

CALIFORNIA BROKER

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SERVING CALIFORNIA'S LIFE/HEALTH PROFESSIONALS & FINANCIAL PLANNERS

SEPTEMBER 2016

Above the Self Funding Storm

*Helping Clients Find Clarity
Through the Clouds of
ACA Regulations*



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Should Big Insurance Become Like Walmart to Lower Health Costs?

By JAY HANCOCK OF KAISER HEALTH NEWS (KHN.ORG).

Walmart is an American multinational corporation that runs large discount stores and is the world's largest public corporation. Walmart holds down prices through brutal negotiation with suppliers. Similarly huge insurance companies might strike better deals with hospitals and pass on the savings, some suggest. Retail titan Walmart uses its market dominance to inflict "ruthless," "brutal" and "relentless" pressure on prices charged by suppliers, business writers frequently report.

What if huge health insurance companies could push down prices charged by hospitals and doctors in the same way? The idea is getting new attention as already painful health costs accelerate and major medical insurers seek to merge into three enormous firms.

Now that hospitals have themselves combined, in many cases, into companies that dominate their communities, insurance executives argue the only way to fight bigness is bigness. Number two health insurer Anthem's proposed marriage to number six Cigna would let the combined company "manage the cost drivers that negatively impact affordability for consumers," Anthem CEO Joseph Swedish told Congress last year. The bigger company could "negotiate better reimbursement rates" with medical providers, says Anthem spokeswoman Jill Becher.

In metro areas with only a few big insurers, hospital and doctor bills tend to be lower than what economists would otherwise expect. If only one or two insurers are bidding to include providers in their networks, hospitals and doctors must submit to the offered deal or risk getting shut out of a huge piece of business.

"There's some literature out there that does show that when you have relatively concentrated insurance markets, they tend to keep actual hospital costs down," said Yevgeniy Feyman, a researcher at Harvard's T.H. Chan School of Public Health and a fellow with the Manhattan Institute.

The American Hospital Association as

well as the American Medical Association, trade groups for hospitals and doctors respectively, have long worried that insurance mergers do just that. Now that Anthem is trying to buy Cigna, and Number 3 health insurer Aetna wants to buy Number 5 Humana, they're even more concerned. Both deals "have the very real potential to reduce competition substantially" and "diminish the insurers' willingness to be innovative partners with providers and consumers," AHA lawyer Melinda Reid Hatton wrote to antitrust authorities after the combos were announced.

But hospitals have built their own market power through numerous mergers, giving them broad ability to raise prices paid by employers, taxpayers and consumers beyond what a competitive market would allow, economists argue. Hospitals "are much more concentrated than insurance markets," said Glenn Melnick, a health care economist at the University of Southern California who has researched the matter. "They face a lot less competition than the [health] plans do."

Why not give hospital giants somebody their own size to negotiate with? For one thing, insurers might just pocket higher profits from low provider prices instead of passing the savings to consumers and employers. "I don't find any evidence that reduction in provider payment leads to reduction in insurance premiums, and I don't know of any study that does," said Leemore Dafny, an expert in insurance markets and an economist at Harvard Business School.

Feyman suggests requiring insurers in concentrated areas to spend 90 percent of their revenue on medical care. That might reduce their ability to boost profits with premium increases while preserving their ability to hold down hospital and doctor costs, he said.

But he sees such a measure as only a "worst-case scenario" for the most monopolized insurance markets, not a recipe to allow the Anthem and Aetna

deals to go through. Antitrust regulators are siding with the hospitals and doctors. Late last month the Justice Department sued to block both insurance mergers, arguing that competition is important to keep premiums down and that the deals "would leave much of the multi-trillion-dollar health insurance industry in the hands of three mammoth insurance companies." They also rejected the Walmart argument, which is related to what economists call "monopsony."

Monopsony is the opposite of monopoly: Instead of using market dominance to raise prices for consumers, huge buyers force down prices from suppliers. Walmart is often described as holding monopsony-like power. But critics of the insurance deals say monopsony can go too far. If the buyer pushes prices too low, suppliers stop producing, making needed goods and services unavailable.

"As a result of the merger, Anthem likely would reduce the rates that ... providers earn by providing medical care to their patients," the Justice Department argued. "This reduction in reimbursement rates likely would lead to a reduction in consumers' access to medical care."

Accepting Walmart logic for health care might bolster arguments for an even bigger, more powerful buyer of medical services: the government. A single-payer, government health system, of the type advocated by Democratic presidential candidate Bernie Sanders, would be the ultimate monopsony: one buyer, negotiating or dictating prices for everybody.

Neither the hospitals nor the insurance companies want that. ★

Jay Hancock joined Kaiser Health News in 2012 from The Baltimore Sun, where he wrote a column on business and finance. Previously he covered the State Department and the economics beat for The Sun and health care for The Virginian-Pilot of Norfolk and the Daily Press of Newport News. He has a bachelor's degree from Colgate University and a master's in journalism from Northwestern University. This article was reprinted with permission from khn.org

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AUGUST 1, 2016

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	Bests	Fitch	S&P									
American Equity	A-	A-	ICC13 MYGA (Guarantee 5) (Q/NQ)	S	2.15%*	5 yr.	None	9%, 8, 7, 6, 5, 0	Yes	\$10,000 (Q) & \$10,000 (NQ)	3.00%, age 0-75 & 2.10%, age 76-80**	
			ICC13 MYGA (Guarantee 6) (Q/NQ)	S	2.35%*	6 yr.	None	9%, 8, 7, 6, 5, 4, 0	Yes	\$10,000 (Q) & \$10,000 (NQ)	3.00%, age 0-75 & 2.10%, age 76-80**	
			ICC13 MYGA (Guarantee 7) (Q/NQ)	S	2.50%*	7 yr.	None	9%, 8, 7, 6, 5, 4, 3, 0	Yes	\$10,000 (Q) & \$10,000 (NQ)	3.00%, age 0-75 & 2.10%, age 76-80**	
*Effective 8/5/16. Current interest rates are subject to change on new issues. **Commission may vary by issue age and state. See Commission Schedule for details												
American General Life Insurance Companies	A	A+	A+	American Pathway Solutions MYG (*Guarantee Return of Premium) (Q/NQ)	S	1.80%* ^a 2.00%* ^b	5 yr.	None	8%, 8, 8, 7, 6, 5, 4, 3, 2, 1, 0	Yes	\$10,000 (Q&NQ)	1.5% age 0-75 .75% age 76-85
*CA Rates Effective 8/15/16. First year rate includes 1.50% interest bonus. a (less than \$100K) ; b (100K or more)												
American General Life Insurance Companies	A	A+	A+	American Pathway Fixed 5 Annuity (*Guarantee Return of Premium) (Q/NQ)	S	1.00%* ^a 1.15%* ^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 7/8/16. Includes 2.00% 1st year bonus, 1.00% base rate subsequent years. a (less than \$100K) b (100K or more)												
American General Life Insurance Companies	A	A+	A+	American Pathway Fixed 7 Annuity	S	1.15%* ^a 1.35%* ^b	5 yrs.	None	9%, 8%, 7%, 6%, 5%, 4%, 2%, 0%	No	\$5,000 (NQ)	3.00% age 0-85 1.50% age 86-90
*(Guarantee return of premium Q/NQ) *CA Rates Effective 7/18/16. First year rate includes 4.0% bonus 1 st year. a (less than \$100K) b (100K or more)												
Great American Life	A	A+	A+	SecureGain 5 (Q/NQ)	S	1.85%	5 yrs.	N/A	9%, 8, 7, 6, 5	Yes	\$10,000	2.50% 18-80 (Q), 0-80 (NQ) 1.50% 81-89 (Q&NQ)
Effective 7/21/16. Includes .25% first-year bonus and is for purchase payments over \$100,000. Escalating five-year yield is 1.85%. For under \$100,000 first-year rate is 1.70%. Escalating rate five-year yield 1.70%.												
Great American Life	A	A+	A+	SecureGain 7 (Q/NQ)	S	2.15%	7 yrs.	N/A	9%, 8, 7, 6, 5, 4, 3	Yes	\$10,000	3.50% 18-80 (Q), 0-80 (NQ) 1.50% 81-85 (Q&NQ)
Effective 7/21/16. Includes 1.00% first-year bonus and is for purchase payments over \$100,000. Escalating seven-year yield is 2.04%. For under \$100,000 first-year rate is 2.05%. Escalating rate seven-year yield 1.94%.												
Great American Life	A	A+	A+	Secure American (Q/NQ)	S	1.25%*	1 yr.	N/A	9%, 8, 7, 6, 5, 4, 3	No	\$10,000	5.75% 0-70 4.65% 71-80 4.40% 81-89
*Effective 7/21/16. Eff. yield is 2.27% based on 1.25% first year rate, 1.00% available portion of 10% annuitization bonus (available starting in contract year two) and 0.02% interest on available portion of bonus at the rate of 1.25%. Surrender value interest rate 1.25%. Accepts additional purchase payments in first three contract years. COM12255												
The Lincoln Insurance Company	A+	AA	AA	MYGuarantee Plus 5	S	1.00%* ^a 1.15%* ^b	5 yr.	None	7%, 7, 6, 5, 4, 0	Yes	\$10,000 (Q/NQ)	
*Rates Effective 7/8/16 (a-for premiums less than \$100K, b-for premiums \$100K or more), and are subject to change												
The Lincoln Insurance Company	A+	AA	AA	MYGuarantee Plus 6	S	1.10%* ^a 1.25%* ^b	6 yr.	None	7%, 7, 6, 5, 4, 0	Yes	\$10,000 (Q/NQ)	
*Rates Effective 7/8/16 (a-for premiums less than \$100K, b-for premiums \$100K or more), and are subject to change												
The Lincoln Insurance Company	A+	AA	AA	MYGuarantee Plus 7	S	1.25%* ^a 1.40%* ^b	7 yr.	None	7%, 7, 6, 5, 4, 3, 2, 0	Yes	\$10,000 (Q/NQ)	
*Rates Effective 7/8/16 (a-for premiums less than \$100K, b-for premiums \$100K or more), and are subject to change												
The Lincoln Insurance Company	A+	AA	AA	MYGuarantee Plus 8	S	1.25%* ^a 1.40%* ^b	8 yr.	None	7%, 7, 6, 5, 4, 0	Yes	\$10,000 (Q/NQ)	
*Rates Effective 7/8/16 (a-for premiums less than \$100K, b-for premiums \$100K or more), and are subject to change												
North American Co. for Life and Health	A+	AA-	A+	Gaurantee Choice (Q/NQ)	S	2.10%* ^a 2.35%* ^b	5 yr.	None	10, 10, 9, 9, 8	Yes	\$2,000 (Q) \$10,000 (NQ)	2.50% (0-80) 1.875% (81-85) 1.25 (86-90)
*CA rates effective 8/2/16 - a (less than \$200K) b(200K or more)												
Reliance Standard	A+	A	A	Eleos-MVA	S	3.25%*	1 yr.	None	8%, 7, 6, 5, 4	Yes	\$10,000	3.25%**
*Effective 2/13/16. Includes 1.50% 1st yr. bonus. Min. guarantee is 1.00%. **Reduced 20% ages 76-80, and 40% ages 81-85												
Reliance Standard	A+	A	A	Apollo MVA (Q/NQ)	S	4.05%*	1 yr.	None	9%, 8, 7, 6, 5, 4, 2	Yes	\$5,000	4.00% to age 75**
Includes 2.00% 1st yr. bonus. Min. guarantee 1.00% **Reduced 20%, ages 76-80, and 40% ages 81-85. Effective 7/19/16												
Symetra Life, Inc.	A	A	A	Custom 7 (Q/NQ)	S	2.50%*	7 yrs.	N/A	8%, 8, 7, 7, 6, 5, 4, 0	No	\$10,000	Varies
*Effective 8/19/16. 2.00% base rate with no guaranteed return of purchase payments. Plus 0.50% bonus for \$250,000 and above.												



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Above the Self

Helping Clients Find Clarity Through the Clouds of ACA Regulations

Self funding is making a comeback in California. In this issue, the experts tell us how to determine which clients are the right fit for self funding, make sure that self-funding contracts are executed properly, and take advantage of tech advances.



Funding Storm

Self-Funding: Making A Comeback in California

by David L. Fear, Sr. RHU

Nearly two years ago, I wrote about the challenges imposed on California employers as a result of the passage of SB-161, the stop loss insurance legislation signed into law in October, 2013. As we fast forward to the fall of 2016, employers have not all rushed to enroll in the Covered California Marketplace. Contrary to some predictions, employers have not dropped their group plans and sent their employees to the individual marketplace.

