC), loans are treated like withdrawals, but as gain first, subject to ordinary income taxes. If the policy owner is under 59 ½, any taxable withdrawal may also be subject to a 10% federal tax penalty.

4 Guardian, its subsidiaries, agents, and employees do not provide tax, legal, or accounting advice. Consult your tax, legal, or accounting professional regarding your individual situation.

GROUP HEALTH CAPTIVES PART 1:

Reaching the Pinnacle of the Group Health Marketplace!

By STUART SLONIN

A passenger arriving from Texas at New York's JFK airport asked his Uber driver: "How do you get to Carnegie Hall. The driver turned to him with a smile and said: "Practice, practice, practice!" And so it goes for agent/benefit consultants facing the realities of the 2018 marketplace. We see all the challenges ahead: an aging population, changing demographics in client companies, limited product availability and increased underwriting scrutiny for the groups we work with. Employers are facing major cost increases (ranging between 5 and 15 percent in 2018). For large employers (51+ by today's definition) that is a sizeable hit to their bottom line. With benefit costs representing almost 40 percent of payroll expense, the need to find and retain quality employees is the number one concern of management. Benefits are the most important component in the employee compensation package.

Recent studies have reported that medium and large employers continue to provide group coverage for their workers and their dependents. Those numbers are large (170 million private sector employees and 90 million in the public sector). Employers there have witnessed a losing battle of cost shifting over the past several years (with deductibles in excess of \$1,000+ and high out-of-pocket costs) to their employees. And if benefit cost increases continue averaging 8 percent or more each year, how long can employers continue to fund their programs beyond 2020?



Fewer employees are able to afford those plans. This also creates participation level problems with carriers in the fully insured marketplace. Employers have become tired of the same spread sheet of fully insured carrier quotes whose plans haven't performed as advertised – and only deliver rate increases. Heading into 2018 and beyond, employers are looking for informed benefit

advisers who bring new strategies for long term planning and who can assist them in bending the cost curve.

ENTER THE CAPTIVE INSURANCE CONCEPT

For those readers considering a captive insurance placement for their clients, the captive concept has a long history of use. Earliest record of the captive risk management concept

dates back to the 1500s as business owners met in London coffeehouses to discuss the retaining, sharing and transfer of risks they faced in their operations. In the 1700s and 1800s there were similar stories of risk transfer transactions by members of specific industries to provide insurance coverage to their members. The term "captive" was officially established in the early 1950s by Frederick Reiss, a property engineer who became an insurance broker at that time. In 1958 he formed an actual management company to help companies set up their own captive entities.

Since those early days, many large corporations have taken advantage of the captive structure to fund their liabilities for workers compensation, general liability and other known P&C risks. Some of these have included: CSX Corp., Columbia Energy, Archer Daniels Midland, Coca-Cola Co., Hormel Foods, Microsoft, GM, Alcoa, Astra Zeneca, International Paper, Memorial Sloan Kettering Cancer Center, Sun Microsystems and United Technologies. These are known as single parent captive programs – owned by these entities. The success they had in their P&C and difficult to place other insurance programs led to using their captives to provide a wide range of employee benefit programs. There are over 7,200 captives worldwide in over 70 jurisdictions. The top North American Offshore Captive Domiciles are Bermuda (#1) and Cayman Islands (#2). The top U.S. Captive Domiciles are Vermont (#1) and Utah (#2). The top European Captive Domiciles are Guernsey (#1) and Luxembourg (#2).

THE ACA AFFECTS BENEFIT DECISIONS FOR EMPLOYER GROUPS

Under the ACA rules, fully insured carriers were required to issue community-rated guarantee issue policies to full time equivalent employees (those working 30 hours or more) and contingent or project employees who qualified over time for ACA qualified policies. These carriers set rates within the ACA pricing structure with no lifetime maximums that drove their pricing higher with fewer carriers willing to offer these plans in the marketplace. The result is a traditional group

marketplace in chaos. Many of these employers have since moved to self-funding. Over time, they ran into other problems at renewal. They now stood on their own claims experience (with the up and down uncertainty of their companies' utilization results). In some cases, they were presented with a "laser" as a condition of renewal. This is a practice where insurers set higher attachment points for certain plan members who have costly on-going claims conditions.

"The 2018 market provides an excellent time and laboratory for agents and their clients to go through the learning curve together and come out the other end fully realizing the vast potential this approach provides."

GROUP CAPTIVES PROVIDE ACCESS TO A MORE CONTROLLED GROUP HEALTH MARKETPLACE

If we agree that we live in a data driven electronically connected world, it comes as no surprise that a captive arrangement is the medium that more small and medium sized companies are gravitating to in today's marketplace. Agents and group benefit consultants now have access to the same data that was once solely the possession of actuaries and underwriters. This new availability of information has helped advisors better understand their clients' unique problems. This helps agents plan strategies to mitigate the risks they can now identify – and provide structures to offset those long-term risks. Agents have found that group captives are a time-tested risk transfer arrangement (since 1956), which offer flexibility and is adaptive to individual plan member needs. Companies entering captive arrangements today are doing so for cost reduction, risk management, or risk control. The timing is

ripe for this kind of increased activity in the captive space.

