


CALIFORNIA BROKER

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SERVING CALIFORNIA'S LIFE/HEALTH PROFESSIONALS & FINANCIAL PLANNERS

OCTOBER 2018



MEDICARE ADVANTAGE ON THE RISE

CONTINUED GROWTH,
STRONG PERFORMANCE
AND NEW GUIDELINES ARE
GOOD NEWS FOR PLANS
AND THEIR MEMBERS

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- Insurtech: New Tools
- Digital Marketing
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- Large Group Insurers
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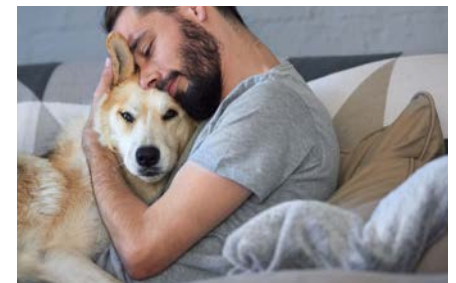


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Trading in the White Collar: Insurance Execs are Joining Startups (and that's a good thing)

By TIM LAEHN

Views expressed in our guest editorial are those of the author, not Cal Broker magazine.

Editor's note: If you have a strong opinion about this editorial or any other pertinent subject, please reach out. We welcome your comments. Please email editor@calbroker.com.

Earlier this year, Charlie Turri traded in his white collar and dress pants for a T-shirt and a pair of jeans—denim jeans.

After spending nearly 25 years working in IT roles for large insurance companies, Turri joined our venture-funded tech startup company as chief technology officer. The company, Denim, is headquartered in Des Moines, Iowa, and offers a mobile and social media advertising automation platform for insurance and financial services companies.

Before Denim, Turri led an IT department of more than 350 employees for Des Moines-based Athene USA, a leading retirement services company that issues, reinsures and acquires retirement savings products. Prior to that, Turri held various leadership roles at American General Life & Accident Insurance, an AIG company in Nashville, Tennessee.

Corporate to Startup

So why did he make the switch? In short, he wanted to make an impact.

"I wanted to be part of something that I really feel will fundamentally change a big business, in this case financial services and insurance," Turri recently told Denim's CEO and Founder Gregory Bailey on an episode of the company's podcast, Denim Rivet. "As I started out in my career, I had a lot of opportunity and was fortunate



to work on a lot of game-changing things. As I progressed, that started to wear away. As I started to think about what's next and what would be really exciting for me, being a part of something that's changing an industry was very appealing."

Turri also said one of the drawbacks of working for a larger company is not always seeing the impact you're making on a day-to-day basis. "What I do here matters right here, right now," he said. "We were standing at the whiteboard moments ago. That will turn into a document that we will build from and have something ready to go very quickly, versus working weeks, months and years. Not that it's right or wrong; it's just how it is in a corporate world. We are allowed to do something a little bit different here."

Another reason Turri made the change is perhaps best summed up by a quote from Margaret Mead that is prominently displayed underneath his bio on Denim's team page: "A small group of thoughtful, committed people could change the world. Indeed, it's the only thing that ever has."

"Meeting the team here and understanding more about what you're doing, how passionate everyone is about wanting Denim to be successful—I really wanted to be part of that passionate, small group," Turri told Bailey.

Bailey can relate: He did the same thing when he founded Denim in 2015. Prior to launching the company, Bailey led national marketing and sales teams at Northwestern Mutual, Mutual of Omaha, CUNA Mutual Group, Pacific Life and Athene.

For Bailey, being able to move at a much faster pace was one thing that drew him to the startup world. "Velocity is the pace at which things happen," Bailey said. "It doesn't matter if you're an insurance company, a financial services company—any type of big corporation is, by its very definition, going to have many layers of approval or processes or people involved in decision-making. And if that's the case, things are naturally going to move slower than a company like ours."

To Turri, that also means the ability to take risks. "Frankly, [corporations] can't take risks the way a company like Denim, number one, can and, number two, has to in order to upset some of the apple carts that we want to upset."

A Larger Trend

Turri and Bailey aren't alone. Here's just a partial list of the accomplished insurance-industry executives who have left their corporate posts in recent years to join startups:

In April 2016, Donna Peebles joined Pypestream as chief customer officer following a 30-year career at the likes of AIG Property & Casualty. In Octo-



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- Business written through partnering General Agencies qualifies.
- CCSB intends to issue incentive payments 90 days following the effective month of a qualifying group. CCSB may modify its payment schedule at any time.

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ber 2016, John Peters left Liberty Mutual, where he held leadership positions including executive vp of commercial insurance operations, chief underwriting officer and chief product officer, to become chief insurance officer for Lemonade.

In April 2017, Cindy Powell became chief financial officer for Root Insurance—after 26 years with State Auto Financial Corp., where she rose to the second-highest accounting position.

In February 2018 John Brisco left his position as Manulife Asia’s chief information officer and chief operations officer to become chief executive officer of Coherent Capital Advisors.

These executives’ decisions to join insurtech startups doesn’t necessarily mean they were unhappy in their corporate roles. However, research indicates many people, quitting or not, are dissatisfied.

According to CareerBuilder’s latest survey more than half of U.S. workers (55 percent) feel they have just a job, not a career, and 38 percent of these workers are likely to change jobs. While a variety of factors may contribute to this discontentment, Accenture conducted a study (across industries) and found the top four reasons employees quit their jobs include:

- A lack of recognition (43 percent)
- Internal politics (35 percent)
- A lack of empowerment (31 percent)
- They don’t like their boss (31 percent)

These factors could also explain why a Business Insider survey of 225 executives found 22 percent want to launch their own companies. Perhaps, like Turri and Bailey, they believe a startup will offer them the satisfaction and fulfillment they’re looking for.

Experience Suggests Success

As it turns out, the popular notion that startup founders are hoodie-wearing, 20-somethings launching highly successful startups from college dorm rooms or their parents’ basements simply isn’t reality.

Almost a third (32 percent) of startup



Gregory Bailey (left) and Charlie Turri (right) of Denim

founders are over age 40, according to a survey of more than 700 founders from First Round, a seed-stage venture capital firm. Forty-eight percent are in their 30s, and only 20 percent are in their 20s.

Not only are many startups founded by more experienced professionals, that experience tends to result in greater success, according to research from MIT and Northwestern economists.

The researchers examined all businesses launched in the U.S. between 2007 and 2014, encompassing 2.7 million founders. They compared founder age to firm performance measures, including employment and sales growth, as well as the exit by acquisition or IPO, and found:

Successful entrepreneurs are much more likely to be middle-aged. For the top 0.1 percent of fastest growing new businesses in the U.S., the average age of the founder is 45.

Middle-aged founders dominate successful exits. A 50-year-old founder is 1.8 times more likely than a 30-year-old founder to create one of the highest growth firms.

Founders in their early 20s have the lowest likelihood of building a top-growth firm.

“Why would entrepreneurs get better with age? It’s not clear, but we have a few theories,” write two of the study’s authors, Benjamin Jones and J. Daniel Kim. “More seasoned entrepreneurs may draw on greater experi-

ence in management or deeper industry-specific knowledge. They may also have greater financial resources and more relevant social networks to leverage the founder’s business idea. For example, our study showed that prior work experience in the startup’s specific industry more than doubled the chance of an upper-tail growth success.”

That’s good news for Denim, whose two top executives have nearly 50 years of combined experience in the insurance and financial services industry.

“There is so much opportunity in the insurtech and fintech space to make vast improvements for insurance and financial services companies and the consumers who rely on them,” said Turri. “I’m thrilled to be able to use my experience as an insurance industry executive to take Denim’s technologies—and our customers’ successes—to the next level.”

My prediction is that we’ll see more insurance execs moving over to insurtech startups. And that’s a great thing. Our industry needs to evolve, but we’ll evolve more intelligently if we include our seasoned veterans with their storehouses of knowledge.

Tim Laehn is director of marketing for Denim, where he leads the company’s communications and content marketing strategies. He has 10 years of experience in marketing and communications, including seven years in the financial services industry. ★

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Insurance Commissioner Works to Get Legal Pot Growers Insured

California Insurance Commissioner Dave Jones recently called on more insurers to enter the marijuana market to help fill gaps in coverage for those whose roles are essential in the cultivation and distribution of the drug. Of course, pot is now legal at the state level but remains illegal at the federal level. Jones organized tours for insurance executives at cannabis businesses and convened meetings between insurance company executives and cannabis business owners to educate the insurance industry about the sophistication, professionalism and risk management of the cannabis industry, according to a California Department of Insurance statement. He noted that he can't force insurers to accept (and cover) the legal marijuana industry, but that his job was to try to ensure Californians and California industries had access to insurance coverage.

Self-Insurance Surprises

About 60 percent of people with employer-paid health benefits are covered by self-insured plans. Naturally, agents know how a client's plan is structured, but be aware that many of your client's employees may not.

One problem is that certain state protections – laws against balance billing and surprise bills, for example—don't include self insured plans because the plans are regulated by federal rather than state law. To learn more about this and other insurance billing issues, go to Kaiser Health News' "Bill of the Month" feature on KHN.org.

Wipro and Opera Solutions Launch Solution to Detect and Address Fraud and Waste in Health Insurance Claims

Wipro, a global info tech firm, announced the launch of an end-to-end solution to address the issue of fraud, waste and abuse in healthcare insurance claims in the United States. The initiative is in partnership with Opera Solutions, LLC.

The solution will combine Opera Solutions' powerful AI and machine learning based Fraud, Waste and Abuse (FWA) detection engine with Wipro's extensive full-service claim processing capabilities in claims review, which includes the forensic examination of questionable claims, audits, adjustments, negotiations, recovery follow-up and payment posting.

Campaign Calls on Insurers to Ditch Fossil Fuels

Amid the Global Climate Action Summit, a new campaign, Insure Our Future, is calling out the insurance industry for its contribution to climate change. The campaign urges the industry to stop supporting fossil fuels. Insure Our Future charges that through insuring dangerous dirty energy projects and investing in fossil fuel companies, the insurance industry plays a critical role in driving the use of carbon-intensive energy sources. The U.S.-focused campaign follows significant movement from major European insurers. In the last three years, 17 large international insurers have divested about \$30 billion from coal companies, and six have stopped or limited insuring the coal industry, including Allianz, Axa, Zurich and Swiss Re. To date, no major U.S. insurer has yet committed to end their support of fossil fuels.