In spite of onerous legislation, such as SB-161, employers are still looking for ways to cut their health care benefit costs without reducing the benefits offered to their employees. So why does self-funding remain a viable alternative for traditional, fully insured coverage? Simply stated, it works and gives the

employers options that they aren't getting from the new ACA compliant plans sold by insurers and health plans. Talk to the hundreds of small, medium, and large employers who have moved into a self-funded arrangement and you'll hear these comments:

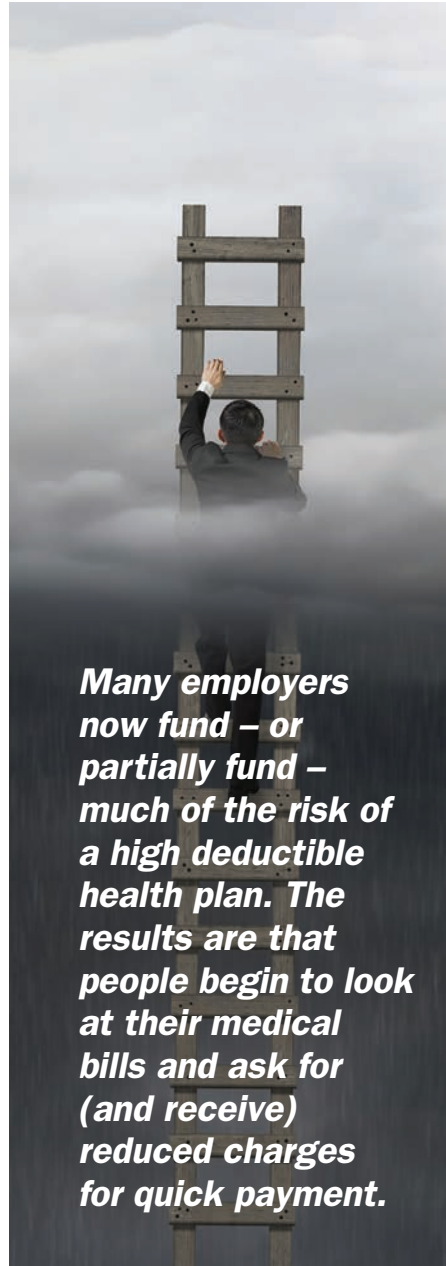
- **"We have been able to stabilize the rising cost of our health benefits."** The cost of health care continues to increase, but employers with self-funded plans are finding that the increase is smaller without the margins that fully insured carriers charge in their plans. These same carriers are now renting their provider networks to self-funded employers, which means that the discounted rates paid to providers are being passed along to self-funded employers. This is a very good thing.

- "If our claims are low, we get to keep the surplus instead of letting the carrier keep the profit." Once again, employers are pretty smart about this. Unlike before, they know how much they are paying out in claims, and they use the surplus dollars (profit) to offset future costs, acting to stabilize their group health benefit budget while fully insured rates continue to escalate at double digit levels.
- **"We implemented a consumer directed plan design along with wellness incentives and are seeing lower utilization of benefits."** In the old days, people had little incentive to ask about the cost of care when deductibles were under \$250. Also, copayments were less than \$20 for routine services. Prescription drugs are a good example. Today most

people ask about less costly Rx alternatives because modern plan designs provide incentives to use generic or formulary brand name drugs rather than just whatever the doctor prescribes. Some people are very critical about consumerism in health care, but without it, the cost of health care services will continue to spiral out of control – something the third party payer system actually encourages.

- **“We protect ourselves by purchasing the right amount of stop loss insurance coverage, reducing our fixed costs, and betting that we’ll control our claims through innovative plan designs.”** Again, while SB-161 put small employers at more risk when they choose to self-fund, the market still responded with innovative products and services. One example of this is employer excess loss insurance, which can offer employers of all sizes a layer of risk protection that allows them to budget for unanticipated risks associated with group health benefits. A big incentive for self-funded employers is to offer a plan design that promotes wellness and helps the employee look at cost efficient health care. Many stop-loss insurers will discount rates based on plan design features adopted by employers including consumer directed and/or wellness incentives.
- **“We transitioned into self-funding over several years; it was the right step for us.”** Many small or mid-sized employers don’t just jump into self-funding. Instead, they move to programs that allow them to take a bit more risk in exchange for reduced costs. Many will adopt an HDHP/HRA program that partially self-funds their benefits. They will then move into a hybrid program, such as level funding, and eventually take more risk over time until they find themselves in a fully self-funded arrangement in which they are actively managing their costs and risks.
- **“We set up a self-funded plan and an HRA plan design and have really been able to control our costs.”** Again, this works for many employers and not as well for others. It all depends on the health benefit plan

design that the employer adopts. Many employers now fund – or partially fund – much of the risk of a high deductible health plan. The results are that people begin to look at their



Many employers now fund – or partially fund – much of the risk of a high deductible health plan. The results are that people begin to look at their medical bills and ask for (and receive) reduced charges for quick payment.

medical bills and ask for (and receive) reduced charges for quick payment. Many employees say that their family doctor begins to talk to them more about preventive care and wellness than simply processing them as another patient. The result of HRAs and consumer directed plan designs are that patients are talking to their doctors about the cost of care. That too is a good thing.

- **“My insurance broker spends**

time with me not just selling me insurance, but also advising me about how this all works and what my real options are.”

Most brokers don’t take the time to review the cost of health care in the proper perspective. They think that showing a client a spreadsheet with hundreds of plans will satisfy them. They couldn’t be more wrong. The fact is that employers of all sizes feel that the money they are spending on health care benefits earns them the right to some sage advice. If they don’t get that advice, they will find a new broker. The fact is that self-funding requires the employer to pay attention to things. At the end of the day, they see the value of having a trusted advisor to lead them through a very difficult path.

- **“Health insurance costs are the second most expensive part of running my business. I need someone to help me control that cost – someone who has my best interest in mind and not their wallet.”** Without question, a good broker should be a trusted advisor. Self-funding requires the broker to know the market, understand plan design issues, and communicate a host of legal and regulatory matters that face the employer and their employees. Self-funding has the potential to stabilize and reduce costs. But it requires the employer to pay attention to things that they have not had to worry about before. Their broker, who is a trusted advisor, needs to be the point person to help the employer work their way through a very complicated market.

Brokers need to work closely with service providers to see that contracts are properly written and executed, stop loss insurance contracts are appropriate, service providers do what they are legally required to do; and the employer’s expectations are met with regard to setting up and managing a self-funded health benefit plan. ★

David L. Fear, Sr. RHU is a founding partner of Shepler & Fear General Agency in Roseville, CA. He is a past president of CAHU and NAHU and the recipient of the 2015 Harold R. Gordon Memorial Award as Health Insurance Person of the Year. He can be reached at 1-877-361-7342, ext 3 or email at davefear@sheplerfear.com.

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Generic Medications:



A ROCKY BALBOA TYPE OF COMEBACK STORY

By DAVID ZANZE

Sandwiched between the advent of biosimilar drugs and the market's obsession with specialty medications, there is the forgotten era of the patent cliff. Let me refresh your memory. From 2010 to 2013, generics were the cost champ of the pharmaceutical industry. During the patent cliff, the market was flooded with generic competition as many blockbuster brand medications lost their patent exclusivity. The availability of these

generics, and the direct competition to the brands, drove plan costs down. The years following have brought additional savings from generics, but nothing like what we saw during the first part of the decade. Focus has shifted away from the tried and true generics to the next big thing in savings. In 2015, specialty became the flashy prize fighter catching the eye of plan sponsors who were looking to gain control of their spending.

WHY GENERICS ARE MAKING A COMEBACK

While specialty medications are driving plan spending now, don't lose focus on generics. Over the next decade, more than 150 medications will lose their patents. This represents \$191 billion in sales. Highlighted on page 16 are some reasons why generic medications are making a comeback against the current champ, specialty medications, and why they

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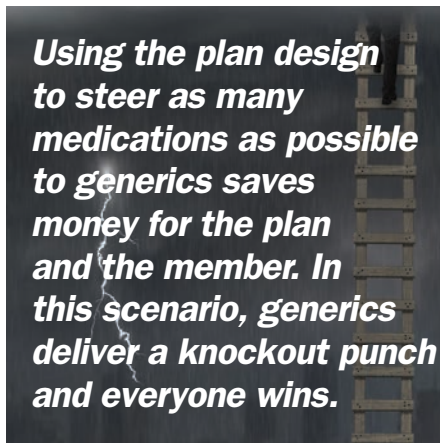
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deserve your attention once again:

- **Inflation:** Inflation rates have remained level this decade, according to the Consumer Price Index. But the same cannot be said for medication prices last year, which marked the third year of double-digit increases. Truveris found that price increases in 2015 and 2014 averaged around 10.9% across most drug classes. Federal government officials predict that annual spending on medications will increase about 6.3% annually through 2024. Brand medications are driving this increase. Health care technology company, Truveris, reported that patients paid 14.8% more for branded drugs in 2015. Those prices rose 9.2% for patients needing a specialty medication to treat more complex or rare conditions, but the price only rose 2.9% for generic drugs, which typically become less expensive over time. Prices for brand medications have soared 164%, from 2008 to 2015, while generic prices continue to fall. Recent news stories have pointed the finger at rising generic prices, but these very specific cases are few and far between. Prices are generally driven by manufacturer consolidation or shortages of generic drugs. The vast majority of generic drugs offer tremendous opportunities for savings for payers and patients. A savvy plan sponsor will implement strategies to utilize as many generic medications as possible to take advantage of the category with the lowest annual inflation.
- **Generic Fill Rate:** The higher the utilization rate of generic drugs by your plan, the less impact inflation will have on plan spending. Every 1% increase in generic-fill rate generates roughly 3% in savings. A plan's generic-fill rate comes from dividing the number of generic medications that have been filled by the overall number of prescriptions that have been filled. It should be a priority to design plans to increase the generic-fill rate as much as possible. Long gone is the time when a 50% generic-fill rate was seen as successful. Plans should strive for generic-fill rates from the mid to high 80 percentages. The closer to 90%

a plan can achieve, the healthier the plan will be. So how can plans capitalize on low inflation and the coming second wave of patent expirations? In other words, how can a plan have a puncher's chance in the unpredictable world of pharmaceutical spending? There are many options ranging from mild to wild, but most plan sponsors choose the path of least resistance for members. While it's certainly the easiest route to have fewer strategies to promote the use of generics, plans that implement more strategies can reduce excessive spending at a far greater rate.



SIMPLE OPTIONS TO SAVE MONEY USING GENERICS

Here are a couple easy options to capture the money that could be lost to the overuse of brand medications:

- **Lower or waive generic copays** to give employees incentives to choose generics over more costly options.
- **Implement a mandatory generic policy:** Requiring generics to be used, if available, should be the norm on all of your plans. Generic medications are required to have the same active ingredients in the same dosage, be delivered the same way, and work as safe as their brand counterparts. Allowances should be made for good reasons to use a brand medication through the use of a prior authorization process. A generic substitution should occur unless the doctor says to "dispense as written" and is willing to provide the reasoning to the prior-authorization reviewer.

Often, a doctor is simply more familiar with a brand name medication and is more comfortable writing the prescription. Many doctors seldom con-

sider the cost of brand medications versus generic medications when writing a prescription. Using the plan design to steer as many medications as possible to generics saves money for the plan and the member. In this scenario, generics deliver a knockout punch and everyone wins.

- **Eliminate Brands:** This can be taken a step further eliminating coverage for brands in categories that have ample over-the-counter and generic options. For example, patients with acid reflux, among other conditions, use proton-pump inhibitors that reduce stomach acid. There are many effective over-the-counter options in this category. Also, an abundance of generic medications are available, as a second-line option, for patients who are not getting effective results from over-the-counter medications. No studies show that brands are more effective than generics or over-the-counter medications in the proton-pump inhibitor category. Since the brands do not seem to be more effective in treating the ailment, it would be wise to exclude brands and encourage the member's doctor to find an alternative treatment.

This article is not meant to take focus off of specialty medications or other drivers of pharmacy spending. The purpose is to remind you of the difference that generics can make. Worrying about the big blow that specialty claims could deliver leaves your plans wide open to a barrage of counter punches from unnecessary spending in areas like brand medications. These can just as easily take the plan's legs out. With a renewed focus on controlling the small, often overlooked parts of a benefit that are within reach, you can lower your spending so that specialty claims won't hurt as much. ★

David Zanze has over 30 years of experience as a leader and innovator in the health care industry. He is the president of PinnacleRx Solutions, a pharmacy benefit manager, Pinnacle Claims Management, Inc., an all-inclusive third party administrator, and Pinnacle Health Management. These companies offer competitive, cost efficient health benefits management and administration in tandem with the latest technology in the self-funded marketplace. For more information about PinnacleRx Solutions, call 844-341-PRXS.