Following the discussion of the single parent captive, we can now look at the group type of captive arrangement. The most common ones are the pure group captive. The pure group captive is established by a group of companies within a captive cell having no relationship with each other except they share the desire to accomplish a common goal: the reduction of costs and control of the plans that the captive provides to member companies. The second common type is the association captive: this is owned or sponsored by a trade, industry or particular service group (example: engineers) who will write coverage for member firms in the same industry only. Both types have been extremely successful over time. There are other types as well. A rent-a-captive is a captive that is owned by an outside entity and open to interested participants for a fee. Another entity is a risk retention group, a form of group captive formed for the purpose of taking on the risks of commercial liability exposure.

Employers have learned valuable lessons from the years they were involved in self-funded plans. They saw the financial benefits of moving away from the fully insured marketplace. They learned the tools, techniques and language of medical stop-loss insurance. This included specific and aggregate cover, attachment points, contract terms and conditions, when to get in and out of those programs and what the net results were over a measured period of time.

Employers have now experienced the full range of the growth of the group health benefit marketplace. The next step for them is the extraordinary flexibility of the captive plan arrangement. The 2018 market provides an excellent time and laboratory for agents and their clients to go through the learning curve together and come out the other end fully realizing the vast potential this approach provides. ★



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

Protecting Your Clients' Eyes in the Digital Age

By KEN STELLMACHER

Advancements in technology influence all aspects of our lives, from professional networking to recreation, to simply interacting with each other and the world around us. This has resulted in a dramatic increase in our exposure to digital devices. In the vision insurance industry, consumers' increased digital exposure has had a profound effect on how we market and sell our products and services.

Overexposure to digital devices is causing a growing concern over the effects of blue light on our eyes. As health care advocates, it is critical that we educate employers about these emerging concerns, and offer preventative care measures in our vision benefit packages. Ultimately, we need to help our clients recognize how important it is to help their employees protect their eyes and stay happy and productive.

THE HEALTH EFFECTS OF INCREASED SCREEN TIME

According to The Vision Council, spending just two hours a day looking at screens can expose your eyes to enough blue light to cause digital eye strain.

Dr. Gary Morgan, a VSP network doctor in Phoenix, Arizona, says we need to be aware of the potential effects digital device use could have on our eyes.

"Whether we're at home, in a classroom or at the office, our eyes are exposed to more and more blue light in today's device-driven world," Morgan said. "Technology continues to change the way we live and allows us to be more efficient and connected, but even with its benefits, we must be mindful of the impact of increased blue light exposure on our eyes. While medical research continues to study the possible long-term health impacts of blue

light, both parents and their children can take practical steps now to reduce their exposure, ease digital eye strain, and maintain good vision."

According to Vision Council research, digital eyestrain has surpassed carpal tunnel syndrome and tendonitis as



the leading computer-related repetitive strain injury for American workers. About 65 percent of Americans experience symptoms of digital eyestrain, but almost 70 percent of those don't think to discuss screen time with their eye doctors. And nearly 75 percent of people surveyed didn't know that blue light-reducing eyewear is available.

WHAT YOU CAN DO FOR YOUR CLIENTS AND THEIR EMPLOYEES

At the end of the day, carriers and brokers have a common objective to provide recommendations that will best suit the needs of our clients. Employers who are on the fence about upgrading their vision benefits might

consider a two-plan approach with anti-reflective (AR) coating offered as an employee buy-up to a base plan. It's an easy and economical way to cover employees who opt-in without impacting your bottom line.

While not all AR coatings reduce blue light exposure, consumers can now order blue light-reducing coatings that absorb, reflect, or absorb and reflect this high-energy light. "Computer eyewear" used to have a decidedly non-flattering yellow-orange tint that only techno-geeks embraced; however, new technology makes some of these coatings almost clear.

For example, VSP Optics Group recently developed a nearly clear AR coating called TechShield Blue that can be added to almost any pair of eyeglass lenses to specifically reduce blue light wavelengths linked to digital eye strain.

Digital eye strain has become such a pressing vision issue that growing numbers of vision insurance plans and employers are accounting for it, and they can tailor plans to meet the needs of employees who spend the majority of their time looking at screens.

THRIVING IN A CHANGING LANDSCAPE

As technology continues to evolve, its impact on our lives is only going to increase. Recommending easy, economical solutions for your clients' employees will allow them to continue using and enjoying their technology, ultimately



ly increasing employee satisfaction, and keeping your clients loyal. ★

Ken Stellmacher is VSP Global, senior VP and general manager – commercial markets.

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