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VSP OFFERS NEW RESEARCH INSIGHTS

VSP Vision Care and market research agency YouGov recently teamed up for some market research. Among the eye opening findings:



8 in 10 people (84 percent) rate vision as the most important sense, and nearly everyone (97 percent) agrees that having healthy eyes is important, but only half of people get annual eye exams.

Virtually no one (1 percent each) knows that signs of serious diseases and conditions like high blood pressure, autoimmune disorders, thyroid diseases and certain types of cancers can be detected through an eye exam. 6 in 10 (61 percent) people worry about diabetes impacting their family's health, but only 4 percent know that eye doctors can detect signs of diabetes through an eye exam.

More than two-thirds of parents worry about their children's eye health more than their own, but only 12 percent of parents know children should receive their first eye exam at six months old.

8 in 10 parents (84 percent) agree that a regular eye exam helps kids do their best in school, but 4 in 10 (41 percent) wait until their child complains about their vision to schedule an eye exam.

Twice as many parents worry about their children's dental problems (15 percent) than their vision issues (7 percent), even though most children lose their baby teeth by age 12 or 13.

After learning about the importance of annual eye exams, 9 in 10 (90 percent) survey respondents agree on the importance of annual eye exams.



LTC Hospitals Under Fire

A National Bureau of Economic Research study found that despite being reimbursed at much higher rates than skilled nursing facilities and home healthcare providers, long-term care hospitals don't produce better outcomes in three important areas: They don't reduce mortality or length of stay and they leave patients with higher out-of-pocket costs. That's why a trio of economists says we need to get rid of higher payments to long-term care hospitals. The suggested change should save taxpayers about \$4.6 billion per year. More than 70 percent of long-term care hospitals are for-profit, and the report said the largest such providers -- Kindred Healthcare and Select Medical -- have reported profit margins between 16 percent and 29 percent. Meanwhile, folks in the hospital business says the study is flawed.



LOWER DRUG PRICES EASY AS 1-2-3

Ever wonder how we're going to get prescription drug costs under control? Well, bloggers for the Commonwealth Fund have it all figured out! It boils down to a three-step plan based on an international approach:

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Life Insurance Owners Are Optimists And Other Fun Facts

Ready for some good ol' life insurance consumer research? This may be counterintuitive, but nonetheless interesting: new research from AIG reveals that 56 percent of life insurance owners are optimists, while only 48 percent of people who don't have life insurance are optimists. For purposes of the research, optimists were identified by their level of agreement with a battery of statements such as "In uncertain times, I usually expect the best," "I'm always optimistic about my future," and "Overall, I expect more good things to happen to me than bad." Sound like optimists to us. Unfortunately, AIG also found that only 53 percent of U.S. consumers ages 21-64 own life insurance.



Other life insurance fun facts from AIG research

- Among consumers who do not participate in a group retirement plan, those who own an individual retirement plan, such as an IRA, are most likely to own life insurance. Of these consumers with individual retirement plans, 64 percent also own life insurance, while only 37 percent of consumers who do not own individual retirement plans own life insurance.
 - Life insurance owners are older and more affluent than non-owners. The median age of life insurance owners is 43, versus 39 for non-owners, and the median annual income of life insurance owners is \$88,000, versus \$70,000 for non-owners.
 - Also, life insurance owners are more likely than non-owners to work full time (71 percent versus 60 percent), be homeowners (76 percent versus 64 percent) and be married (64 percent versus 53 percent).
- What does this mean for you? Younger, less affluent consumers are underserved when it comes to life insurance. Of course.

And In Case You Haven't Had Enough...

LendEDU also recently released a life insurance survey. Here are a few key findings from that research:

- Among insurance policy holders, 33 percent indicated that they don't fully understand their life insurance policy. Amongst policyholders, 38 percent have a term-life policy, 41 percent have a whole-life, and 20 percent are not sure which policy they have.
- Amongst respondents that were also repaying student loan debt, 65 percent would rather have their employer provide an equally valuable monthly student loan payment, while 30 percent opted for the equally valuable free life insurance policy provided by their employer



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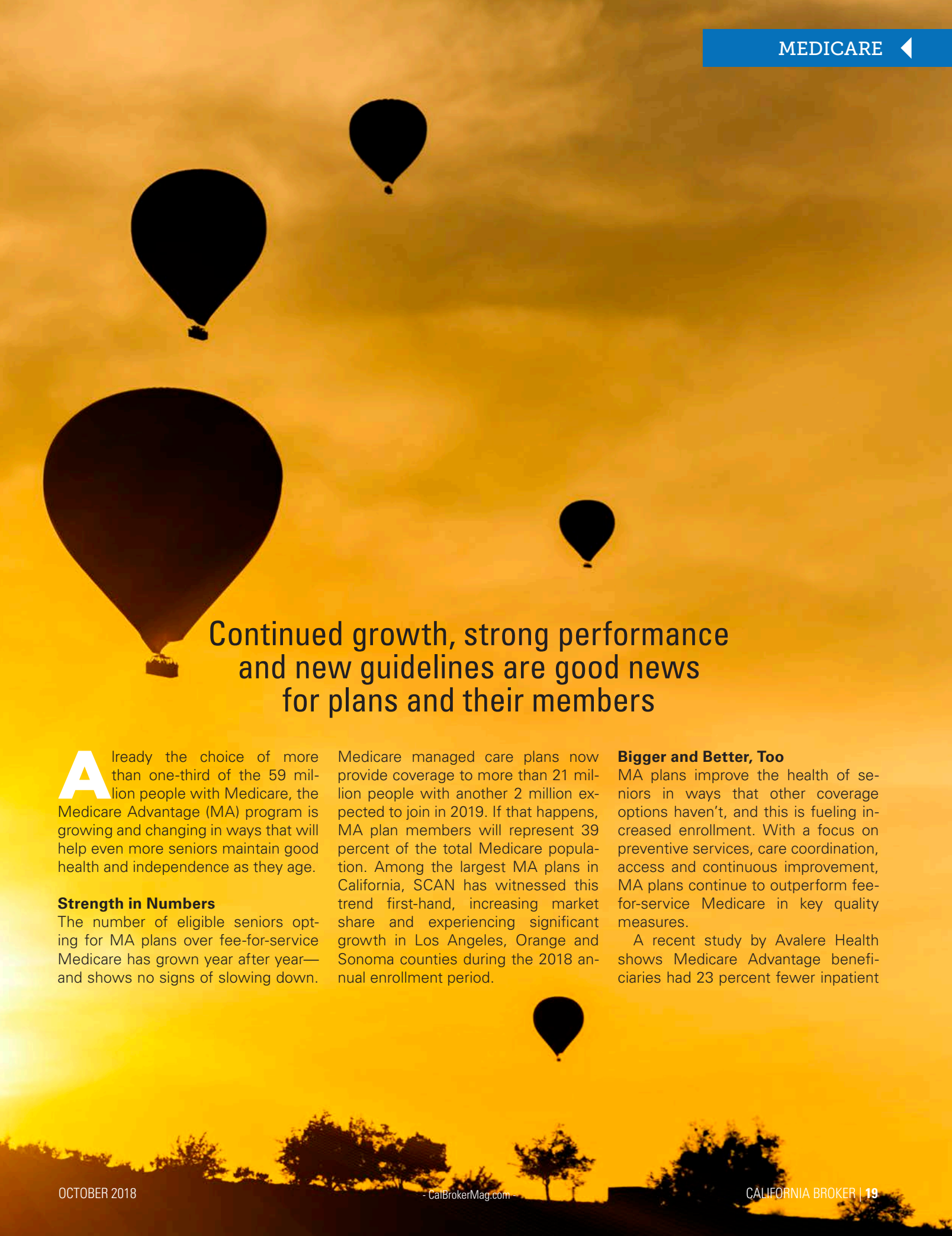


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MEDICARE ADVANTAGE ON THE RISE

By BILL ROTH



Continued growth, strong performance and new guidelines are good news for plans and their members

Already the choice of more than one-third of the 59 million people with Medicare, the Medicare Advantage (MA) program is growing and changing in ways that will help even more seniors maintain good health and independence as they age.

Strength in Numbers

The number of eligible seniors opting for MA plans over fee-for-service Medicare has grown year after year—and shows no signs of slowing down.

Medicare managed care plans now provide coverage to more than 21 million people with another 2 million expected to join in 2019. If that happens, MA plan members will represent 39 percent of the total Medicare population. Among the largest MA plans in California, SCAN has witnessed this trend first-hand, increasing market share and experiencing significant growth in Los Angeles, Orange and Sonoma counties during the 2018 annual enrollment period.

Bigger and Better, Too

MA plans improve the health of seniors in ways that other coverage options haven't, and this is fueling increased enrollment. With a focus on preventive services, care coordination, access and continuous improvement, MA plans continue to outperform fee-for-service Medicare in key quality measures.

A recent study by Avalere Health shows Medicare Advantage beneficiaries had 23 percent fewer inpatient

stays, 33 percent fewer emergency room visits and better health outcomes overall than individuals enrolled in FFS Medicare at similar costs to regular Medicare. People with chronic conditions, such as diabetes, in particular benefit from the extra benefits and programs available through Medicare managed care, experiencing better health outcomes and fewer complications, including serious complications, from their conditions.

Findings like these are important for several reasons. For one, they confirm that what providers of MA plans like SCAN and others like us are doing is making a meaningful difference in the lives of members, particularly those who need help the most. They also underscore plan's commitment to providing high quality benefits and services that meet members' individual needs related to health and independence. Knowing that MA plan members have better experiences can also be useful to our broker partners, because when you present an MA plan to your clients, you can be confident you are offering them coverage they can rely on for high-quality care, improved access and better health.

When it comes to MA, quality begets even greater quality. Since Medicare pays a bonus to plans demonstrating the highest quality, well-performing plans can reinvest these bonuses, continuously improving benefits, access and quality of care for the member. SCAN's 4.5 star rating for 2018 from the Centers for Medicare & Medicaid Services is not only a reflection of our efforts to improve quality and services, but an investment that pays off in a meaningful way for us, our provider partners, and our members.

New Laws, New Opportunities

MA's success in providing high-quality, value-driven and cost-effective care has not been lost on lawmakers. At the federal level, MA plans have earned bipartisan support, with more than 360 members of Congress pledging to preserve the program. They showed their support in an even more tangible way earlier this year with legislation that will make it possible for plans to further improve services and health outcomes: Special Needs Plans, which until now were temporary demonstra-

tion projects, can now be offered by MA plans on a permanent basis. This change will allow more of the nation's frailest seniors to benefit from programs that help them age successfully at home for as long as possible. Health plans that already offer SNPs can begin to think in the long term, while other plans that were put off by the uncertainty of past SNP rules will likely begin exploring these options. The result: More seniors with chronic illnesses and other special needs will have access to programs and services designed to support them.