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Why Does Self Insurance Make Sense for Some Employers from 50 to 99?

By SIMA REID

As you think about what may happen with your clients' premium costs when they renew this year, keep in mind that self insurance may be advantageous for their company and their employees. In the past, there were very few options for small companies that wanted to move to self insurance. Today there are many options to consider. Self insurance is not right for every company – certainly not every company from 50 to 99. So you may be asking yourself which are the companies from 50 to 99 that are the right fit for self insurance? If self insurance is a viable option, how do you determine which of the structures and programs available make the most sense for the specific group?

Let's start with these critical factors that should be considered in determining if self insurance makes sense for a company:

- You can have a conversation with the owner/CEO/CFO/controller, and they are open to learning about self insurance.

ance.

- The employer contribution is favorable, and the company has good participation as a result.
- The employer's last three years of rate increases have been at or below trend.
- The employer knows about employees on leave or on workers' compensation to determine if they may be a potential large claim. They may even know about family members with ongoing or costly health conditions.
- The employer has employees in California and outside of California, and wants to provide the same plans to all employees.
- The employer wants to provide health care insurance to their employees.

It is important to look at each of these aspects very carefully. If as an example, the employer is looking for a silver bullet, self insurance may not be a fit for them. As we all know people go to the doctor, needs tests, have surgery, and become hospitalized. If the

employer wants the lowest possible cost and has low participation due to the plan(s) they offer and the contributions they make, they may not be a good candidate for self insurance. Self insurance is not a silver bullet, but has saved many companies a lot of money over time.

When talking with an employer about self insurance, they must believe that it will be advantageous to have increased cost transparency, the ability to see how their dollars are being spent, and increased control over plan design. If they only focus on the worst case scenario of the plan maximum liability, they are focusing on the wrong thing. There are great opportunities for many companies. It is important to have a senior person in the company who believes that self insurance makes sense once you have outlined the pluses and minuses and why it is a good fit.

When you have determined if an employer is a good fit for self insurance, it is important to figure out which structure and program will work best for them. Structures include those that are bundled and unbundled. Bundled plans have all plan components, claims payment, medical management, stop loss, and pharmacy all with one company. Unbundled plans allow for different companies to provide the needed services for the self insured plan. These models are different and each have their pluses and minuses.

Programs available to companies from 50 to 99 are level funded or traditionally funded. Level funded pro-





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grams work well for some employers. They almost look like a fully insured plan since the employer pays the same dollars each month regardless of the claims that have been incurred. The variation is only in the number of members covered each month. Depending on the carrier you use for the level funded plan, if there are any dollars under what was expected left after year end, the employer will share that savings 50%/50% with the insurance company or get back 100% of the excess. With some level-funded plans, each employee is required to answer medical questions. A carrier/stop loss underwriter that requires this process will not finalize rates until after all the employees go through this process. Some underwriters will accept the employer's signature for final disclosure, not requiring the employee underwriting.

When reviewing the numbers, you may find the level-funded plans requiring medical underwriting to be priced competitively. It is important to remember that the numbers may not be the final numbers.

For some employers, a traditional structured plan will make sense. In a traditional structure, the plan is built using a third party administrator/medical manager, a stop loss underwriter, network and pharmacy benefit manager. When building a traditional structure plan, if one of the carriers/vendors is not a right fit in the future, it is much easier to make a change. As with the level funded plan, the stop loss is the

most difficult since no claims information is available. Some stop-loss underwriters will accept the risk with the employer signing off on the final claims disclosure. The carrier doing this will require historical information on rates, plans, any large claims, contribution, and participation. They need to be confident the group has been vetted properly and is a good candidate for self insurance so they don't incur large undisclosed claims.

How do you compare the projected costs of self insurance to the fully insured numbers? If you compare the fully insured plan costs to the maximum liability, it will be rare that the self insured plan seems to make sense financially. With most self insured plans, the aggregate coverage is set at 125% of the expected claims. The fully insured plan includes an assumption for expected claims plus a risk factor. The risk factor imbedded in fully insured plans is much less than 25%.

Timing is critical when you talk with your clients and prospects about self insurance. If you start the conversation when you are meeting to discuss their renewal, it is way too late. There is a process you need to go through to educate them on the pluses and minuses of self insurance. You may need to gather additional information that you don't need for your fully insured quotes. If you determine that the level-funded structure makes the most sense, you need to go through the employee medical underwriting process way in advance of open enrollment

when you must communicate the new plan to employees.

If you moved your 50 to 99 group to a December renewal, now is the time to start the process in considering self insurance. Set up a time line that includes enough time to educate your client; try to figure out if employee medical underwriting will be required; plan out the timing of when you can finalize the numbers; and be sure there is enough time to build the plan. All of this needs to happen before open enrollment. The process of moving a group from fully insured to self insured can be accomplished for the right employer when you have a thorough strategy and a realistic time line. ★

Sima Reid is president of twentytwenty Insurance Services. She has more than 30 years of experience in the insurance industry specializing in the development of stop loss/reinsurance products and employee benefit programs for large regional and national employers. Before forming twentytwenty, Sima was president of Brentwood Benefits and Consultants. There she was responsible for the management of the support staff handling a premium base of approximately \$40 million. Before joining Brentwood, Sima served as Executive Director of the Los Angeles Office Health Care Unit for Alexander & Alexander where she was responsible for over \$25 million in annualized premium. Reid began her career in the insurance industry with Great West Life Insurance Company, where she was responsible for field underwriting, complete plan installation and the on-going administration of large fully-insured and self-funded employer groups. For more information, visit www.twentytwentyins.com.





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SELF-FUNDED + TECHNOLOGY = A USER-FRIENDLY BENEFIT EXPERIENCE

By NANCY REARDON

Brokers and employers are between a rock and a hard place. Insurance premiums continue to rise and increasing medical costs show no signs of abating. High-deductible plans are becoming commonplace and shifting regulatory developments are causing more confusion than clarity. Brokers are asking themselves, “What can I offer to employers to ensure that their benefit packages are cost-effective, simple to understand, and easy to navigate?”

At what point did we veer from this simple yet oh-so-important tenet? How do we make benefits people friendly again? I’d venture to say that any broker would welcome a conversation and a road map to this promised land. Well, here’s a start. It’s called “self-funded insurance.”

More than 50% of covered workers in small and large firms are enrolled in self-funded plans, according to the Kaiser Family Foundation. Self-funded has materialized as a key cost-control strategy. More than 80% of brokers said their firm was increasingly advising employers about self-funded health plans, according to a December 2015 study by Maestro Health.

Brokers must be savvy technology adopters to stay competitive in the self-funded insurance marketplace, and enable employers to control costs and improve the health of their employees. A better understanding of different technology platforms will enable employers to identify at-risk employees earlier than ever. Armed with this insight, employers can keep employees healthy, happy and productive, while avoiding costly claims.

Have I convinced you? If not, let me go deeper. Until now, employers have over-focused on network discounts. This has caused a reluctance to stray from large carriers. Typically, self-funded administrative fees are lower than fully insured plans – allowing for more dollars to be committed to claims. By this logic, the most ef-

fective way to offset rising premiums is to reduce claim expenditures. But how can brokers help employers drive down costs? A third party administrator (TPA) can add value to brokers’ core claims administration offerings by leveraging data from enrollment, utilization, and comprehensive care management programs including on-site screenings. This will help deliver a 360-degree view of a population’s health. It will also reveal the health status of employees, which will help engage employees at a more personal level than ever before.

Instead of chasing discounts, comprehensive care management programs can eliminate costly claims in the first place. Smarter technology will help TPAs get to the root of population health risks more efficiently. The benefit to employers is lower costs.

Consider the following example of an employee enrolled in high blood pressure and diabetes care management programs. During a regular assessment call with his nurse coach, he mentioned periods of shortness of breath and a sudden weight gain of 15 pounds over one month. He attributed his fatigue and difficulty breathing to medication. His coach reviewed his medication list and noticed that he was not on a diuretic medication, which put him at risk for congestive heart failure.

The nurse coach was able to educate him about signs and symptoms associated with the condition, which led to personalized care and the best treatment possible. Given his symptoms, his coach recommended an in-person visit with his doctor. The employee saw his physician the next morning, who diagnosed him with early congestive-heart failure. He was immediately placed on a diuretic medication to help relieve the stress on his body and heart from excessive fluid. The doctor said that the visit saved his patient from an inpatient hospitalization. Just one day after starting his



diuretic medication, the employee said that his shortness of breath was gone and he lost about nine pounds.

When care management programs are powered by data-driven technology, employers can catch at-risk employees before they experience costly emergencies. This technology can review claims data, flag risk aversions, and automate preventative care compliance. With the right strategy, self-funded employers can multiply the cost-savings, flexibility, and control of self-funded insurance by implementing a private exchange solution. Although private exchange adoption has not met the lofty predictions set a few years ago, adoption continues to steadily increase. Accenture recently reported that eight million employees are part of a private exchange in 2016. The largest growth has come from companies with 250 to 2,500 employees. Coincidentally, this is also a sweet spot for self-funded.

Self-funded insurance and private exchanges can work together to create a more informed and user-friendly experience for employers and employees. In a self-funded model, claims data belongs to the employer. With complete visibility into benefit use, employers can provide better, more personalized support and guidance for everything from plan selection to wellness activities. The need for innovation in the benefit marketplace is on the rise. More than 53% of brokers say that success is directly tied to innovation through technology solutions, according to a study by Maestro Health.

The self-funded revolution is just beginning. Stay ahead of the market. Embrace the ways technology can enhance self-funded client services by creating a path toward lowering costs, creating better experiences, and, most importantly, promoting healthier lives. ★

Reardon is the chief product officer at Maestro Health. For more information, email info@maestrohealth.com or call 312-517-3500.

Beat the Rush with Early Renewal

By CHRIS PATTON

As an industry, we will reach the height of the Affordable Care Act's implementation during this upcoming holiday season. With many sectors of the health insurance marketplace planning to renew at the end of the year, we need a "get your holiday shopping done early" strategy to beat the seasonal rush. Early renewal strategies to stave off the implementation of metallic plans and other elements of the ACA have only served to postpone the inevitable, but now the time has come—and with it, enough work to keep us burning the midnight oil as we ring in the New Year. This strategic renewal game has resulted in what I like to call "The Great Convergence."

Essentially, every area of the health insurance arena will be renewing at the close of 2016. An estimated 80% of all group plans renew for coverage beginning December 1 or January 1. The open enrollment schedule for group health insurance been compressed into a tight time frame. Also, as a result of the small group expansion earlier this year, employer groups with 50 to 100 full-time equivalent employees will be incorporated into the mix of the individual marketplace and Medicare open enrollment periods. This rapid influx of enrollees can create an implementation bottleneck and result in a strain on the entire industry. This means that your clients may be affected by enrollment delays, prolonged turnaround times, and other service issues.

Avoiding the negative effects of "The Great Convergence" means encouraging your small group clients to move their open enrollment to earlier in the year. It saves you the burden of having to shop the market and service your clients during what is expected to be one of the busiest enrollment periods in recent history. Also, there is opportunity for you and your small busi-

ness clients to benefit in other ways. An early renewal strategy not only allows your clients to avoid the holiday rush, but also give them more time to access their greatest resource—you. As their agent, early renewal allows you and your clients more flexibility to explore options and time to navigate the new and ever changing landscape of group health insurance, maximizing their premium dollar and avoiding costly mistakes and penalties.

It has been estimated that nearly one third of 50+ groups that previously renewed on non-ACA plans will benefit from reduced premiums associated with ACA-compliant plans. Blue Shield, for example, is touting lower rates for small groups renewing prior to fourth quarter that could save them up to 10%. Insurance providers, such as Health Net, are offering incentives to agents that conduct client renewals between the months of July through October. Moving open enrollment to an earlier month on the calendar might allow those companies with 50 or more full-time equivalent employees that originally delayed offering ACA-compliant health plans a chance to secure third quarter 2016 rates prior to 2017 increases.

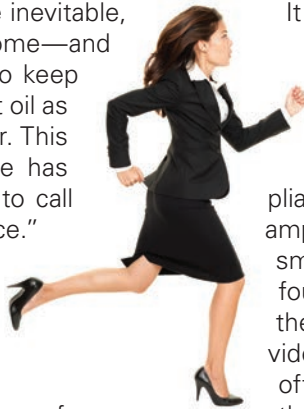
Platforms that are most conducive to managing these swift mid-year changes are multi-carrier, multi-plan exchanges, which are nimble enough to accommodate new plan designs and other elements of insurance without having to move the entire group from one carrier to another. Thirty percent of the currently enrolled small business market in California is expected to enroll in a multi-carrier exchange within the next three years, according to a recent study chartered by Covered California for Small Business and conducted by PricewaterhouseCoopers. This is great news for public and private exchanges, and can be an excellent opportunity for

agents looking to protect their book of business and save time on renewals in the years to come.