The definition of "primarily health-related" supplemental benefits has been expanded to allow MA plans to

When evaluating which MA plan is right for each client, think about both the nature of the benefits and the stability of the plan. While it's exciting to offer "more" and "different" benefits, it's also imperative that the plan will be there for the long-term.

offer food, counseling and other non-medical services as long as they can help prevent, cure or reduce illness or injury.

TeleHealth made headlines when the Bipartisan Budget Act was signed into law in February. The legislation allows MA plans to include delivery of telehealth services in a plan's basic benefits. This can enable a member to access mental health services from the privacy of their own home, or provide a convenient way to ensure post-hospitalization follow-up care is received.

While plans in the past have been required to offer the same benefits to all their enrollees, new regulations also allow MA plans to tailor benefits to groups within their membership with specific health conditions. For example, a plan could offer all members diagnosed with diabetes additional

coverage for podiatry services, offering another way to better tailor plan coverage to member need.

Many MA plans have likely incorporated the new benefit flexibility into 2019 plan bids for approval by Medicare. While 2019 benefits have not been released as of press time, I'm confident that many in our industry are thinking of new and creative ways to provide the most value for members under the new guidelines.

A Strong Choice for Seniors

These "new developments" align with SCAN's history as a social HMO and our decades of experience caring for the frailest seniors. As a long-time advocate for changes that would allow greater flexibility in meeting seniors' individual needs, we are excited to be looking at ways to once again provide benefits that can more directly help each member age safely in the setting of their choice.

When evaluating which MA plan is right for each client, think about both the nature of the benefits and the stability of the plan. While it's exciting to offer "more" and "different" benefits, it's also imperative that the plan will be there for the long-term. Make sure the plan under consideration is adding benefits and services at prices that are sustainable year over year. While more customized coverage options will only add to MA's appeal, plan members—your clients—depend on stability of cost and coverage. The plan should work as hard to retain existing clients as it does to gain new ones.

The bottom line is this: 2018 has been a good year for seniors! The many benefits that already come with membership in a Medicare Advantage plan will inevitably get even better. ★



Bill Roth is the president of SCAN Health Plan and oversees the organization's operating and financial performance. An accomplished healthcare executive, Roth has more than 20 years of managed care experience with prior roles at CIGNA HealthCare in Connecticut, Aetna, Blue Cross of California and WellPoint. He earned both his Bachelor of Science and Master of Business Administration at Indiana University.

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HEALTH

CONSUMER DEMANDS ARE DRIVING CHANGE IN DELIVERY

By DENISE VANCE-RODRIGUES AND NOORI DHILLON

Previous generations had simple needs when interacting with the healthcare system. To book an appointment with their primary care physician, they'd pull out their calendar, pick up the phone, and call the office. They'd take whatever appointment was available, pencil it into their calendar, and wait. For after-hours care, they would either call their doctor and wait for a nurse to call back or make an expensive

trip to the ER. While this system was straightforward, it was rarely personalized or consumer-centered.

In recent years, the healthcare system has undergone a major evolution to serve consumer's needs and expectations. Younger generations have grown up with advanced technology and have high expectations from the world in which they live. Simultaneously, older generations have watched the world go digital. As a result, there is a growing expectation that the healthcare system should be easy and accessible.

With the rise of high-deductible health plans, modern consumers now assume more financial risk for their



healthcare. As a result, they need tools that empower them to be cost-conscious utilizers of healthcare, which means smart healthcare systems need to adapt to meet these growing needs and expectations if they want to succeed.

Younger Consumers Are Driving Healthcare Innovation

Millennials and Gen Xers account for roughly half the population—and they expect convenient delivery methods and digital touchpoints at every step throughout their healthcare journey. And because different demographics have different needs, healthcare organizations must develop unique ap-

proaches that meet their expectations and let them take a more active role in their care.

In November and December of 2016, in collaboration with FORTUNE Knowledge Group, Oliver Wyman—a leading global management consulting firm—conducted an extensive digital survey of 2,016 American healthcare consumers. The survey found nearly half of millennials view healthcare as a consumer good. This means they are more willing to shop around.

Furthermore, the majority of millennials want new healthcare products and services. One study suggests that 60 percent of millennials are interested in telehealth and 71 percent want to manage their preventive care through a mobile app. They are also more likely than baby boomers to want consultations with experienced patient advocates.

Technology Has Changed All Consumers' Expectations

We've become accustomed to a personalized, data-driven consumer experience that is responsive, transparent and accessible. We shop for everything from cars to financial services



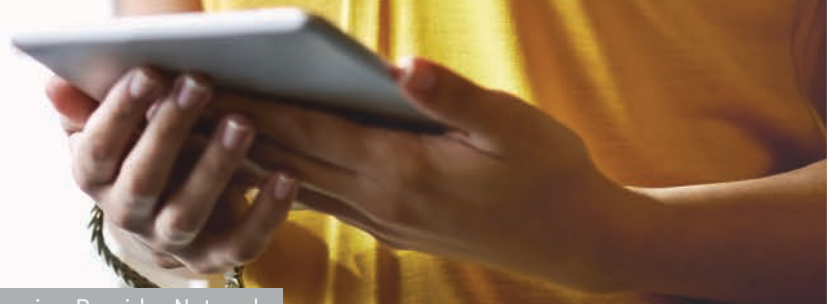
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Our Growing Provider Network



The most recent CDC data reports more than 43 percent of all Americans under the age of 65 have high-deductible health plans. This means they are paying thousands of dollars for their healthcare before their health plan will cover even a portion of their expenses.

online—reading reviews and comparing prices. We access order histories with ease, renew services with the click of a button, and text our stockbrokers. Accordingly, modern consumers now expect similar offerings from their healthcare organizations.

Consumers are looking for ways that technology can simplify their health and wellness needs. Provider-centered models of healthcare delivery—where consumers have limited input or access to information—no longer meet their expectations. Instead, they want healthcare on their own terms and tools that give them easy access to care and empower smarter decision-making.

Financial Risk Impacts Consumer Healthcare Decisions

The Oliver Wyman survey also confirmed that cost, especially rising premiums, is a major concern among every age group. There's a clear trend toward value-based, high-quality care. Of those polled, the top three concerns were related to cost—including rising premiums, care not covered by insurance and prescription prices.

The most recent CDC data reports more than 43 percent of all Americans under the age of 65 have high-deductible health plans. This means they are paying thousands of dollars for their healthcare before their health plan will cover even a portion of their expenses.

In addition to cost, however, many other factors influence consumer choice—including convenient access to timely and effective care, cost and communication transparency, and the quality of the healthcare alliance's physicians and hospitals. These concerns have spawned a more empathetic "patient as person" paradigm in place

of the outdated "patient as profit" system. This movement places the member in control of their care and has become the preferred model in the Bay Area, as several networks have implemented a convenient, transparent, and cost-effective member experience—improving outcomes and increasing efficiency.

Healthcare Systems Must Respond to Consumer Demand

Leading healthcare organizations have responded to consumer demand by implementing new tools and technologies, including:

Accessibility and Integration—When providers work together, patients experience less frustration and receive better care. Today's consumers use multiple access points for their needs—including telehealth, walk-in clinics and their doctors' offices. Modern healthcare organizations utilize advanced systems to facilitate interconnectivity across the myriad touchpoints of the healthcare system.

Digital Tools—Digital systems facilitate the seamless exchange of information between providers and members through mobile apps, member portals, and expense-tracking tools. Today's healthcare organizations have started offering digital tools, such as telehealth options, digital ID cards, cost estimators, and other powerful tools that empower consumers to interact with the healthcare system on their own terms. They allow members to choose their care venue, understand their costs, and improve their health outcomes by increasing their health literacy.

Meeting Consumers Where They Are—Due to increased financial risk, consumers are becoming aware of the importance of preventive care. How-

ever, taking control of your health can be daunting. Successful healthcare systems implement population health management strategies that use biometric data to identify at-risk populations and coordinate preventive care based on their unique needs.

These tools empower individuals to take control of their care at key touchpoints and place them in charge of how their care is delivered. Mobile apps and member portals trigger notifications to patients that keep them involved throughout the healthcare continuum, allowing them to interact with the healthcare system on their own. Along with telehealth, these tools and processes create a more transparent, accessible, affordable and involved healthcare experience.

Now, instead of leaving members to figure out their care, treatment and follow-up on their own, modern organizations are supplying them with helpful features throughout their healthcare journey to improve outcomes and prevent potential medical issues. While pricing remains a major concern for most consumers, an improved healthcare experience will likely improve trust between patients and providers, increase consumer engagement and lead to optimal healthcare outcomes. ★



Denise Vance-Rodriguez is the business development director for Canopy Health.



Noori Dhillon is director of product strategy for BayHealth Development.

IT'S TIME FOR MANY INSURANCE PROFESSIONALS TO RE-THINK THEIR THINKING!

By **SHERYL HUNSINGER**

Working in the insurance industry for the past 20+ years, I have met a lot of different personalities. The one personality that has always been surprising to me is the broker who firmly believes that employees and individuals only need the types of insurance that they would purchase for themselves. They would give me the list they approved of—health, dental, vision, along with inexpensive term Insurance, and maybe long-term disability (one of the most important benefits a person could purchase!). Many of them were not interested in learning about new products that were coming into the marketplace each and every year, and how their clients could benefit from some of these great products and services. Over the years, I have met with many clients who asked me “Why didn’t my broker tell me about this?” Many times this same question was running through my mind.

We are now entering into another crucial period in our Industry, where brokers need to be much more open-minded, educated about the new products and services available to employers and individuals, and what will be the best solution for the client based on the client’s needs. Whether it’s an individual you are working with, or a group of employees from various backgrounds, you will need to also understand what appeals to the differ-

ent generations of clients that you are serving, and place products that will best serve those wants and needs. Millennials, for instance, are looking for immediate access to what they need, and will be looking for the “app” to load on their phone to address that need. Gen X wants all the facts and costs available to them so they can quickly make a decision, and boomers are concerned about having coverages and services that can address unforeseen illnesses that can arise as you get older. Boomers don’t need unexpected financial surprises. There is no cookie-cutter, canned product design for all these folks, especially since every person’s personal situation is different. With this in mind, brokers need to constantly be listening, learning and developing strategies and offerings that can assist everyone at different phases of their lives. Listening is imperative, because if you have already decided what you are going to offer someone before they stop telling you what their needs are, then your clients are not being well served.

Brokers also need to become creative thinkers when advising clients on health insurance, the costs of these benefits, and educating them on the new products that are coming into the marketplace that are both insurance and non-insurance. Many of these products will assist with managing the costs of their healthcare. Enhanced

benefits that were mainly offered at the group level will now be available directly to individuals through general agencies. These specialty GAs are constantly reviewing and analyzing how new programs can assist brokers, employers and individuals in managing their health plans, the costs of their health plans, and maneuvering through the sometimes very confusing world of medical care, insurance coverage, physician care and an unexpected diagnosis.

There are professionals working in our industry who understand all these things and approach our work with an open mind, and clients will be seeking out these types of brokers and retaining them! ★



Sheryl Hunsinger is president and CEO of the Hunsinger Group, LLC. She received her bachelor's degree in business administration from Cal State University Fresno, and has spent the last 23 years in the Insurance industry. For nearly two decades Sheryl was senior corporate officer for Chimienti & Associates Insurance Services, a managing general agency in California, specializing in enhanced employer benefits and related employer services. The Hunsinger Group specializes in providing individuals and their families solutions to the rising costs of medical care. Sheryl can be reached at sheryl@hunsingergroup.com.



INSURTECH

IMPLEMENTING NEW TOOLS TO ENGAGE THE MILLENNIAL AUDIENCE

By JASON WALKER

Millennials, Generation Y, Gen Next, Boomerang Generation, no matter what they are called, this group of 20 to 30 years olds have been wreaking havoc on the market across industries – perhaps with the insurance sector facing the most disruption. These consumers want on-demand service whether it is for shopping, paying bills, or conducting insurance transactions. If agents can't provide the customer service they require, they find agents, or insurtechs, that can. Product preferences are also shifting. Ride sharing and living-with-parents after college have reduced needs for auto and home insurance. Less compulsory products like life insurance are becoming an even harder sell, with the next generation thinking about life insurance as something they might eventually want, but most certainly do not need at this point.

Many millennials graduated during the downturn of the economy. They often possess significant student loan debt and are frugal, preferring to save their big purchases for life experiences such as exotic trips and unique activities rather than planning for life crises.

Moreover, what's worked in the past, won't work as well in the future. Agents also need to adjust their cur-

rent processes to make the life insurance transactions more efficient. Millennials put a high premium on speed and ease in doing business.

This is where digital solutions can help. Most life insurance agents have quoting and proposal tools and a customer relationship management (CRM) system. But these solutions aren't enough when targeting the younger generation. New communication outlets, including social media and text messaging, can take the agent/client relationship to platforms where customers feel most comfortable. Automating routine functions can speed up the application process.

Here are three key areas to consider to make the most of digital technology

1. Keep it personal, but embrace the virtual

Traditionally, life insurance sales revolved around face to face interactions; that sometimes resulted in 14 to 16 meetings a year with a top client. But millennials are wired to other communication methods including text messages, email and social media. And even face-to-face no longer requires two people in the same loca-

tion. Agents can have virtual meetings using platforms like Skype or even FaceTime.

Life insurance agents need to be flexible and willing to adjust their communication methods to fit their clients' preferences. For some customers, this may involve the traditional multiple in person meetings at the agent's office accompanied by follow up phone calls and emails between visits. But for other clients, they might only meet the agent once in her office and then rely on other communication outlets that extend beyond phone and email. If the client has a quick question about the application process or her policy premiums, she might choose to send the agent a quick text message in the hopes of getting a speedy reply. For additional meetings and check-ins the customer might opt to have a video conference with the agent instead of trekking into the agency.

Agents should incorporate a scheduling tool to help manage their calendars and to keep track of the communications preferences of their individual clients. Steady communication is very important in the life insurance industry and automating scheduling and rescheduling can create a much better experience for clients and prospective

Millennials are disrupting how all industries operate and life insurance is not an exception. This demographic has different priorities and the tactics that worked on previous generations will not be sufficient to engage this consumer group who expect fast, on-demand and simple service.

clients. It also saves the agent time enabling them to communicate with more people on a daily basis.

Agents should also ensure they have access to the technologies their customers are using. Some services like Skype or Google Hangout are free for video conferences and used by a large number of consumers. But agents may also need access to a web conference platform. In addition to talking with clients about their needs and projections for the future, agents need to share a variety of information and documents with them to meet compliance standards including state mandated notices, buyer guides, and disclosures forms required by the state and insurance company. This platform allows agents to not only communicate with clients, but also share presentations and documents that enable the agent and customer to review information at the same time ensuring they remain compliant.

Finally, life insurance agents need to have a social media presence. This not only provides another outlet for customers to reach out and communicate, but it also is a great platform for recruiting new clients. Prospective clients will often turn to social media to request recommendations from their peers on a variety of topics including financial and insurance topics. According to the research organization, LIMRA's Insurance Barometer Study, more than a third of Americans and more than half of millennials are likely to ask for recommendations for an insurance agent or financial advisor on social media. With active accounts on these platforms, life insurance agents can insert themselves into the conversation.

2. Turn the want into a need

Life insurance for many millennials,

who are trying to pay off student loan debt, seems like an added expense they can do without. They are young and the odds are in their favor that they will not need to be cashing in a life insurance policy anytime soon. Agents should work to shift this narrative and demonstrate why it's important to buy policies now. Life insurance is tied to key variables – health and age which typically do not improve with time. Consumers have access to the most favorable life insurance rates when these two variables are on their side.

Helping clients look ahead 10 years, 20 years and even 30 years can help them see and understand the multiple opportunities for insurance at different stages of life. Incorporating an account aggregation tool can help facilitate these projections. Agents can get a clear window into their clients' finances, which gives them an accurate view into the customers' current circumstances. It allows agents to make product recommendations and to serve the client holistically. It also advances the customer/agent relationship, turning the agent into an advisor that can recognize other planning opportunities outside of just life insurance sales.

3. Life insurance application process shouldn't feel like a lifetime

Millennials want the trusted advisor and tailored advice that a seasoned life insurance agent can provide – but they don't want huge hassles. Agents should digitize as much of the enrollment process as possible. Can the initial forms be filled out and submitted online? What documents can be signed using e-signature and returned via email, eliminating the need for the client to locate a stamp and mail the physical copy?

Agents should also implement an online service portal for their existing customers. For routine simple edits such as beneficiary changes, bank information or new address, millennials would prefer to not have to do an email exchange, or make a phone call to the office for these adjustments. Portals enable customers to log into their own account and make these changes themselves. It also reduces the agent's workflow, giving them more time for sales and complex client issues.

Millennials are disrupting how all industries operate and life insurance is not an exception. This demographic has different priorities and the tactics that worked on previous generations will not be sufficient to engage this consumer group who expect fast, on-demand and simple service. With the right digital tools, agents can interact with the clients the way they prefer and shift the narrative demonstrating that life insurance is not a luxury, but a vital tool that could benefit the customer and her family for years to come.



As managing partner at Smart Harbor, Jason Walker oversees the strategy, development and delivery of the company's technology solutions and analytics platforms for the insurance market.

He brings both significant insurance and business-to-business technology marketing experience to his role. He was previously founder and executive of People To My Site, a company that developed digital marketing programs for automotive dealers and franchises. He is currently an advisory council member for the Insurance Digital Revolution, an industry organization focused on advancing digital technology adoption among independent insurance agents.



LARGE GROUP VIEW FROM THE TOP

Compiled by THORA MADDEN

California Broker went to two insurance industry insiders—David Fear, Sr. and Rob Carnaroli—for their view of what's happening with the large group health market.

SOME OF CALIFORNIA'S TOP LARGE GROUP HEALTH CARRIERS OFFER INSIGHTS ON THE CURRENT STATE OF THE INDUSTRY

Cal Broker: What are the most important trends affecting large groups in California? For example, do you believe the AHP rule will have an impact on the large group market?

David L. Fear, Sr. RHU, president, Shepler & Fear General Agency: The biggest trend that we see right now is the continuing battle to contain health care costs. Employers of all sizes are very concerned about this, yet it is the large employers who have the ability to do something about it that will directly affect their health benefit plan costs. Considering that a majority of large employers are now “self-funding” their health benefits, they are looking at cost containment alternatives including reference-based pricing. By limiting their health plan payments to a factor of Medicare, employers are seeing a reduction in the cost of their stop loss coverage, as well as a leveling out of their claim costs. Many employers still offer a managed care option such as an HMO which transfers risk back to the provider. That is an effective tool to manage costs. But at the same time we see large employers adopt more consumer directed programs such as health reimbursement arrangements and are now offering these through both HMO and PPO/RBP plans.

Rob Carnaroli, vice president, health plan products, Sutter Health: One of the biggest trends I see that impacts large groups in California is the external market pressure to re-imagine what health care should look like. This includes pending mergers between large pharmaceutical companies and insurance carriers, and with non-health care companies like Amazon, Berkshire Hathaway and JPMorgan Chase. Alphabet, Google’s parent company, is another disruptor spending significant capital to influence health care delivery. All of this places a heavy demand on the traditional healthcare marketplace that we elevate the model and look for ways to become better. It is no longer about just price, benefits and network—digital capabilities, unexpected convenience and modernization are the real motivating factors.

As far as the latest news on the federal government allowing association health plans, AHPs, for small groups, I’m not convinced this is the silver bullet for small groups and associations. It’s certainly too early to opine on how this will play out in the large group market.

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

David L. Fear, Sr.: Frankly there is more uncertainty outside of California because California is one of a few states that strongly supported the ACA and passed enabling legislation to make it firmly in place here in the Golden State. For fully insured plans, California reforms will continue to apply regardless what happens in Washington, D.C. We tell brokers that while the individual mandate is going away at the national level, it might come back in some states like California that want to continue to have a higher percentage of insured population. And we advise brokers that in spite of the termination of the individual mandate, the employer mandate (called the “Shared Responsibility” provision of the ACA) has not gone away. In fact IRS began last November to start sending out letters to employers to collect fines/penalties for not offering coverage to their employees. That first wave of IRS letters applied to “Applicable Large Employers” for the 2015 tax year. The next wave of letters have gone out from IRS to employers who appear to be liable for this for the 2016 tax year. So we are telling brokers to get over to their large employer clients (50+ employees) and check on their status as an ALE since 2014 because IRS is definitely sending out collection letters. So to summarize: Tell clients that reform here in California is not going away and tell large employers that they are still subject to the employer mandate – the IRS is seriously going after them for money they may owe.