Investing in your clients early exchange enrollment will reward you and your clients with a program that will be infinitely adjustable over time. Although employers and employees may initially have more questions about the enrollment process, exchanges are flexible enough to accommodate future plan design changes and are built for longevity. While they may take a little more of your time to implement, they will virtually eliminate the need to move the group in search of better rates or more competitive plans in the future.

Now is the time to take action and to have this conversation with your clients. The first step to setting this shift in motion is to discuss the reality of the upcoming renewal season, its implications, the benefit of early renewals, and the difficulties that will accompany those small businesses waiting until the last minute to renew. The close of 2016 represents the last of the ACA migration and will undoubtedly materialize as one of the most demanding open enrollment periods in history. Although the next few months present tremendous opportunity to gain new business, taking the time now to spread your existing group renewals throughout the calendar year will ease the burden of doing it all in fourth quarter. The bottom line is, especially with exchange plans, take the time to renew your small business clients early, and the payoff will be worthwhile. ★

Chris Patton has over 15 years of industry experience in the California market with knowledge of both the retail and wholesale distribution of group health insurance products. As the Vice President of Sales for Covered California for Small Business, Patton and his team are staffed statewide to support the role of Covered California's certified insurance agent community and to ensure the successful and ongoing distribution of California's small business public exchange program.



A MUST-HAVE CHECKLIST FOR **Open Enrollment** THAT EVERY EMPLOYER NEEDS

By ROB CARNAROLI

Open enrollment is fast approaching for many employers. Advance preparation can make the difference between a positive experience and one that frustrates you, your clients, and their employees. As a broker, you can help your clients with a smooth and hassle free process by addressing a number of important items.

KNOW WHY THEY OFFER BENEFITS

Establish clarity around why your clients offer benefits. Typically, it's to retain valuable employees and attract talent in the marketplace. Addressing this reason up front sets the tone for discussions and activities that follow—from benefit plan design through enrollment and beyond.

ANSWER "WHAT'S IN IT FOR ME?"

While your clients often make benefit decisions with financial considerations in mind, their employees want to know how it affects them. They want to know "What's in it for me?" Employees want to feel that their needs and the needs of their families are met, and that benefit offerings are robust enough to keep them around. The "What's in it for me?" question is one new talent asks too, as they consider the effect a job change might have on them and their families. The following will help employers answer this question.

ENGAGE STAFF

People today expect to participate in, or at least understand, decisions that affect them. Your clients should consider eliciting employee perspectives early in health benefit discussions. Involve employees from different levels in the organization—administrative staffers, middle management, technicians and other professionals, and senior managers. Including a variety of ages and family situations gives your clients a broader perspective, too.

Often, the person who fills the HR position in a smaller firm wears other hats and would welcome employee input into benefit offerings. Building consensus takes the pressure off that person, who may or may not feel qualified or comfortable making decisions on their own.

SET EXPECTATIONS

Make sure you and your client are on the same page before enrollment begins. No one appreciates last minute changes or unexpected surprises. Set expectations around the length of the open enrollment period, what level of employee education needs to be provided, the lead time for getting information to the carrier so plan documents and identification cards can be produced and distributed, and more.

COMMUNICATE, COMMUNICATE, COMMUNICATE

Your clients' employees should be fully aware of what's happening with their health benefits. Employers should consider a variety of communication channels: group meetings, one-on-one discussions, information sheets or brochures, posters, social media posts, custom website content, digital decision-making tools, etc. This helps your clients get their employees on board with changes, options, time lines, and responsibilities.

"Early and often" is a cliché, but it's valid. Repetition reinforces messages and minimizes knowledge gaps. So does variety. Your clients should consider designing communication pieces and activities based on their workforce demographics. Baby Boomers take in information differently than Gen-Xers or Millennials.

LEAVE INDUSTRY JARGON AT HOME

HSAs, CDHPs, HDHCs, and HRAs are acronyms that represent an easy way for benefit enthusiasts to communicate, but industry lingo may confuse your clients and their employees. Ditch the alphabet soup. Spell things out in terms that everyone understands. Keep it simple.

ILLUSTRATE SCENARIOS

Give your clients real-life scenarios to drive the message home and help employees understand their benefit options. For example, instead of simply presenting the various metallic plan levels to your clients, break down the benefit options in terms of family and health

status. Use a few common scenarios—the healthy couple with two children; a person with a medical condition that requires costly medications and frequent trips to the doctor; or the healthy young woman who rarely needs to visit the doctor. Then use these examples to explain what benefit plans each should seriously consider.

IDENTIFY THE DECISION MAKER

While you most likely work with the decision maker at the business level, don't forget about the decision maker at the employee level. In fact, it may not even be the employee—it's no secret that women usually make health care decisions for the family. Help your clients understand this as they implement their communication plan. They should be prepared to answer questions multiple times and provide information that can be easily consumed and understood.

ADDRESS SPECIAL SITUATIONS

If your client is changing carriers, you need to help them understand any coordination of care issues. Your client may have employees affected by such a change—an expecting mother or father, someone with a surgery scheduled, or an employee who needs a costly specialty medication. You need to work with the new carrier on the coordination of care protocols and procedures, and then communicate them to your client and any impacted employees.

This is, by no means, an exhaustive checklist. In fact, it could probably be twice as long—maybe more, when considering tasks that are required post-enrollment. But addressing these issues early will go a long way in ensuring a positive enrollment experience for your clients and their employees. ★

Rob Carnaroli serves as vice president of Sales for Sutter Health Plus. Prior to joining the health plan in November 2014, Carnaroli served as Health Net's Northern California director of sales and Health Net's Western Region director of major accounts for Arizona, California, Oregon and Washington. <http://www.sutterhealthplus.org>.



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Individual Short-Term and Limited Medical Plans: A Closer Look

By BRENT HEURTER

Covered California just announced that rates will be increasing 13% on average for 2017, with some rates going up as much as 36%. With these increases coming our way, your clients may want to see options to help reduce their out-of-pocket costs. Two such plan types that can exist along-side or *in lieu* of core medical plans include limited medical and short-term plans.

SHORT-TERM MEDICAL PLANS

In some cases, a short-term medical plan may be a viable alternative for clients seeking to save on health care costs, especially if they're healthy. A six-month short-term plan with a \$5,000 deductible could cost a 30-year-old male living in Los Angeles as little as \$99 a month, according to an analysis conducted late last year by HealthPocket, a California company that ranks and compares health plans. Compare this to an average unsubsidized premium of \$286 a month for an individual and \$727 for family coverage. Some short-term carriers even offer a discount of up to 30% when the premium is paid in advance.

With the savings from purchasing a short-term medical plan, the insured can purchase supplemental benefits, such as accident or critical illness insurance plans, that pay cash benefits. The money from a supplemental plan can be used to help pay for out-of-pocket medical costs, such as deductibles and co-pays, or to help pay for living



expenses due to loss of income while at home recuperating.

Another advantage to short-term plans is their wide acceptance among health care providers, unlike limited or narrow networks. Most short-term

plans use a PPO network for repricing medical services, which can provide savings of up to 50% or more. The network repricing is a huge benefit not to be overlooked and is a strong reason to buy a short-term medical plan, even if

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you have a pre-existing condition.

Short-term medical plans were originally designed to provide temporary coverage to help bridge a gap when someone is in-between jobs and employer group medical plans. However, with the advent of the ACA, short-term plans have gained in popularity for consumers seeking coverage outside of the open enrollment period. And still, some consumers see short-term medical insurance as part of a longer-term strategy to save on health care costs.

However, short-term medical plans are not without drawbacks. For one, short-term medical plans, by themselves, do not satisfy the Minimum Essential Coverage (MEC) requirements of the Affordable Care Act. Individuals and families that opt for a short-term medical plan may have to make a shared responsibility payment for not having minimum essential coverage. Even with the penalty, this option still may be more affordable for many. There is even an online tool that will display the premium of a core medical plan as compared to the cost of a short-term medical plan coupled with the penalty at https://hiiquote.com/plancostestimatorb/premium_calc.php.

Short-term medical plans also do not cover pre-existing conditions. Anyone needing coverage to pay for on-going medical care will not be a good candidate. Short-term plans are not required to cover the 10 essential health benefits mandated by the ACA, such as preventive care, maternity, and mental health. While the short-term plan may not pay any benefits under the policy for pre-existing conditions, significant savings can be achieved by using a network medical provider.

Unlike ACA plans, short-term medical plans are not guaranteed issue. Depending on the state, these plans have a limited term of six or 11 months (California is six months). At the end of term, insureds will have to reapply for coverage and will be subject to underwriting.

Short-term medical benefits can vary widely depending upon the plan and carrier. A typical short-term policy has a deductible of \$1,000 to \$10,000 with no first-dollar coverage. Some plans may provide a limited benefit amount, \$50 for example, for one to

three office visits or have a \$50 copay for urgent care visits. Most short-term plans do not provide coverage for outpatient prescriptions, but may include a prescription discount card, which can reduce the cost of some medications by up to 85%. After the deductible, the plan typically pays 50% to 80% of covered costs, subject to an out-of-pocket maximum, with lifetime benefits up to \$1 million to \$2 million dollars.

With a limited medical plan, anyone under 65 is approved for coverage. Rates do not increase with age and won't be subject to annual increases. Rates for a limited medical plan are not affected by gender or zip code, and the cost is the same for a 64-year-old as for an 18-year-old.

When explaining the benefits of a short-term policy to a client, it is very important that the client understands what they are buying and the differences between the benefits of a short-term plan and an ACA-compliant plan. Recently, the state of Arkansas issued a cease and desist order against a carrier alleging that the company used fraudulent and dishonest practices in an attempt to sell short-term medical policies.

Pros and cons aside, if a customer is seeking coverage and does not have a qualifying life event to enroll in an ACA plan, short-term medical plans can be the best option for coverage.

LIMITED MEDICAL PLANS

Limited medical, or "fixed indemnity," plans also have been growing in popularity. Limited medical plans provide the least amount of protection among the plan types discussed, but premiums typically cost one-third or less of the lowest-cost ACA plan available in a region.

Clients and prospects in the categories below may benefit from purchas-

ing a limited benefit plan:

- 1) Do not qualify for premium tax subsidies.
- 2) Cannot afford major-medical coverage.
- 3) Do not qualify for a special enrollment period and cannot meet underwriting requirements for a short-term medical plan.
- 4) Undocumented individuals and families (many limited medical plans will accept an individual if they have been present in the United States for 12 or more months).

Limited medical plans are sometimes referred to as "permanent coverage." As long as premiums are paid, the coverage under a limited medical plan continues up to age 65 and is not subject to a maximum policy term or annual renewals.

With a limited medical plan, anyone under 65 is approved for coverage. Rates do not increase with age and won't be subject to annual increases. Rates for a limited medical plan are not affected by gender or zip code, and the cost is the same for a 64-year-old as for an 18-year-old.

Limited medical plans provide "first-dollar coverage," meaning the insurance company pays a fixed benefit first, then the insured is responsible for the balance. For example, the plan may have a \$50 benefit for office visits and include a national PPO network that can provide a savings of 40% to 60%.

As an example, let's say that a doctor normally charges \$150 for an office visit and is a network medical provider. With network repricing, that cost may be reduced by 50% and will amount to only \$75 after the network discount is applied. The insured's plan includes a \$50 benefit for office visits, so the doctor's office bills the insurance company \$50 and will balance bill the insured the remaining \$25. Under this scenario, the insured paid only \$25 for a doctor office visit that would normally cost \$150.

It's argued by some that limited medical plans are a better deal for young and healthy individuals that are risk-tolerant. With a major medical plan, there is no benefit unless you have medical claims that exceed the deductible plus the cost of the annual premium. This same healthy indi-

vidual could have purchased a limited medical plan and received first-dollar benefits for any medical services they receive. The substantial premium savings can be used to purchase supplemental coverage, which can help pay for all out-of-pocket medical expenses should something major happen plus, there would still be savings left over.

FEDERAL REGULATORS WEIGH IN ON SHORT-TERM AND LIMITED MEDICAL PLANS

In June, the Dept. of Health and Human Services (HHS) announced a series of actions they felt would strengthen the Marketplace risk pool, curb premium increases and ensure the Marketplace is viable in the long-term. One of the key actions includes "curbing the abuses of short-term plans." HHS is taking the position that short-term plans "exploit gaps in current rules to use medical underwriting to keep some of the healthiest consumers out of the Affordable Care Act's single risk pool."

Under the proposed rule, insurers

would only be able to offer short-term medical policies that last less than three months with no potential for coverage extensions. Currently, short-term medical plans are not considered individual health insurance and are therefore exempt from ACA mandates.

The proposal to limit the duration of short-term plans is subject to 60-day public comment period after it is finally published. After that, it will be up to regulators to decide whether to adopt the rules as proposed, make changes based on feedback or abandon the proposal altogether.

Insurance carriers offering short-term medical plans have been, for the most part, quiet when asked for comment on the proposal. If passed, it's a general belief that at least one major carrier will sue the HHS stating that it has no authority when it comes to regulating how short-term plans are treated under the ACA. If this happens, we'll have to wait to see if the courts rule in favor of the insurance

carriers once again.

Carriers offering limited medical plans won a major court decision in June when a federal appeals court ruled that HHS has no authority under the Affordable Care Act to regulate how consumers use fixed indemnity health insurance or other "excepted benefit" products.

Whether it's a core medical plan and/or a combination of "non-traditional" plans that provide appropriate coverage at an affordable price point, there is much to consider before making a recommendation to your clients and their families. ★

Brent Heurter is the president and chief marketing officer for WOW! Insurance Marketing, an independent marketing organization helping insurance agents enhance their businesses with innovative products and practices. Brent will partner with Dickerson Employee Benefits, a Los Angeles-based General Agency, to conduct informational and sales strategy workshops for individual producers in the coming weeks. Brent can be reached via email at brent@iluvwow.com.

GOING NUTS LOOKING FOR INSURANCE INFORMATION?



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A CACHE OF CALIFORNIA'S PRODUCT SOURCES IS COMING SOON!

The Right PEO Partner Can Be Good for Brokers

By JESSICA WORD



Reaching out to a past opponent can be difficult, but it can also be rewarding. It's important to remember that people and organizations can change. A rival from childhood could become a good friend later in life. A former competitor could be your future business partner. Old attitudes fade because they need to change. It's a new world to grow your business, if not to retain your client base, you need to look at market solutions with fresh eyes.

In our world, let's look at professional employer organizations (PEOs). Employers outsource their employee benefits and other management tasks like payroll, workers' compensation, risk and safety management, HR, and training to these firms. A few years back, brokers perceived PEOs as a threat due to their success at taking appointments from brokers. Since then, there have been some decidedly broker-oriented changes at a few of these organizations. That said, not all have made the migration (or full migration) to broker friendly status.

Understanding why PEOs have suddenly become a hot item – and discovering how to tell the broker friendly from the phony – is critical. First, let's explore why the model appeals to some groups. Some PEOs allows small groups to fall under a single, large group banner in terms of accessing benefits. This is accomplished through a co-employment agreement with the group. This simply means that, while the owner of the group continues to own, manage, and control the company, the PEO implements compliance and HR activities as well as other administrative tasks – all while allowing the employer to retain their own State Tax ID number. This is all overseen by

in-house HR professionals and attorneys to help avoid litigation and compliance exposures, and, importantly, to keep your employer client from having to wrestle with the hassles of performing all these HR related tasks.

COMPOSITE RATES FOR SMALL AND LARGE GROUPS

From a benefits perspective, let's look at how this works by taking a fictitious PEO with 100 groups, each with 10 employees. Under the co-employment arrangement, this now becomes a single 1,000-life group, which allows carriers to issue a single master policy for large group benefits. However, each sub-group can still be underwritten (for both the health and workers' compensation). Since they are no longer under a small group policy or rating rules, each sub-group's premium will reflect its true experience, risks, and ages. As a result, the PEO can generate an accurate composite rate for each sub-group. That is something to keep in mind for 51 to 100 groups that will otherwise lose their comfort-zone composite rates, as they move to Affordable Care Act (ACA) compliant coverage and the new definition of small group.

This means potentially favorable rates for healthier and younger groups along with single, integrated professional HR management for the perplexing range of California and federal labor laws along with ACA reporting requirements. Interestingly, under Department of Labor and IRS rules, each of the fictional PEO's 100 groups with 10 lives can enjoy the advantages of a large group policy without having to meet ACA rules for 50+ groups. In some ways, this produces a best of both worlds opportunity. Each group can still maintain its own state Tax ID Number.

A BROKER-FRIENDLY, INTEGRATED BENEFITS ADMIN SOLUTION

PEOs have made significant efforts to be more broker-friendly. A current PEO model offers a single, integrated health, payroll, and HR platform – in the same way that online agencies and e-brokers are gaining broker-of-record letters. Where these e-brokers do not deliver, the PEO does deliver on this promise because it is truly an integrated platform, with no smoke and mirrors. From the employer's perspective, a functioning single source, integrated health, total benefits, and HR/compliance solution is very appealing. Employers want to manage their businesses, not their benefits, especially if they can keep their current broker. That's where the new PEOs come in – few have always only worked with brokers. However, as many of you can unfortunately confirm, most have not. In fact, many have been quite aggressive in their efforts to take business from you.

Because of the growing success of broker-friendly PEOs, a few of the more aggressive direct sale entities are now testing broker channels. In fact, at least three California general agencies now have these relationships.

A critical test of a PEO's new found broker faith would be to ask two questions:

- 1.) Do they still take cases directly or do they rely 100 percent on broker sales?
- 2.) If they claim to take only cases through brokers, ask them if you can take back any of your cases they may have taken.

Here's my recommendation: Use the accompanying checklist to help find a reliable PEO partner you can trust

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without the fear of their direct sales channel calling on the group, with or without you, next year. To determine if your current or prospect group is a fit for a PEO, a good prospecting place to begin is with the following:

- Any group you lost to a PEO in the past;
- One that is at risk of going to an e-broker or another PEO; or
- A 51 to 100 employee group that is uncomfortable at the idea of losing its composite rating (this group would be a candidate for a PEO because it can retain composites on certain PEOs).

Because the sale is more than just medical, you will want presentation support from your PEO partner to ensure the value proposition is fully explained to your group – and to manage that on-boarding and installation. The good news is that many of the PEOs do that for you. Your PEO partner needs to guide the sale through the integrated road map of payroll, HR, workers' compensation, and benefits. The many technical issues require an expert's presence and, ideally, you (as the group's broker) and the PEO consultant will co-present the solution

together. Finally, a truly broker-friendly PEO will insist you retain your visibility and assist with health-related service issues throughout the year, leading up to the group's renewal where they will assist with your open enrollment.

There are broker-friendly PEO products available that truly deliver an integrated employer system, a solution that the broker community has been asking for. Due to the changes in our industry, to maintain your success, I strongly urge you to consider reviewing a PEO product for those clients that fit the profile. ★

Broker's PEO Checklist

QUESTIONS TO ASK

Does the PEO also sell direct without brokers?

Do they pay broker commissions on all health sales?

Do they pay commissions on the Dental and other ancillary coverage?

Do they pay commissions on the group's setup and admin fees?

Can you carve out workers' compensation?

Can you carve out health and offer the PEO services on an administrative services only (ASO) basis?

[An ASO arrangement is where the employer funds benefits but uses a third party for administration.]

Does the broker retain visibility after the PEO sale?

Can the group retain its California Tax ID Number?

Are the PEO fees transparent?

WHY THIS IS IMPORTANT

Some PEOs do; some do not. For example, some PEOs are belatedly reaching out to brokers while still maintaining aggressive direct sales tactics. What will they do with data on the groups that don't buy?

Some PEOs pay broker commissions on all health plans in addition to the broker receiving commission on the setup and admin fees charged to the group. Other PEOs only pay on one of two offered plans, but they also pay commissions on the group's setup and admin fees.

Some PEOs do. Some PEOs don't.

Yes! Here's a big plus for brokers who in the past did not generally see any, or much, compensation on fees for payroll, HRIS, COBRA, etc. Most PEOs will pay you on these non-Medical Loss Ratio (MLR) services.

Yes, some PEOs allow this, which is important for P&C brokers; it is an indicator of the PEO's flexibility to customize around the needs of each group or broker.

Yes, some PEOs allow this. Again, an indication of a PEO's interest in working with you versus taking over the entire group. With some PEOs, in an ASO arrangement, an employer can carve out needed services like payroll, workers' compensation, and compliance as well as the employee benefits package. For example, this can be a great way for your group (and you) to test a PEO while you carve out the health.

Yes, some PEOs allow this. It is important for brokers to remain active in the servicing and renewal of the health package. Some PEOs prefer you slip away quietly while others empower your visibility.

Yes, some PEOs allow this, which can be a valuable advantage. Retaining the group's state Tax ID number makes it easier for a group to leave if the relationship is not working out. Broker-friendly PEOs won't try to trap you if the employer wants out.

Some PEOs itemize their fees; itemized fees show the organization is transparent and not trying to hide anything. Other PEOs lump fees together with the health premiums; this can make evaluating the overall costs more complicated. ★

Jessica Word, RHU, is president of the Word & Brown General Agency headquartered in Orange, California.

Annuity Buyers in 2016 Should Be More Creative

By SCOTT SADAR



In most years, the decision to buy an annuity is relatively cut-and-dry. In large part, this is because the majority of buyers are pre-retirees and retirees who predictably want to temper the risk of volatile equity markets by moving some of their money into a product offering guaranteed lifetime income. Most prospective buyers do, in fact, want an annuity. It's mostly a matter of what type and how much to invest.

But this is not the case this year. Insurance companies are trimming payouts on many annuities. This may be offset later by higher interest rates, but there are no guarantees. And what do

clients do if now is the time they want to make a purchase decision?

Annuity payouts started heading south in 2015 and will continue to do so in 2016 because insurance companies have been adopting new mortality tables that show people are living longer, requiring insurers to offer guaranteed lifetime payments for additional years. Payouts are commonly being trimmed about 10%.

There is a good chance that some or all of these cuts will be reversed late this year if Federal Reserve-engineered increases in short-term interest rates translate into increases in long-term interest rates. This is usually

the scenario. Higher long-term rates would benefit insurance companies because they're constantly investing in new bonds. And they're motivated to increase payouts – if they can retain profitability – to offset sluggish annuity sales.

This will not happen overnight, however, and it may not happen until 2017, begging the question of what your clients should do until then. What they should not do is wait to buy annuities. Annuities pay considerably more interest than bank CDs, are virtually as safe and in many cases will pay more if customers buy and postpone their payouts sooner, rather than later.

This year, clients, in particular, should re-consider buying popular-selling variable or fixed-income annuities. Instead, they should seriously consider buying a ladder of fixed annuities with different maturities, which aren't impacted by mortality table changes. These offer relative flexibility and respectable income while the ladder hedges, in part, against the risk of rising rates.

NEW MORTALITY TABLES

New mortality tables show that 65-year-old men, for example, are living three years longer than they did in 2000 (for 88.5 years) and 65-year-old women more than two years longer (for 90.3 years). Insurance companies must adjust to this to make profits. Annuity payouts have already been declining for years, largely because of a sharp drop in interest rates. Mortality table-induced adjustments last year and this year, however, will mark the deepest and most widespread cuts since 2008.

But if these cuts had to come, the timing is propitious. As explained, Federal Reserve moves may offset the pain with a lag. Without those moves, the pain would be unmitigated because insurance companies would be stripped of a likely opportunity to increase profits via higher investment returns.

Purchase of a basket of fixed income annuities. Specifically, the multi-year guarantee annuity (MYGA) is the answer to the inevitable lag in higher rate increases. These generally pay 2% to 3.25% annually for three to 10 years, and taxes, unlike a CD, are deferred until withdrawal in a non-IRA account. This allows the annual yield to compound and grow more.

LADDER SPECIFICS ARE IMPORTANT

One good path utilizing a MYGA ladder would be the assembly of a three-year, five-year, and seven-year MYGA, which, at current rates, pay 2%, 2.65% to 2.8%, and 3% respectively (assuming clients want the option to withdraw 10% of principal without penalty). This provides a partial hedge against the uncertain timing of rising interest rates. If, say, rates rise after three years, the



buyer has collected their money from the three-year MYGA and can transfer it to another, now higher-paying MYGA – and as a non-taxable event.

In short, a MYGA ladder buys fare better if rates rise and isn't hurt if they do not. For those who need more current income, the best route today may be not a ladder but the purchase of one seven-year MYGA, which pays more and still keeps buyers' options open to some extent.

Down the road, insurance companies are looking for an excuse to improve annuity payouts. That's because dwindling annuity payouts, which were falling well before the adoption of new mortality tables, mostly because of ultra-low interest rates, have hurt sales. In the first nine months of 2015, the latest figure available, total annuity sales totaled \$169.6 billion, down 2% from the same period in 2014, according to the Insured Retirement Institute. This shouldn't be happening given that the Baby Boomer generation, the most affluent and second-biggest in history, is retiring in mass.

PAST ANNUITY SALES MUCH BETTER

In healthy years in the past, such as 2006 and 2007, annual sales, spurred by more generous benefits and gener-

ally lower fees, rose 10.3% and 8% respectively. Insurance companies would love to see those kinds of gains again, industry observers say.