Rob Carnaroli: While there’s still much uncertainty around the current health insurance reform, the most important factor in any future proposal is that it protect health care coverage and keep the existing reforms that have positively transformed health care delivery in place—especially for consumers. At Sutter Health, we have a clear path forward based on what we know consumers want and need from us: access to high-quality and affordable care. It’s incumbent upon the consulting community to stay current on state and federal changes and how local, regional and national payers and providers are innovating amidst all this—and then share this information with clients and advise them as subject matter experts.

Cal Broker: What are the most effective ways to sell to large groups?

David L. Fear, Sr.: The tried and true method is the CONSULTATIVE APPROACH. Many brokers today work the 5500 filing database for large employers in the market and this tells them the basics of what they need to know about the prospect: What carriers they offer, how much they pay, who is the existing broker, etc. A good broker will meet with the employer, ask a lot of questions about what they have now and what services they expect to get from their broker. A big focus will be on compliance assistance, alternative funding, provider issues, medical cost containment strategies and related issues. This process will take months (not days) and brokers need to know that going in—they need to present a strategy to the employer that meets their needs and helps contain costs of their benefits. Simple spreadsheets won't cut it anymore—everyone can do them, so you have to present solutions to the challenges that you were able to glean from the employer in the consultative process. If the broker is not capable of that, then they need to partner with someone who can support this method of sales.



David L. Fear, Sr.



Rob Carnaroli

fordable price. At Sutter Health, we believe it's critical that employers see the value we bring to Northern California and our continual focus on innovating to meet customer demands. The launch of Sutter Health Plus in 2014 and the recent formation of a new joint venture healthcare company, Sutter Health Aetna, introduced new health plan options for employers to purchase for their employees.

New models that combine the delivery system with the financing of care give us the unique opportunity to work toward a goal of operating more efficiently, coordinating care among providers to improve outcomes, creating a differentiated member experience, and making healthcare more affordable. Additionally, today's consumer expects innovation in health care beyond the traditional brick-and-mortar provider office—they want new and convenient front doors such as retail clinics and virtual care—and that's something we're now able to deliver through walk-in care centers and video visits. Employers see the value in this and recognize what we're offering—and they want it for their employees. ★

David L. Fear, Sr. RHU, is president, Shepler & Fear General Agency, in Roseville, California. He can be reached at davefear@sheplerfear.com
Rob Carnaroli serves as vice president of sales for Sutter Health Plus. He can be reached at cararrj@sutterhealth.org

Rob Carnaroli: The most effective way to sell a large group is to deliver on the commitment of quality care at an af-



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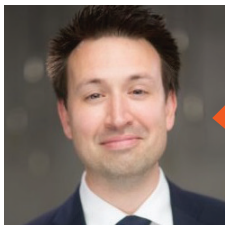
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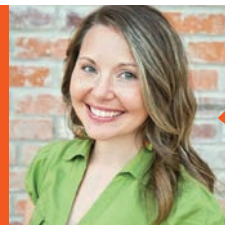
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4 REASONS ADVISORS SHOULD EXPLORE DIGITAL MARKETING

By MICHAEL CARVIN

For decades, advisors and brokers have depended on face-to-face and referral marketing to grow their businesses. This included strategies such as hosting dinners and seminars in order to meet and woo potential new clients. However, in today's day and age those methods are less trackable, less targeted, more time- and money-intensive and contribute very little to a positive online reputation compared with many digital marketing methods. If you haven't yet used any digital marketing tactics, now is the time to do so. Here we'll discuss why we recommend a carefully considered and planned digital marketing program to help grow your business.

Digital Marketing is Trackable

You need to be tracking the return on your marketing budget. If you're spending money on any marketing strategies, it's critical to measure your success to make sure it's increasing your assets under management relative to how much it costs.

Digital marketing makes tracking your leads easier than ever. For instance, if you distribute an e-newsletter, you can track how many of your leads click through to your website. Further, if you set up a contact form on a landing page of your webpage, you can see how many people actually reach out to you as a result of your e-newsletter. This helps you determine how much you want to spend, if it's successful – or scale back your spending on e-mail marketing if it's not generating the new business you want.

Digital Marketing is Targeted

Modern digital marketing software can help you laser-focus your outreach on the audiences you most want to turn into clients so you don't waste

your time on prospects who are not appropriate for your particular area of expertise. Traditional in-person seminars or client dinners may not attract the leads that are most appropriate for your practice; it's what we call a "spray and pray" approach in that it's marketing to the masses and hoping at least one person turns out to be both interested in becoming a client and being the right fit for your practice.

Online lead generation services like SmartAdvisor, Dave Ramsey and Paladin can be very effective in helping you focus on the potential clients you really want. For instance, with our own SmartAdvisor platform, advisors can customize the leads they receive to a very granular detail. Potential investors fill out a survey including factors such as investable assets, age, location, family and retirement status, risk tolerance, savings habits and about fifteen other criteria. They are then matched to a financial advisor who has indicated he wants to receive leads with their specific profile. Not only are these leads very targeted, these investors have already indicated – by completing such a long survey – that they are high-intent leads looking to form a relationship with an advisor.

Digital Marketing is Cost-Effective

We've spoken to financial advisors who have spent upwards of \$10,000 on a seminar and client dinner and never received a single new client through that time- and cost-intensive endeavor. Conducting a traditional direct mail campaign can cost thousands of dollars in design development, copywriting, email list purchase, printing and mailing. But with digital marketing, you can keep a much tighter control on how much you spend and where.

Have the cost of your Google AdWords gone up without delivering you more clicks? Pull back on that marketing channel. Banner ad on a local website receiving more clicks than you had planned for? Give the word and have it embedded to similar websites that your prospects look at regularly. Overall, with digital marketing, you have much tighter control over how much, when, where and how you spend your marketing dollars. This enables you to be agile and dynamic in how you craft your marketing budget so you are getting the most bang for your buck.

Digital Marketing Also Enhances your Online Reputation

When you market to potential clients online via your website, blog or social media channels, all of the content you are distributing helps to elevate your online reputation. That means that when people search online for a financial advisor, not only will you show up, but potential clients will see positive information that you are controlling. This will hopefully influence their decision to retain a financial advisor.

In short, it's time for financial advisors to take a strategic foray into the newest methods of reaching your potential clients using digital marketing so you can track it, target it, save money, boost your online visibility, and ultimately control the growth of your practice. ★



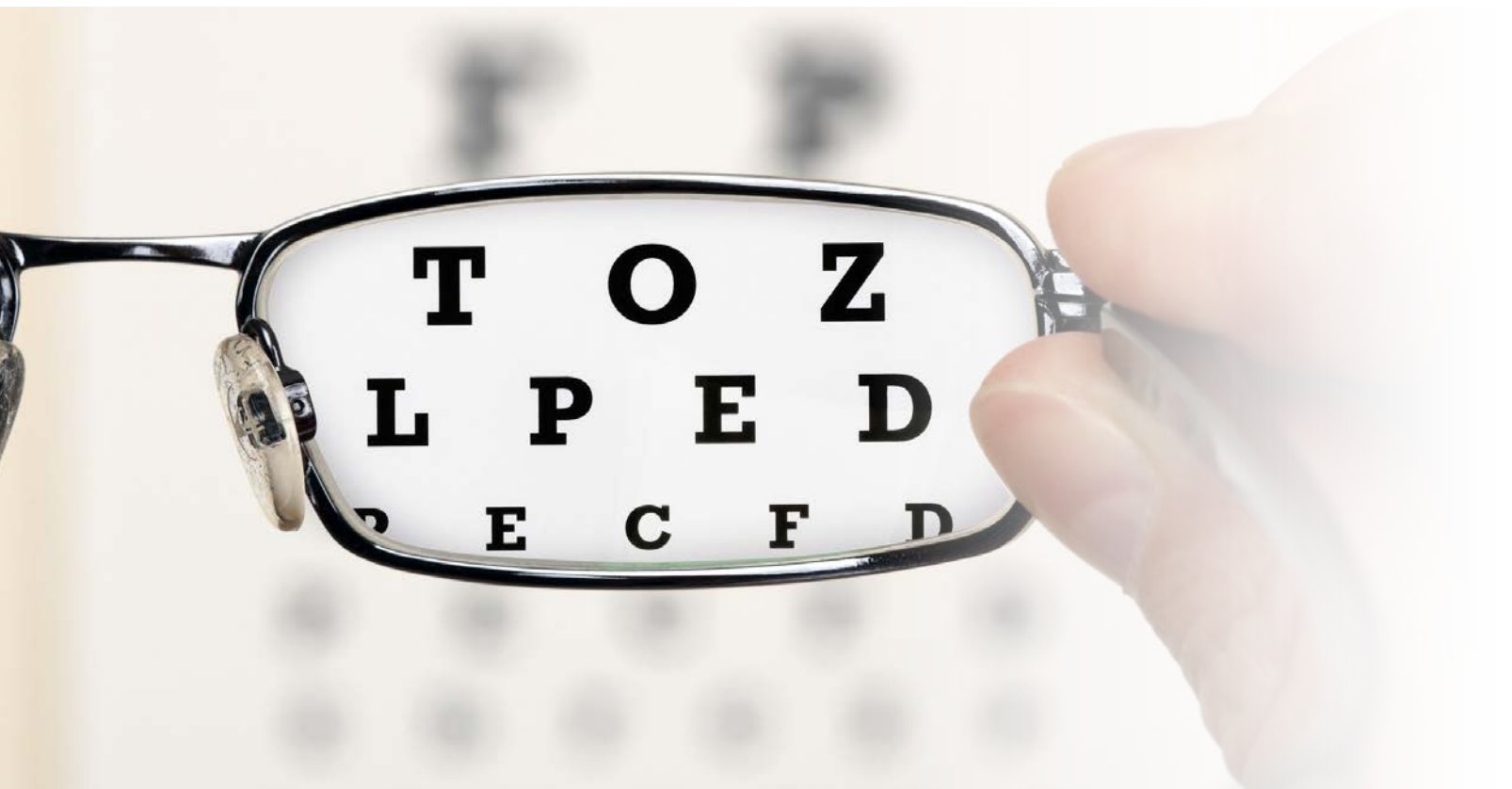
Michael Carvin is the CEO and co-founder of SmartAsset, a financial technology company providing the SmartAdvisor lead generation service for financial advisors.

Visit www.SmartAsset.com and www.SmartAsset.com/financial-advisor/about for more information.

VISION

5 STRATEGIES TO HELP EMPLOYERS SEE THE VALUE OF VISION TRENDS TO SHARING IN OPEN ENROLLMENT

By LAURIE LOFRANCO



Game of Thrones. Wonder Woman. Ariana Grande. What do these three topics have in common? They all earned top spots last year on Twitter's trending topics list. While brokers and benefits professionals don't need to be up-to-date on the most popular TV shows or pop songs, they should be in tune with what their employees want out of their benefits—especially with open enrollment here. This means looking beyond general medical benefits and taking a

deeper dive into how to present popular ancillary benefits, like vision.

One of the most popular elected benefits, vision benefits are also among the most desired by employees—and simply offering them can give employers a tremendous leg up. In fact, 98 percent of employees believe that offering vision coverage shows that a company cares about its employees' well-being, according to the 2017 Transitions Optical Employee Perceptions of Vision Benefits survey

(online survey of 1,000+ nationally representative U.S. adults ages 18+, employed full-time or part-time, whose employers offer vision benefits). Additionally, 87 percent of employees say they'd be more likely to stay at a company offering vision benefits covering premium lens and frame options.

In order to present the best possible vision packages to customers, it's important for benefits brokers to stay on top of the latest offerings and trends in vision benefits. What are these

trends? According to the 2018 Transitions Optical survey, the top three motivators for employees to enroll in a vision plan are:

1. Having access to full coverage of premium lens options.
2. Having a better understanding that simply getting eye exams can provide early detection of several serious health issues.
3. Understanding that utilizing their vision benefits can help them save on their overall medical costs.

Below are five strategies exploring these trends and more—helping brokers better navigate the benefits enrollment period and ensure their customers are seeing the value that vision benefits can bring to their workforce.

1. Emphasize coverage of premium lens options

True or false: if an employee is seeing 20/20, that employee is seeing his or her best. False. While getting an updated eyeglass or contact lens prescription is critical, optimal vision goes beyond this. Consider the process you'd go through if you were picking out a new television or camera. It's all about the optics, isn't it?

Premium lens options—like anti-reflective coatings to reduce glare and photochromic lenses, which adapt and darken in changing lighting conditions—can help to improve visual clarity. Many photochromic lenses also provide protection from harmful blue light and ultraviolet (UV) light, which can lead to short and long-term visual problems. Offering these premium lens options through a vision plan isn't just helpful—it's desired. According to the survey, 92 percent of employees said they would be more likely to schedule an eye exam within the next 12 months if their vision plan covered

at least one premium lens option. Those belonging to Gen Z—which will soon make up a growing portion of the workforce—were significantly more likely to say they would be very likely to schedule an eye exam. Additionally, offering premium lens options can also help to sway employees who aren't already taking advantage of this important benefit option. According to the survey, of the employees not already enrolled in a vision plan, six in 10 said they would be more likely to enroll if the plan provided full coverage of premium lens options.

2. Educate on the link between eye health and overall health

It's not a secret that routine eye exams—covered by many vision benefits plans—are instrumental in helping to ensure employees have an up-to-date prescription. But beyond vision correction, eye exams are also imperative for maintaining both eye and overall health.

According to The Vision Council, more than 10 million Americans have undiagnosed eye conditions or problems that can ultimately lead to visual impairment, vision loss and/or increased medical costs. Additionally, many of the most common eye conditions or diseases—like glaucoma and age-related macular degeneration—have little or no early warning signs. Glaucoma, specifically, has often been referred to as the "silent thief of sight" because of this reason.

Annual, comprehensive eye exams—with dilation—can act as preventive measure for detecting many common eye conditions. Beyond eye health, comprehensive eye exams can also play a vital role in protecting an employee's overall health and wellness. Because signs of certain systemic diseases—such as diabetes and hypertension (high blood pressure)—

can be seen in the eye, these conditions can often be detected through a dilated eye exam. Eye exams are particularly important for those who are at risk for diabetes—as signs of the disease can be seen in the eye in its earliest stages. For this reason, the eye doctor may even be the first health professional to make an initial diagnosis of diabetes—being able to make referrals for earlier management to help reduce overall health costs and burden of the disease.

It's important for benefits brokers to communicate the link between eye and overall health to employers so that they can, in turn, communicate this to their employees. Consider that nearly six in 10 employees (56 percent) said they would be more likely to enroll in a vision plan if they knew that eye exams could provide early detection of serious health issues, according to the Transitions Optical survey. Offering this education is important to all employees. Understanding the role that vision benefits play in overall health was the highest motivator for enrollment for Gen X employees—and the second-highest motivator for millennials, baby boomers and Gen Z employees.

3. Put your sight on savings

Beyond contributing to a happier and healthier workforce, offering vision benefits can also affect an employer's bottom line. This is a strong selling point for clients. When employees can't see well, they often don't feel well—with poor or miscorrected vision leading to problems such as eyestrain, eye fatigue and headaches. Sub-par vision also means employees won't be able to work as well—leading to reduced productivity or even time away from work.

But don't just tell this to customers—show them. Many vision plans

What's the Generation Breakdown?

The generational breakdown for the 2018 Employee Perceptions of Vision Benefits survey

- Generation Z: Ages 18-19**
- Millennials: Ages 20-36**
- Generation X: Ages 37-52**
- Boomer: Ages 53-71**

According to The Vision Council, more than 10 million Americans have undiagnosed eye conditions or problems that can ultimately lead to visual impairment, vision loss and/or increased medical costs.

and companies offer insights into the savings possible through vision benefits. Transitions Optical, for example, offers a Vision Plan Savings Calculator, which can be used free-of-charge by benefits brokers and employers to calculate the savings possible for a workforce through a premium vision plan.

The interactive calculator—which can be found at HealthySightWorkingForYou.org/Calculator—allows employers to input their company's workforce demographics by age, gender and ethnicity (or use pre-populated national averages) to determine how many of their employees are likely to have vision- and eye health-related issues. The calculator explores how routine, comprehensive eye exams can provide early detection and treatment of various eye diseases and serious overall health issues—reinforcing the important role that vision benefits can play in preventive care. The calculator also reviews the impact of several common and correctable vision problems, which can take a huge toll on an employee's health and productivity if left untreated. Additionally, the calculator provides information about the importance of selecting a plan that covers premium lens options—which can enhance and protect an employee's vision.

4. Jackets, scarves and dental—it's time to bundle up!

Are your clients ready to bundle up? While you may have a couple of months left before it's time to start thinking about a winter wardrobe (especially here in California), open enrollment is fast approaching—and bundling vision and dental benefits under the same plan is a great option for increasing enrollment and staying competitive with offerings. According to the survey, nearly nine in 10 employees (88

percent) say they'd be more likely to enroll in a vision plan if it included dental benefits as part of a bundle. Vision and dental benefits don't have to be offered by the same company to be part of a bundle deal. For example, if an employer already offers EyeMed benefits and is satisfied with this vision plan, it can be bundled with a dental plan from a different company as part of one offering.

5. Stock your toolkit: educate, educate, educate.

Perhaps the most important thing benefits brokers and employers can do when offering vision benefits is to provide education. Nearly all employees surveyed (96 percent) said that if they have a better understanding of the options that their vision plan includes, they will be more likely to enroll. Start compiling your education toolkit with information on the topics that matter most to employees, including coverage of premium lens options, information about eye and overall health issues, cost savings possible through a vision benefit and information about package bundles.

Many vision plans already offer online portals and toolkits for their members that provide this type of education—which can make it easier for both benefits brokers and employers. For example, EyeMed encourages employee enrollment and utilization, as well as employer open enrollment support with a number of simple, but helpful, tools.

Members can visit enroll.eyemed.com to understand the vision benefit and get help to think through enrolling in the vision benefit with its interactive "concierge" decision tool, LevEye. Because benefits communication is important to do throughout the year,

these tools are available to employees at any time.

And for employers, EyeMed provides easy self-service open enrollment resources online at eyemedeyeq.com/oe/. It offers things like cut and paste intranet articles and email content, videos, fliers, signs, postcards, brochures and buckslips—in English and in Spanish. It's important to have many options available to tailor the communication to the needs of each company and their employee population.

Other optical companies and websites—such as HealthySightWorkingForYou.org—also offer complimentary tools that can be used by brokers, employers and employees.

Staying ahead of trends in vision care—and making sure they're front and center when talking about benefits with clients—is imperative to ensure both employers and their employees not only understand the importance of vision benefits, but are also taking full advantage of them. Employees want coverage of premium lens options—as well as education about the link between routine eye exams and improved overall health—so why not give it to them? ★



Laurie LoFranco, vice president, Keenan & Associates, has more than 28 years of experience in human resources and employee benefits. Laurie joined Keenan & Associates in 2008 after spending the previous 12 years as the human resources director at a city in Southern California. Laurie graduated from the College of Notre Dame with a degree in human services and holds a Master's Degree in public administration from California State University, San Bernardino.

MEDICARE ADVANTAGE

PLANS NEED EFFECTIVE RISK, QUALITY AND CARE STRATEGIES

By SCOTT HOWELL

Licensed Medicare insurance brokers provide invaluable guidance for retirees making health-care coverage decisions that can have serious consequences on their health and financial well-being. Therefore, it's critical that they have a firm grasp on trends, innovations and helpful solutions in the Medicare Advantage (MA) space.

First of all, the nation's untenable rate of healthcare spending has sparked a growing reliance on MA plans, which provide an alternative to traditional fee-for-service (FFS) Medicare. In fact, MA plans now represent 30.6 percent of all Medicare enrollees and 28.9 percent of Medicare's 2017 gross spending budget.

Second, individuals can get Medicare benefits from original Medicare or a MA plan, such as an HMO or PPO. With the former, the government pays for Medicare benefits. With MA plans, the coverage is offered by private companies approved by Medicare. MA plans provide all Medicare Part A (hospital insurance) and Medicare Part B (medical insurance) coverage.

The Best Possible MA Plan

The most effective MA plans on the market look at the full spectrum of the patient and apply an end-to-end solu-

tion. When done effectively and efficiently—and combined with payment reform—it's possible to enhance care coordination using analytics, in-home care, retrospective solutions and care management to significantly improve outcomes.