Prospective annuity owners who remain reluctant to make a purchase should weigh their investment options outside the annuity world. Many experts believe that long-term stock market returns will be a more modest 6% to 8% annually, down from an historical annual average of 10%. If true, that gives stocks a less compelling edge over other investments.

Insurance companies obviously have to offer good value to thrive. Some huge annuity vendors, such as Nationwide and Guggenheim, have already begun to improve terms on select annuities. As interest rates start climbing, watch for them to roll out still more attractive annuities and for other insurance companies to join the bandwagon. The mortality table issue won't disappear, but it will become more palatable. ★

Scott M. Sadar is executive vice president of Portland, OR-based Somerset Wealth Strategies and a Certified Financial Planner. A financial planning professional for more than 15 years, prior to Somerset he worked in annuity sales and in advanced market/estate planning at Jackson National Life and in advanced markets sales consulting for MetLife.

**WHAT CLIENTS
DON'T KNOW
CAN HURT THEM**

Four Tips for Offering Voluntary Insurance

By ANDY GLAUB

Like drinking water from a fire hose, open enrollment can leave employees feeling overwhelmed with an influx of new options flooding them all at once. For many employees, proper research on benefits often falls by the wayside. They don't take the time to investigate options like voluntary insurance benefits, which can help them prepare for unexpected incidents — not to mention the accompanying financial implications. Ninety percent of employees choose the same benefits year over year, according to the 2015 Aflac Open Enrollment Survey. Many feel that selecting benefits is mundane so they select the same offerings as usual, even if those offerings aren't the most beneficial.

Instead of letting clients get overwhelmed, you can use the open enrollment period to highlight the value of voluntary insurance benefits, especially with their growing role in your product portfolios. Here are four keys to capitalizing on the open enrollment season while building strong client relationships:

- **Understand the portfolio:** First and foremost, to understand which products will appeal to a client, it is critical to understand the needs of each employer and which products can support them best. No one wants to be served a generic sales pitch. Instead, get the inside scoop: What is the organization's long-term strategy for retaining employees? What do they value most? What do they feel they could improve in their offerings? Align each benefits approach with the company's overall strategy.
- **Don't underestimate the power of face time:** In a world dominated by technology, the power of face-to-face communication is more critical than

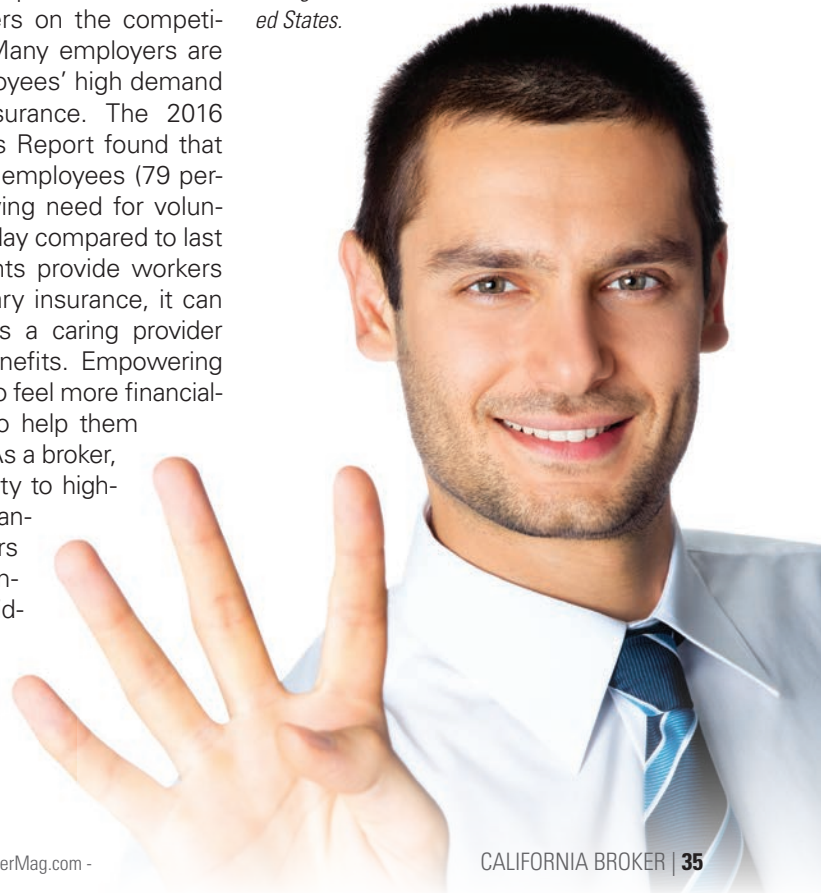
ever. Taking advantage of this time and answering your clients' questions will allow you to showcase the value voluntary benefits can provide and inform clients about new factors.

- **Overselling is overrated:** Of course, it seems more beneficial in the short term to encourage your clients to expand their packages. However, it's more sustainable to work toward building a long-term relationship. Focus on selling employers the two or three products they need most, rather than pushing every single option their way. By doing so, you will establish yourself as a trusted expert, which in turn will eventually allow you to propose additional products like critical illness or hospital insurance. When it comes down to it, selling ethically and professionally trumps all.
- **Educate employers on the competitive advantage:** Many employers are unaware of employees' high demand for voluntary insurance. The 2016 Aflac WorkForces Report found that nearly 4 out of 5 employees (79 percent) see a growing need for voluntary insurance today compared to last year. If your clients provide workers access to voluntary insurance, it can establish them as a caring provider of meaningful benefits. Empowering their employees to feel more financially secure will also help them retain top talent. As a broker, you have the ability to highlight these advantages to employers who may be unaware of this hidden asset within your portfolio. In many cases, reeducation can lead to re-enrollment.

MUTUALLY BENEFICIAL

Your biggest obstacle could be a prospective client's lack of awareness. By using the open enrollment season as an opportunity to demonstrate to your clients how voluntary insurance can help their employees build financial security, you will build their confidence and will help them feel more comfortable committing. When your efforts as a broker bring your clients positive results and enhance their bottom line, your relationship will grow as a result. ★

Andy Glaub, senior vice president and director of sales, began his career with Aflac in 1985 as an associate. In his current role, Andy is responsible for the day-to-day operations of the sales force, developing programs and initiatives to enhance U.S. sales strategies and advance Aflac's sales throughout the United States.



How a Legal Plan Helps Employees Caring for Aging Parents



by Ann McDonald



With Baby Boomers aging out of the workforce, a younger generation of employees, is confronted with new challenges in the workforce. One of the biggest challenges this generation of employees faces is caring for aging parents. A recent survey conducted by Pew Research found that 25% percent of adults with at least one parent over the age of 65 said that their parents needed help handling their affairs or

caring for themselves.

Taking on the responsibility of caring for aging parents can be a time consuming task and there are many legal issues to consider. Research conducted by Harris Poll on behalf of Hyatt Legal Plans found that among working adults, 44% of those who became a caregiver and 55% who chose a nursing home in the last five years needed legal help.

Unfortunately, due to the high cost

of seeing an attorney, often averaging over \$290 an hour, many people cannot afford to seek the legal help they need. A group legal plan is a benefit that provides affordable assistance to working adults for legal issues they face, including elder law matters. Having access to an attorney that can provide legal guidance for estate planning and long term care planning addresses a key need for employees who are caring for their parents.

ESTATE PLANNING CONSIDERATIONS

Harris Poll found that only 42% of working adults have a will. Many adults do not prepare these documents in advance, leaving it up to their caregiver to handle. One of the first things a caregiver needs to do is make sure that their parent has all of the necessary estate planning documents in place, including a will and healthcare and financial power of attorney documents. If a parent already has these documents, a caregiver will want to make sure that they are all up to date.

Members of a group legal plan have an option to cover their parents under the legal plan, giving their parents direct access to attorneys to draft wills and power of attorney documents. Members can also contact an attorney to have them review these documents and see how they may impact them. For example, if a parent has chosen the caregiver as their financial power of attorney, it will be important for the caregiver to be aware of all the financial accounts and documents that may need to be handled going forward.

Ensuring that a parent has the proper power of attorney documents is particularly important for a caregiver that may be dealing with a parent with Alzheimer's or some other form of dementia. In these situations, it will be necessary for the caregiver to make sure that the parent has designated someone to make financial and healthcare decisions for when the parent becomes unable to do so.

LONG-TERM HEALTHCARE PLANNING

At some point, many caregivers may need to make decisions about long-term care for their parent. This can involve making plans for a nursing home or looking into Medicaid to cover the long term costs of healthcare. Both of these matters bring with them complicated legal issues to consider.

When choosing a nursing home, not only do caregivers want to find the right fit for their loved ones, but they also need to be sure that they've done their research on the facility and read through the contracts. One thing a caregiver should be aware of is who the guarantor is according to the contract. The agreement should be between the facility and the parent,

but some contracts include language about a responsible party or "guarantor" who will be liable for any charges if the money runs out, so it's important to be aware of that before signing.

Another important matter to consider is what the nursing home agreement says about Medicaid. Due to the high cost of nursing homes, it may be necessary to rely on Medicaid if a parent or loved one is in the nursing



home for an extended period. Some contracts include language that states that Medicaid cannot be used to cover the individual's nursing home costs, so caregivers will want to make sure the place they choose can accommodate their family's financial situation down the road.

An attorney can be an invaluable resource for reviewing these contracts to ensure that they cover what the family needs. It's also essential for a parent to meet with an attorney if they think Medicaid might be in their future, as they can let them know the rules and regulations since they vary by state and can be very complicated. For example, if there is a good amount of time before the parent will need to be on Medicaid, an attorney can suggest asset protection devices, gifting programs and estate planning tips.

Dealing with these issues, as a care-

giver, can be time consuming and expensive. A group legal plan offers affordable access to attorneys who can counsel them on how their parents' legal issues may affect them. Legal plan members also have an option to cover their parents under a legal plan so they can draft wills and the other estate planning documents they need for their future.

Taking some of the stress away from

employees who are balancing caring for aging parents and children is one of the key benefits of a group legal plan. A recent survey found that 73% of those who are enrolled in a legal plan feel prepared for unforeseen events, and 82% worry less about financial issues because of their employer benefits. For employers looking for ways to improve employee wellness, providing access to affordable legal help is a benefit that can bring peace of mind to employees, especially employees acting as caregivers. ★

Ann McDonald is the Communications Manager for Hyatt Legal Plans, a MetLife company and the country's largest provider of group legal plans. Hyatt Legal Plans helps American workers address important life issues through group legal plans. The company serves three million people at more than 2,000 organizations, including 169 Fortune 500® companies.

Why Consumers Prefer to Buy Long-Term Care Insurance From Their Employer

By BRIAN HARRINGTON

There is a strong likelihood that most of our lives and careers will be touched by long-term care – as a recipient or caregiver. With group long-term care insurance, employers can help employees address real-life challenges, build a competitive benefit package, and prevent lost productivity.

Group long-term care insurance fills a gap in benefits that no other coverage can fill including medical or disability insurance. Health insurance pays for doctors and other medical expenses. Life insurance provides a death benefit. Disability insurance provides supplementary income due to illness or injury and inability to work. And retirement plans help employees build a nest egg.

None of these types of insurance covers the cost of services and support that people need when they can no longer care for themselves because of an accident, illness, or cognitive disorder. This in-

cludes help with activities most of us take for granted, such as eating, bathing, dressing, and walking, whether living at home or in assisted living or nursing facility, or attending an adult day center.

Long term care services can be expensive. Employees and their families are often shocked by the cost and the fact that these services are not covered by existing insurance. The cost of long-term care continues to rise year over year, especially for services in the home, where most people choose to receive care, according to Genworth's 2016 annual Cost of Care Study. Nationally, the median monthly costs for the services of a homemaker for 44 hours a week are \$3,813 and \$3,861 for an in-home health aide. The national median monthly cost is \$7,698 a month for private nursing home room; \$3,628 per month for assisted living, and \$1,473 a month for adult day services.

Contrary to popular belief, long-term care insurance isn't just for older people. It can be used by policyholders of all ages who are permanently or temporarily unable to perform at least two activities of daily living or suffer from a cognitive disability. In fact, our study found that long-term care recipients are actually getting younger. The age of care recipients 65 and older fell from 81% in 2010, the first year of the study, to 60% in 2015. That means that 40% of people who

need long-term care services are under 65. That same survey also found that the reasons for needing long-term care are shifting from illness to accidents.

Long term care is also touching younger people as caregivers. Our survey showed that 60% of caregivers are 25 to 54. In fact, the average age of caregivers has decreased from 53 to 46 since 2010.