Value-based contracting generates cost efficiencies and improves clinical outcomes in MA. For MA plans and risk-bearing entities to remain sustainable, however, they must adopt innovative quality and risk adjustment programs to meet the growing demand for effective care strategies. For example, MA plans can gain clinical insight into risk-adjusting conditions to enhance their traditional analytical platforms.

How Does a Risk Adjustment Model Work?

Risk adjustment is an actuarial tool used to calibrate payments to health plans based on the relative health of the at-risk populations. If insurers are limited in the extent to which premiums can vary by health status or other factors that are associated with health spending, risk adjustment can help ensure that health plans are appropriately compensated for the risks they enroll.

Significantly, most claims in fee-for-service Medicare are paid using procedure codes, which offer little incentive for providers to record more diagnosis codes than necessary to justify ordering a procedure. In contrast, MA plans have a financial incentive, since the current risk adjustment model was introduced, to ensure that their providers record all possible diagnoses because higher enrollee risk scores result in higher payments to the plan.

Consider two examples of how an MA plan can be optimized: Advantmed's Physician Record Review (PRR) is a two-stage retrospective chart review process from a 1) certified coder and 2) board-certified physician.

Advantmed's Prospective Health Assessments (PHA) provide a robust view of members and their care needs. Providers can also rely on PHAs to lay the groundwork for developing more accurate reporting documentation, improving patient engagement and compliance, enhancing disease management and reducing utilization.

This kind of full-spectrum, end-to-end approach to care helps providers identify gaps in care and manage plan members more productively. It also helps health plans that are serving as



intermediaries, executing solutions and assuming risk.

Ultimately, the greatest benefit goes to the plan member, who will be guided toward more preventive care and self-management early in the care process.

Innovative Approaches

Value-based contracting can drive utilization patterns and improve clinical outcomes among chronically ill, elderly MA members. One study tested the hypothesis that payer-provider risk contracting promotes high-value care and concluded that in the future, more clinicians will have to bear the monetary risks associated with healthcare utilization.

The MA program provides a unique milieu for investigating provider groups that have either risk-bearing or fee-for-service contracts with private health plans.

Full-risk capitation combined with a revenue gainshare agreement sparked a clinical practice transformation at the provider group level, associated with increased office-based care and decreased hospital-based services.

The clinical practice transformation resulted in a 6 percent survival benefit and lowered the hazard of death by 32.8 percent.

Value-based contracting benefits all stakeholders

The intervention group’s overall survival rate was 82 percent, and the control group’s was 76 percent. This 6 percent survival benefit first became apparent at 16 months after the intervention, coinciding with the first year that the intervention group had higher office-based utilization than the control group.

Age provided a natural time-scale for calculating the hazard of death for this elderly population with multiple comorbidities and a higher risk of all-cause mortality. Intervention-group members had a 32.8 percent lower hazard of dying ($P < .001$). The survival benefit was more apparent among those aged 82 to 96 years. Randomization inference confirmed these survival data, whether time ($P < .001$) or age ($P < .001$) was the time scale.

Improved survival is related to and attributable to the Centers for Medicare and Medicaid Service’s (CMS) Hierarchical Condition Category (HCC) data and value-based contracting, which then transform primary care delivery.

Brokers should also be aware that CMS expanded how it defines the “primarily health-related” benefits that

private insurers are allowed to include in their MA policies, with insurers including these extras on top of providing the benefits of traditional Medicare. For instance, air conditioners for people with asthma, healthy food, rides to medical appointments and home-delivered meals may be among the new benefits offered to Medicare beneficiaries who choose private sector health plans, when new federal rules take effect. This means MA beneficiaries will have more supplemental benefits and be better able to lead healthier, more independent lives. ★



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plans, provider groups and risk-bearing entities to optimize risk adjustment and quality improvement programs. Our integrated and technology-enabled solutions improve health plan financial results and offer insights on health plan members. For more information on Advantmed’s solutions, visit www.advantmed.com. Look under the “resources” tab for our recently published whitepaper on the federal policy and the economics of Medicare.

MEDICARE FRAUD

By KAREN JOY FLETCHER



LEARN HOW TO HELP YOUR CLIENTS PROTECT THEMSELVES

Medicare fraud costs an estimated \$60 to \$90 billion a year. Losing billions of dollars to fraud is a waste of taxpayer money, and fundamentally increases the cost of healthcare for everyone. It can also jeopardize beneficiaries' personal and medical identity, and their ability to access entitled benefits and services. Knowing about fraud is key to protecting yourself and your loved ones.

Types of Medicare Fraud

Medicare fraud comes in all shapes and sizes reflecting Medicare's huge and complex program with its Parts A, B, C and D (for readers who don't sell Medicare yet: Part A is hospital insurance, Part B is outpatient medical insurance, Part C is Medicare Advantage plans and Part D is prescription drug coverage). This is a lot of information, so let's get started....

Overview on various types of fraud

Medicare fraud most commonly occurs in: Billing for institutional facilities such as nursing homes, residential facilities, hospitals, home health and hospice.

Billing for physician visits and services not rendered or not medically necessary.

Billing for durable medical equipment such as wheelchairs, body jackets, incontinence supplies or diabetic supplies without a doctor's prescription.

Improper marketing of health insurance plans through phone calls, door-to-door sales and misleading flyers.

Provider Fraud

Providers can commit fraud if they submit bills for services not provided, or unnecessary services.

They can also commit fraud if they upcode a service. This is when a provider charges Medicare for a more expensive service than was provided. For example, a provider may bill for surgery, when only a bandage was placed over a cut.

Unbundling services can also be fraud. This occurs when a provider submits separate bills for lab services that combine three or four tests, which are intended to be billed as one service.

Billing for non-covered services as covered services is also fraud. This

occurs when a provider bills a service such as routine toenail clipping (non-covered service) as foot surgery (covered service).

Suppliers and Recruiters Fraud

Suppliers can commit fraud if they: bill for different equipment than what the beneficiary received, bill for home medical equipment after it is returned or solicit, offer or receive a bribe or kickback. Recruiters may stop Medicare beneficiaries on the street or make an at-home visit, offering money and promotional gifts as incentives to take "free" medical exams, after which they give the beneficiary medical equipment they do not need.

Insurance Broker Fraud

Insurance brokers can commit fraud if they bribe, mislead, or coerce a beneficiary to enroll into or switch plans just to make a commission even though the plan may not be the best choice. Or if they enroll a beneficiary into an MA plan without the beneficiary's consent or make unsolicited phone calls, emails or home visits.

Pharmacists Fraud

Pharmacists can commit fraud if they dispense expired drugs or short the beneficiary on the number of pills in the prescription they deliver.

Beneficiary Fraud

A beneficiary can commit fraud if they provide their Medicare number in exchange for money or a free gift. In some cases, beneficiaries may unknowingly commit fraud in this way.

One of the best ways for your Medicare clients to detect fraud is to examine both their Medicare Summary Notice (MSN) they receive from Medicare after their claims are paid, and the Explanation of Benefits (EOB) they receive from their Part C and D plans. (Clients can access their Medicare account at mymedicare.gov). These are some helpful questions to ask when clients review their MSN and EOB:

Did they receive all the services/prescriptions listed?

Were they billed for something they didn't get? Or billed for the same thing twice?

Did the doctor order the services?

Do the prescriptions listed match their prescriptions?

Are the dates of the services/prescriptions correct?

If after answering these questions, your clients suspect fraud, they can call our California Senior Medicare Patrol (SMP) at 1-855-613-7080.

Common Recent Scams

The most common fraud schemes our California SMP currently sees are hospice fraud, new Medicare card scams and "free" back brace scams.

Medicare's hospice benefit provides palliative care for people who are terminally ill and have 6 months or less to live. Yet scammers are signing up healthy people for this benefit while offering them "free housekeeping services covered by Medicare," or "free milk for an entire year covered by Medicare!" They get beneficiaries' Medicare numbers in exchange for the "free" benefit and sign them up. In addition, some beneficiaries residing in low-income housing units are offered assistance with cooking and cleaning while unknowingly being placed in home health or on hospice. Help

keep a look out and spread the word on these schemes to stop this fraud.

Beneficiaries should have received their new Medicare cards by now in California. If they haven't, though, it is coming soon in the mail. Of course, there is no charge for the new card, so remind clients not to be tricked into sending money to scammers.

Postcards, TV commercials, ads offering a "free" Medicare-approved back brace in exchange for your Medicare number.

Medicare only covers braces and other durable medical equipment (DME) that are medically necessary with a doctor's prescription. Scammers, however, hope people don't know that. They just want beneficiaries' Medicare numbers to bill Medicare for equipment they never deliver, or to bill Medicare for much more expensive equipment. If clients think they need a back or knee brace, they should call their doctors first.

Open Enrollment Fraud Tips for Clients

In addition to all the scams we've covered thus far, more scams come during Medicare's annual open enrollment (October 15 through December 7). This is the time beneficiaries can enroll into or change their Medicare Advantage and/or Part D plan, or return to Original Medicare. As MA and Part D plan coverage can change annually, it's important for beneficiaries to review the changes in their coverage for the coming year. Navigating this information can be confusing and hence makes open enrollment a ripe time for scams. Below are a few tips for clients to protect themselves from fraud during this time.

Beware fake Medicare sales representatives: Make sure clients understand not to believe a salesperson who claims to be a Medicare representative. Of course, Medicare does not send "representatives" to solicit anyone's business.

Federal regulations prohibit unsolicited telephone calls, door-to-door visits, emails and other forms of sales without permission. Make sure clients understand that if they have not requested that someone contact them, it may be a scam.

Guard personal info: Tell clients to never give out personal information such as a Social Security number, bank account numbers, or credit card information over the telephone.

Keep good records: Advise clients to keep records of who they speak with – even you!—and the information that they provide.

Take their time: Clients shouldn't feel pressured to make a quick decision. Tell clients to be sure that they understand the details of a plan before they enroll. They should verify copayment amounts and whether their medical providers participate in the plan that they are considering.

Change isn't mandatory: If clients are satisfied that their current plans will meet their needs for the coming year, they don't need to change plans. They should confirm the details of their current plan before making a switch.