Why is this important to employers? Sixty percent of caregivers were employed at some point in the past year while caregiving. Twenty-five percent were Millennials and half were under 50, according to a 2015 report by National Alliance for Caregiving and the AARP Public Policy Institute. Among them, 56% worked full time. Sixty percent said that caregiving affected them on the job, such as cutting back hours, or having received warnings about performance or attendance. The bottom line is that productivity can suffer when employees are consumed by their obligations as caregivers.

The beauty of group long-term care insurance is that it can provide long-term care protection for employees and their immediate families. Employees' spouses, parents, grandparents, and adult children can apply for long-term care insurance and receive the same group rate, even if the employee chooses not to enroll. The only difference is that family members are required to go through full underwriting. Caregiving can take a toll on careers and put caregivers' savings and retirement funds at risk. According to the survey, 77% of caregivers missed time from work; 52% had to work fewer hours; and more than 25% missed advancement opportunities. Sixty-two percent of caregivers said they used their own savings/retirement funds to pay for care, up from 41% in 2010.

Group long-term care insurance offers another significant benefit that can help employees balance work and caregiving responsibilities: care coordination services for policyholders and their loved ones if they go on claim. This is important to caregivers who are in a crisis situation and don't know what options are available or even where to start. In addition to developing a services plan to meet policyholders' specific care and financial needs, long-term care insurance carriers can even source care for them.

With group long-term care insurance, employers can help employees address real-life challenges, build a competitive benefit package, and prevent lost productivity.

Our own internal research has found that three out of four consumers would prefer to buy long-term care insurance from their employer because the insurance would have already been vetted by their employers and could be obtained through a simplified underwriting and application process. The survey reveals these additional reasons why consumers prefer to buy long-term care insurance through their employers:

- **Portability:** The ability to take the policy with you when you change jobs is a game changer for consumers; they view it as the most attractive feature of group long-term care.
- **Easier payment options:** Employees can pay premiums via direct billing

or payroll deduction if offered by the employer.

- **Family coverage:** Family members, including spouses, parents, grandparents, and adult children can take advantage of the group pricing, which is a great way to help ease the emotional, physical and financial burden of caregiving on employees.
- **Affordability:** Employees can start small, buying some long-term care insurance in the beginning and then adding to their coverage over time as their budgets allow.
- **Fewer underwriting requirements:** Because group long-term care insurance is partly underwritten at the group level, there are fewer underwriting requirements at the individual level for employees during initial enrollment. Family members must be approved after full underwriting.
- **Online enrollment:** Consumers we surveyed like the idea of being able to learn about long-term care insurance and apply online.

WHAT'S IN IT FOR EMPLOYERS AND BROKERS?

Group long-term care insurance can help lighten the financial and emotional burden on employees, minimize the loss of productivity for the employer, and be an important factor when recruiting or retaining key employees. It lines up well with the menu of other benefits offered by employers and is an effective tool for standing out from the competition. For employee benefit brokers, offering group long term insurance is an opportunity to deepen relationships with a benefit that provides the missing piece of the puzzle. And it's a powerful solution to a pressing social issue that will likely touch all of us at some point in our lives as care recipients or caregivers. ★

Brian Harrington is distribution leader and head of group long-term care insurance at Genworth.



DISABILITY

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

GROUP CRITICAL ILLNESS & ACCIDENT COVERAGE

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

WELLNESS

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

NON-MED TERM LIFE

eLife LLC introduced "eTerm Express," a life insurance offering with

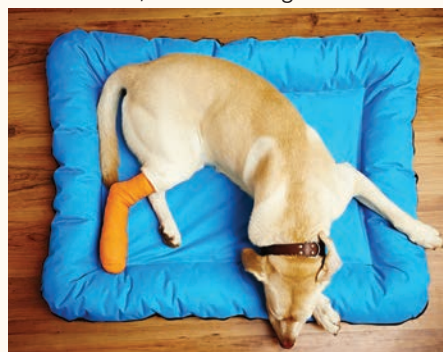
an entirely paperless application and approval process. It enables agents to serve middle market life insurance buyers easily and cost effectively. Face amounts are from \$100,000 to \$500,000. Qualified applications are approved in minutes with multiple underwriting classes. For more information, visit elifesolutions.com.

DIGITAL BUSINESS CARD

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

ONLINE HOSPITAL-SHOPPING PLATFORM

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



PET INSURANCE

Figo Pet Insurance created the Pet Cloud App. You can keep all of your pet's records, locate dog parks, or find your pet with their pet tag. Figo offers pet insurance plans averaging

less than a \$1.50 a day. It covers all non-pre-existing illnesses or injuries with no limits on claim payouts. It reimburses up to 100% of the vet bill; is accepted at any licensed veterinary practice, emergency hospital, or specialist; and has a yearly deductible instead of the traditional (and more expensive) per-condition deductible. For more information, visit <https://figope-tinsurance.com>.

MARKETPLACE BROKER TRAINING FROM NAHU

NAHU is one of two vendors selected to provide CMS-approved agent/broker training on federally facilitated marketplaces. This does not apply to California, which is a state-based marketplace. It does apply to about half of the states including Alabama, Alaska, Arizona, Florida, Georgia, Indiana, Kansas, Louisiana, Maine, Missouri, Montana, Nebraska, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin, and Wyoming. All agents and brokers must complete the federally facilitated marketplace registration and training to help consumers enroll through a federally facilitated marketplace. Agents and brokers have to register through the CMS agent/broker portal for plan year 2017. They will be able to select their preferred provider of the federally facilitated marketplace training. The training provides online instruction with webinar modules and a final exam. NAHU training will include continuing-education credits issued on a state-by-state basis. For more information on the new training, please contact NAHU's Learning Institute at nahu-ffm@nahu.org.

INTERNATIONAL MEDICAL

The Blue Cross Blue Shield Association BCBSA introduced a suite of newly branded, international private medical insurance products for multinational employers and individuals traveling globally. There are options for U.S. workers in other countries, foreign nationals in the U.S., and foreign nationals in other non-U.S. countries. Newly branded products, sold by Geo-Blue, include the following:

- International major medical insur-

ance and assistance services. This plan is designed for workers on international assignments and their families when they leave their home countries for six months or more.

- Group supplemental medical benefits and services for business travelers outside of their home country for trips up to 180 days.

For more information, visit bcbs.com.

HISPANIC HEALTH INSURANCE LITERACY TOOLS

FAIR Health introduced educational tools and articles for Spanish-speaking consumers. For example, the article "Immigration and Health Insurance Coverage: What Are Your Options?" has been translated into Spanish. The article gained widespread media attention when published in English for the simple and straightforward way it explains public health coverage options available to immigrants. For more information, visit fairhealthconsumer.org.

EASY-TO-BUY ANNUITY

Vantis Life Insurance is offering "Tax-Saver Freedom," a series of easy-to-understand annuity products with competitive rates. Vantis Life primarily sells through banks and credit unions. The company created the products without complicated features that are typical of indexed and variable annuities. TaxSaver Freedom annuity products offer competitive, fixed interest rates guaranteed for five or seven years. The rates range from 2% to 2.5%. One variation also offers a guaranteed return-of-principal during the guarantee period. All versions offer nursing care facility waivers and terminal illness waivers. There are no front-end loads or annual fees. The minimum investment from non-qualified funds is \$5,000 and the maximum is \$500,000. Taxes on interest earned during the life of the annuity are typically deferred until funds are withdrawn, generally when the individual is subject to a lower effective tax rate. Unlike some other annuities, the new Vantis products are not automatically renewed with new surrender charges at the end of the term. For more information visit vantislife.com. ★

IN NEWS

MAKING THE MOST OUT OF OPEN ENROLLMENT

Nearly half of employees are stressed by the open enrollment process and only half are confident about the benefit decisions they made last year, according to a study by MetLife. Millennials are the most stressed and confused. When asked about the most effective benefit resources, respondents ranked one-on-one consultations well above other resources. In fact, Millennials led their generational counterparts in valuing one-on-one consultations. However, only half of employers offer one-on-one consultations. Sixty percent of Millennials consult with their families and friends on benefits. MetLife says that employers need to help their employees connect the value of non-medical benefits to their day-to-day lives. Employers should also do the following:

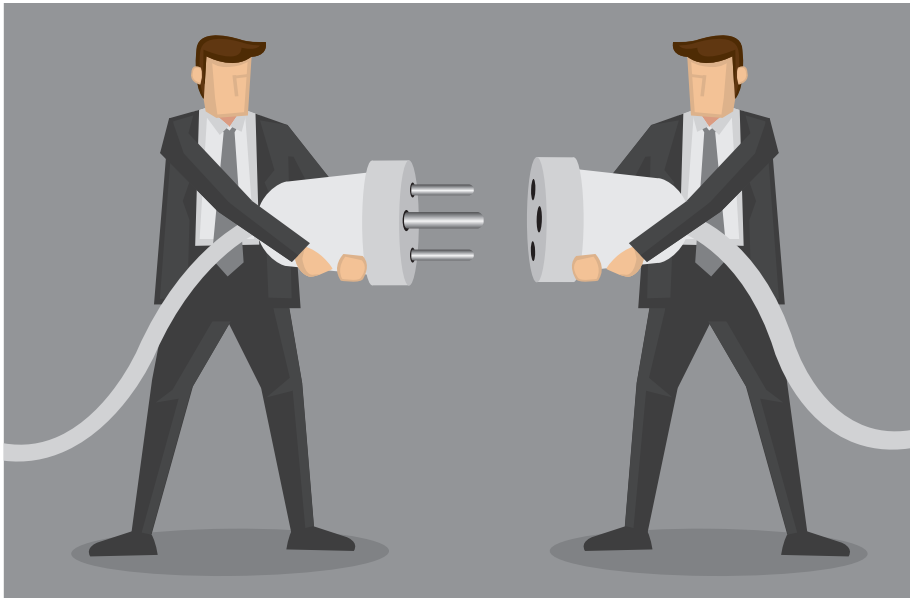
- Make sure that employees fully understand key terms such as "deductible," "premium," "PPO," and "HMO."
- Have employees ask themselves, "Do I have a big life event coming up, such as marriage or retirement?" It's critical to choose benefits based on present and future needs.
- Make sure that employees review their benefits and fully understand them. Only half of employees said they thoroughly reviewed their benefits choices last year.

The survey also reveals how employees feel about their benefits:

- Financial uncertainty: In contrast to decreasing unemployment numbers, American workers remain pessimistic about their financial future. Less than half feel in control of their finances. Even fewer expect their situations to improve in the next year (46% in 2015, compared to 52% in 2014). More than half are concerned about having enough money to cover

out-of-pocket medical costs as well as meeting monthly living expenses and financial obligations. These worries that have increased every year since 2012.

- Job Satisfaction: More than half of employees are satisfied with their jobs and are committed to the organizations' goals. An increasing number plan to be with their companies a year from now.
- Financial Benefits: 71% of employees consider work to be the foundation of their financial safety net. Sixty-two percent of employees want more financial security benefits. Millennials are more financially vulnerable compared to their counterparts. Gen Xers say they are less secure than other generations.
- Appreciation of benefits: Half of employees agree strongly that their benefits help them worry less about unexpected health and financial issues. Seventy percent of employees say that having customizable benefits would increase their loyalty to their employer.
- Supplemental benefits: Employees continue to ask for a range of solutions, especially for more common benefits, such as medical, prescription, 401(k), dental, life, and vision care. Employers are keeping pace with many of their employees' top benefit requests. However, there are large gaps in accident insurance, critical illness, and hospital indemnity. Most employers understand how non-medical benefits can provide financial protection, such as offsetting out-of-pocket medical expenses. Yet, only 47% of employees believe that supplemental health benefits can help close these gaps.
- A streamlined plan design: Plan design, claims management, and implementation rank highly as advantages of streamlining the number of



carriers that employers use.

- Use of enrollment firms: Three-quarters of employers have positive attitudes towards enrollment firms. Seventy-one percent of employers say that working with an enrollment firm helped them improve benefit communications.
- Wellness plans: More than two thirds of employees are interested in physical well-being programs that reward healthy behavior. This is especially true among Millennials (75%) and female employees (72%).
- Retirement Benefits: Forty percent of employees say that having retiree benefits is a key reason to stay with their employer. Millennials feel the most strongly about this, probably due to their lack of financial confidence. About a third of employees plan to postpone retirement, an increase of 5% over 2015. Almost 6 in 10 employees plan to work or consult once retired. Of this 60%, 44% plan to work part-time.
- Older workers: With today's workers redefining what it means to be a retiree, employers must also redefine what retiree benefits look like in order to appeal to this rich reservoir of talent. For example, 63% of employees say that dental is a must-have retiree benefit while only 42% of employers offer it. Similar gaps can be found across other critical non-medical benefits, such as vision and life insurance. More than half of employees say that their employer does not

offer any employer-paid non-medical benefits. With retiree benefits being such an important loyalty factor for many employees, employers have an opportunity to keep pace in 2016 and beyond.

For more information, visit benefit-trends.metlife.com

EMPLOYER SPONSORED INSURANCE RATE REMAINS STABLE

Since 2009, employer-sponsored insurance has been on the decline in California. A key question around the Affordable Care Act (ACA) was whether the reforms would further erode employer-sponsored insurance coverage. A recent survey by the California Health-Care Foundation finds that employer-sponsored insurance in the state has remained stable from 2013 to 2015. Worker eligibility for employer-sponsored insurance also remained stable, and even increased among some groups. However, the percentage of eligible workers who chose to enroll in employer-sponsored insurance declined from 86.4% in 2013 to 80.2% in 2015, bringing California closer to the national average take-up rate of 79%. This decline could be caused by the availability of alternative coverage options through Medi-Cal and Covered California. For more information, visit chcf.org.

HMOs BEAT PPOs ON COST AND QUALITY

California's commercial HMOs out-

perform commercial PPOs on most clinical quality measures. They also consistently provide less costly care. The average yearly cost is \$4,245 per HMO enrollee versus \$4,455 per PPO enrollee, according to the California Regional Health Care Cost & Quality Atlas. The report comes from the Integrated Healthcare Assn., the California Health Care Foundation, and the California Health and Human Services Agency. Differences in benefit designs don't explain the cost variation since the total cost of care includes enrollee cost-sharing (deductibles and coinsurance) as well as insurance payments to providers.

HMOs may be performing better because they rely on integrated care networks, which generally accept capitation (fixed per-member, per-month payments). So they are accountable for the patients' health and are generally rewarded for it, according to the report. So why is HMO enrollment declining? PPOs are often less costly for employers since they reduce premiums with higher enrollee cost-sharing, such as deductibles and coinsurance. But employers should look at the whole picture since HMOs produce superior results when you consider quality and the total cost of care, according to the report.

Quality of Care: California's commercial HMOs perform better than their national counterparts on every clinical quality measure except asthma medication management. At the same time, California's commercial PPOs perform worse than the national average on five of the six measures. When Kaiser Permanente is removed from the analysis, the difference in clinical quality between HMOs and PPOs is cut by about half. Also, the performance difference on risk-adjusted total cost of care narrows substantially, but HMOs still outperform PPOs. Quality is highest in Northern California, solid in Southern California, and weakest in Central California. The study reveals these regional differences is quality:

- Northern California outperforms Central and Southern California on clinical quality.
- Central California falls below the statewide average on key clinical measures for cancer, diabetes, and asthma.

- The lowest performing region is the Eastern region 13, which includes Central California counties Mono, Inyo, and Imperial.
- The highest performing region is Contra Costa County region in Northern California.
- Clinical quality scores vary significantly on some measures. For example, 33% of commercial enrollees with diabetes in Alameda County region six have poorly controlled blood sugar, compared to 75% in the Eastern region 13.
- In Southern California, San Diego County region 19 is the highest performing region, outperforming Northern California regions: San Mateo County region eight and San Francisco County region four.

If all commercially insured Californians got the same quality of care as top-performing regions, nearly 200,000 more people would have been screened for colorectal cancer and 50,000 more women would have been screened for breast cancer in 2013. If care is provided to all Californians at the same cost as in San Diego, the cost of care would decrease 10% for commercially enrolled people. Many factors contribute to regional performance, including socioeconomic characteristics and the availability of medical services.

Medicare Advantage: The quality and cost of care varies widely for seniors enrolled in Medicare Advantage. For example, in North Bay counties, 91% of women have gotten appropriate breast cancer screening compared to 70% in the Eastern region 13. The average annual per-enrollee total cost of care for Medicare Advantage enrollees ranges from \$11,500 in San Diego County to \$14,500 a year in Los Angeles region.

Cost of Care: Geographic variation in cost of care is dramatic—a difference of \$1,800 in the average annual per-enrollee total cost of care between the most costly and least costly regions. With one exception, all Northern California regions have higher annual per-enrollee costs than the statewide commercial average of \$4,300 while all Southern California regions fall below the statewide average. Central California regions show mixed results

on cost. HMOs have a lower average total cost of care than do PPOs in 12 of the 18 regions. More tightly managed care in HMOs may contribute to a lower cost of care. Yet, inpatient bed days and readmission rates are similar for HMOs and PPOs. Emergency department visit rates are actually higher for HMOs. The statewide average annual per-enrollee cost of care for commercially insured Californians is \$4,300. Kern County is the least costly HMO region. It's \$1,800 per enrollee, per year less than in Santa Clara County, which is the costliest HMO region. The least costly PPO region is Los Angeles at \$2,400 less than San Francisco County, which is the costliest PPO region. For more information, visit <http://costatlas.iha.org>.

HEALTH PLAN OFFER RATES SINCE THE ACA

A study by the Employee Benefits Research Institute (EBRI) reveals that large employers have had steady health insurance offer rates since passage of the ACA. In fact, 99% of employers with 1,000 or more workers offer health insurance as do 93% to 95% of employers with 100 to 999 workers. However, offer rates have been falling since 2009 for employers with fewer than 10 workers, from 36% in 2008 to 23% in 2015. Offer rates for employers with 10 to 24 workers went from 66% in 2008 to 49% in 2015. Offer rates for employers with 25 to 99 workers went from 81% in 2008 to 74% in 2015. For more information, visit ebri.org.

DO WELLNESS PROGRAMS ACTUALLY HELP PEOPLE MANAGE CHRONIC CONDITIONS?

Forty-four percent of consumers enrolled in wellness programs have a diagnosed chronic condition, according to a HealthMine report. But just 14% say that their wellness program helps them manage their disease. Only 29% say their wellness program offers a disease management program. Only 11% participate in disease management through their wellness program. And just 6% have connected a disease management application/tool to their wellness program. Bryce Williams, CEO and president of HealthMine says, "Health plans and wellness pro-

grams need to have real time analytics that guide each member on health actions. We are loaded with health data including lab results, insurance claims and more, but we are not analyzing the data or offering recommendations consistently enough. Programs that do will close gaps in care, thus helping members manage their chronic conditions and minimize costly co-morbidities and utilization." For more information, visit healthmine.com.

METLIFE U.S. RETAIL BUSINESS TO RE-BRAND AS BRIGHTHOUSE FINANCIAL

MetLife will re-brand its U.S. Retail business as Brighthouse Financial. In January, MetLife announced its plans to separate a substantial portion of its U.S. Retail business. The company is evaluating options on the structure and timing of the separation. Steven Kandarian, MetLife chairman, president and CEO says, "As a separate entity, Brighthouse will benefit from greater focus and more flexibility in products and operations. This separation will also bring significant benefits to MetLife as we focus...more...on our group business in the U.S...as well as on our international operations." Brighthouse Financial will be led by MetLife executive vice president Eric Steigerwalt. For more information, visit www.metlife.com.

COMPANY BUYS DENTAL & VISION COMPANY

Unum purchased H&J Capital, LLC, parent of Starmount Life Insurance Company and AlwaysCare Benefits. Starmount is an independent dental and vision benefits company. Unum president and CEO Rick McKenney said, "This is an excellent fit for our Unum US and Colonial Life businesses and is an important component of our long-term strategic growth plan." ★



FOUR EASILY REFUTABLE MISCONCEPTIONS EMPLOYEES HAVE WHEN Purchasing Life Insurance

By JENNIFER GASSAWAY



With enrollment season just around the corner, you may be thinking of ways to refresh your sales approach. The next few months will be a marathon session of in-person benefits meetings, lunch and learn sessions, and one-on-one conversations that focus on the need for benefit coverage. But, have you thought about your strategy to help employees understand the need for insurance coverage?

MAKE LIFE COVERAGE STAND OUT

One product often makes brokers, regardless of their tenure in the business, struggle to find new ways to freshen up their enrollment presentations. Group or voluntary life insurance enrollment often hinges on a broker's ability to make the need

for the product well understood to employee groups that have neither a base understanding of what they need, nor time to spend thinking about their coverage gaps.

There are a number of misconceptions around the need for life insurance and/or selecting additional voluntary coverage, especially among Gen X and Millennial employees. These employees, who have skipped or delayed typical life "milestones," such as marriage, home ownership and children, may be unaware of the need for robust life insurance coverage or how it can help provide their loved ones with financial security in the event something happens to them.

Continue on to the following page to see a few common misconceptions you may hear during enrollment

meetings this fall, and ways you can help refute them.

MISCONCEPTION 1: "I SHOULD BE COVERED BY MY EMPLOYER'S BASE POLICY."

Group life insurance is often provided as a standard employee benefit. Employees have come to expect that their health, dental and vision benefits also may come with some type of base life insurance coverage, such as a \$25,000 policy. While a \$25,000 life insurance benefit may sound like a lot of money, many employees may not know the amount of coverage they should have at-the-ready. A recent study from LIMRA found that 4 in 10 consumers don't know how much life insurance coverage they actually need or what to buy. Not only that, some employ-

ees haven't thought about what the coverage is used for or what expenses their families may still have to pay for if something unexpected were to happen to them.

When discussing life insurance, remind employees that life insurance coverage would need to supplement the income their families would miss out on. Help make this more digestible by bringing up common expenses, such as mortgage or rent payments and car payments. In this context, \$25,000 may not go very far to help ensure long-term financial stability for an employee's family.

MISCONCEPTION 2: "I HAVE MORE IMPORTANT FINANCIAL PRIORITIES."

Making the case for employees to pay for additional benefits, including voluntary life insurance options, can be a tough sell. Employees may feel stretched thin already or have their eyes on bigger-ticket expenses after years of saving.

LIMRA recently found that 29% of Millennials cited saving for vacation as a priority over purchasing some or more life insurance. And 23% of Gen Xrs said paying for recreational activities, such as restaurants, movies, or shopping was a priority over purchasing some or additional life insurance.

It seems interesting that these two employee groups haven't thought through the financial impact of not having coverage. Especially since 43% of people say they would feel a financial impact within six months if the primary wage earner died. Consider bringing up these stats about financial preparedness as part of your enrollment conversations. Many households haven't accumulated a rainy-day savings fund and could be caught in a precarious situation without proper life insurance coverage.

MISCONCEPTION 3: "IT'S TOO COSTLY."

Millennial and Gen X employees have a lot on their plates. Gen Xrs are often caring for young children and aging parents while Millennials are trying to make up for years of lower salaries during the recession and high student loan payments. Because of this, these employees may be hesitant to add additional bills to the stack they are already paying.

However, 80% of consumers mis-



judge the price for term life insurance. Gen Xers typically overestimate the cost by 119% while Millennials often double the price for life insurance and overestimate it by 213%.

With employer-sponsored life insurance coverage typically costing only a few dollars per paycheck, help equate the monthly or annual cost to something an employee knows more about: a gallon of milk, their morning mocha or a tank of gas. Not only that, the cost is usually deducted from the employee's paycheck, making it one less bill for which they'll have to write a check.

MISCONCEPTION 4: "I'M NOT MARRIED/DON'T HAVE CHILDREN, SO I DON'T NEED COVERAGE."

Gen X and Millennial employees have approached getting married and having children in a different way than the generations before them. But that doesn't lessen their need for the financial protection that life insurance provides. One way to make the connection is by reminding employees (married or unmarried) that there are expenses their families could incur after their death, such as funeral expenses and private loan payments.

A second way to help make the need more apparent is by promoting the additional benefits that come with life insurance policies. These extras are beneficial for any employee, including travel assistance benefits, which can help if an unexpected situation pops up away from home, or financial planning tools, which could include anything from identity theft assistance to investment advice. These tools can help keep an employee's financial house in order, or make it easier on beneficiaries to help settle financial matters.

With employees of different ages, backgrounds and life experiences in your upcoming enrollment meetings, consider how you can help refute common misconceptions and help better educate employees on the need for important life insurance protection. ★

Jennifer Gassaway is a marketing product manager with Standard Insurance Company. She is responsible for product planning and marketing for The Standard's group life insurance product. Jennifer holds a Bachelor of Arts degree from Grinnell College and a Master of Business Administration from the Univ. of Maryland. She has been with The Standard for 14 years and has managed The Standard's group life insurance product for the past seven years.

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A SHARED COMMITMENT TO CLIENTS.

As an agent, Guy Rogers is committed to helping clients find the right solution to their health insurance needs. His devotion to helping others is deeply rooted in his personal experience, which influenced his decision to become a broker. It's a devotion he also sees in Word & Brown employees, who he describes as caring, supportive, and always available to answer questions to help him better serve his clients.



See what fuels Guy's dedication
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