Thanks to all of you for being the "eyes and ears" of Medicare and watching out for scams. Please share this information and report any suspected fraud to our California Senior Medicare Patrol at 1-855-613-7080. More information on Medicare fraud, resources for education and outreach are in the fraud and abuse section of our website at calhealthadvocates.org. ★



Karen Joy Fletcher, MPH, has over 19 years of experience in Medicare training, education and advocacy and has served as CHA's Publications Consultant since 2004. She is the primary researcher, writer and editor of CHA's website content, including

CHA's newsletter and blog. She also develops and revises key educational materials, spearheads CHA's social media and chairs the Senior Medicare Patrol Media Team and SMP superheroes skit team.

In addition to her work in Medicare advocacy, Karen teaches Earthgym and Qigong at schools, conferences, festivals and retreat centers around the country and abroad, and co-leads Qigong and wilderness retreat trips in China. She also enjoys ample nature and family time in the Cascadian forests and mountains.

TRAVEL INSURANCE

Insurtech Makes this Untapped Market More Appealing

BY RAJEEV SHRIVASTAVA

The opportunities for brokers to sell travel insurance are growing and made even more attractive with advancements in insurtech that make the comparison, selection and purchase of insurance simpler and less time-consuming. The emergence of third-party providers for intermediaries makes it easy for any licensed life and health broker to add travel insurance to current product portfolios.

The global travel insurance market is projected to generate \$66.1 billion by 2022, growing at a compound annual growth rate of 4.7 percent over the next 10 years. Insurance intermediaries are forecast to be the highest revenue-generating market segment through 2022.

Travel Insurance Claim Form

Travel Insurance Claim Form

Information
Name
Passport number
Home address
County

PASSPORT



The emergence of insurtech providers for brokers makes it easy to add travel insurance to your product portfolio

About 15 percent of travelers experience some type of a medical incident (Consumer Reports, May 17, 2018). However, the majority of travel insurance policies are purchased for trip cancellation or interruption coverage (USTiA Market Survey, 2015). Overall, an increasing number of travelers are opting for comprehensive policy coverage for incidents such as medical emergency, lost luggage, flight delays and global incidents from terrorism or natural disasters.

As global travel continues to rise, a corresponding rise in travel mishaps will continue to plague travelers, prompting them to think twice about relying on their credit card to cover missed or delayed flight expenses, or their U.S.-based health insurance plan to cover them for medical emergencies while overseas.

Extend Your Impact with Travel

Most Americans are lulled into a false sense of security assuming that their domestic health insurance policy will cover them when they are abroad. Your customers may not be thinking of services such as extended in-patient stays, ambulance transport, emergency medical evacuation or repatriation, which may run into six-figure expenses, depending on the country. And, the definition of what constitutes a medical emergency will differ with each policy, further increasing the likelihood that medical treatment claims may not be covered.

If a medical incident occurs abroad, all out-of-country claims must be paid out-of-pocket before being sent to the provider for reimbursement. This can be a financial hardship for many, and financial devastation for some if the incident is a catastrophic injury, heart attack or acute condition due to a pre-existing condition.

Global Travel Insurance Landscape

Driven by an uptick in overall global travel – rising 7 percent in the past two years (UN World Tourism Organization) – senior travel, increased business travel expenditures, travel insurance

visa requirements and an unquenching thirst for adventure travel – the travel insurance market does not give any indication of slowing down.

Unlike other types of insurance policies, over 71 percent of travel insurance purchases are one-time expenditures with an average coverage span of 10 days. The general trend in travel is people are taking more frequent trips of a shorter duration instead of opting for one, extended yearly vacation. And, for frequent travelers, multi-trip policies are on the rise (Allied Market Research, November 2016).

As global travel and business travel expenditures increase amidst a backdrop of natural disasters such as the eruption of Kilauea, the increased threat of terrorism, and an overall increase in leisure travel – more and more travelers will be opting for comprehensive travel health insurance.

While single trip policies continue to dominate purchases, multi trip travel insurance policies are expected to be the fastest growing travel insurance category through 2022 (MarketResearch.biz, November 2016).

Your customers may not be thinking about unforeseen travel expenses like these:

- Ambulance transport
- Emergency medical air evacuation
- Repatriation
- Lost or stolen passport
- Border entry denial
- Terrorism
- Kidnapping, ransom

Travel Insurance Can Make a Dream Vacation

Some homeowner's and renter's insurance policies cover theft of personal belongings while abroad, but do not include coverage for immediate cash disbursement due to incidents such as lost luggage or a lost or a stolen passport.

Travel Insurance Market Segments

Not accounting for business travel insurance expenditures, seniors and millennials purchase the most travel insurance (AARP Research, November 2016). This may be somewhat surprising given the social media-addicted perception often thrust upon

this younger demographic. GenXers, most with families and heavy career demands, round out the coverage purchases.

Seniors: Golden Opportunities

Senior baby boomers are most likely to have disposable retirement income allowing them to travel more often, and for longer periods of time. They are also the market segment most likely to have pre-existing conditions such as diabetes, hypertension and heart conditions, providing an opportunity for the purchase of additional policy riders for acute onset of pre-existing conditions.

An acute onset of pre-existing conditions policy covers any acute episode related to the condition, such as a diabetic having severe hypoglycemia or a ketoacidosis episode. The policy rider would cover an acute episode, but would not include routine care, treatments or medications for any pre-existing condition.

Medicare Coverage Abroad?

Medicare only covers subscribers while within the U.S. As many health and life providers know, some Medicare supplemental plans offer worldwide emergency care – but for travelers with pre-existing conditions, a comprehensive travel insurance policy and a separate policy rider is essential to provide peace of mind.

The opportunity for selling traveling seniors comprehensive travel insurance policies, acute onset of pre-existing conditions riders and supplemental Medicare policies that cover medical emergencies abroad could not be brighter.

Millennials: Glued to their smartphones and ready for adventure

Millennials aren't waiting for the golden years to start checking off their bucket list. Gone is the quintessential backpacker on a Eurail pass. Today's millennial travelers build adventure, ecotourism and extreme sports into their vacations. They want all purchases to be mobile-based, seamless and completed in minutes. They are a huge driver of advancements in insurtech and travel insurance purchasing technology.

Insurance brokers will be the highest revenue-generating market segment through 2022

(Allied Market Research, November 2016)

They purchase travel medical coverage, enjoy lower rates due to their age, and typically add a hazardous sports rider to their comprehensive policy if they know they will be participating in adventurous sports activities.

Millennials and adventurer travelers offer a life and health broker the opportunity to sell pricey travel insurance riders for extreme sports coverage activities such as scuba diving, skiing, snowboarding and snowmobiling. Many providers do not cover all hazardous sports – bungee jumping, kayaking, mountain biking, river rafting, ziplining, mountain-climbing and mountaineering are a few activities that may only be covered by a handful of providers.

A hazardous sports rider is often sold with a larger, comprehensive package that includes emergency medical air evacuation, ambulance transport and repatriation in the case of severe injury or death. Brokerages in an active state like California are more likely to have a market for adventure clients. Offering amended general exclusions that will cover these typically-excluded activities can prove financially beneficial.

Executive Travel Insurance: Not just table stakes

Business travel insurance policies are driven by the same needs as tourist

travel, but the stakes are much higher. Business travel insurance expenditures accounted for the highest revenue share in the 2017 global market. A missed flight could mean millions to a company on the cusp of closing a deal, and for an executive with lost luggage, the immediate replacement of toiletries and clothing require coverage and cash reimbursement that is fast and efficient.

Business travelers purchase multi-trip or annual travel insurance policies for frequent trips. For those doing business in unstable or developing countries, terrorism insurance and increased medical coverage for infectious or tropical diseases may be needed. Many companies opt for kidnapping and ransom policy riders should a senior employee be seized. Business travelers offer a stable and profitable customer base to a brokerage selling travel insurance.

Family Travelers: The oft-forgotten GenXers

Family travel insurance policy purchases are made largely by GenXers. This generation may still be paying student loan debt and is most likely to have a family with younger children. These travelers are likely to have substantial life insurance coverage and would be inclined to purchase comprehensive

travel coverage to avoid financial calamities.

Many travel purchases made by this generation are often from first- or second-generation immigrants who host their parents or other relatives from abroad or take an extended visit for as long as their visas allow.

The travel insurance market is booming – any licensed health and life broker can expand their customer base with minimal onboarding, and property and casualty brokers need only secure an additional license to add travel insurance to their portfolio. With such a huge market growth potential, it makes sense to consider adding travel insurance coverage to your brokerage portfolio. ★



Rajeev Shrivastava serves as CEO to global insurtech company VisitorsCoverage, a popular online travel insurance marketplace that allows travelers worldwide to acquire and manage their

travel insurance online. He has also founded several online technology brands including TMQuotes, an online platform that empowers insurance agents to sell travel insurance online. VisitorsCoverage works with the travel insurance industry's most trusted providers including, IMG, Seven Corners and Lloyd's of London. For more information please call 408-763-9640.

An untapped market: Insurance coverage for your customers

For brokers with an established health and life practice, adding travel health insurance can provide an immediate revenue boost. This can be significantly increased by extending U.S.-based coverage for parents or other relatives while visiting or coming for studies in the U.S.

Why your customers should purchase a U.S.-based travel insurance policy for visiting relatives:

- Most non-U.S. citizens are used to some level of government-provided health care and do not realize the huge financial risk of not being covered for medical emergencies while traveling to the U.S.
- Many non-U.S. travel insurance providers require a medical exam before issuing coverage.
- Non-U.S. travel insurance providers may decline any coverage at all for applicants in their 70s and 80s.
- Policy maximums may not be as high as younger applicants, but the potential for financial devastation from a medical incident far outweighs the risk of not having any coverage at all.

PET INSURANCE

BY STEVE SHELL



WHY CLIENTS NEED TO PROTECT THEIR FOUR LEGGED FAMILY MEMBERS

Insurance is there to help your clients protect the things that matter most to them: their health, their homes, the future and security of their loved ones. Now it's time to add pets to that list. After all, Americans are crazy about their pets, and they're willing to do what it takes to keep them happy and healthy. In fact, a 2016 survey from Packaged Facts reported that 43 percent of pet owners prefer spending money on pet toys and other pet products than on purchases for themselves.

But when it comes to spending on pets, it's not all catnip-filled mice and Kong chew toys. The American Pet Products Association (APPA) estimated that Americans spent \$17.07 billion on

veterinary care in 2017—and with that number increasing from \$15.73 billion in 2015, these costs are only going up.

Before adopting or purchasing a pet, most people factor in routine expenses like food, litter, toys, vaccines and grooming. However, it's the unexpected veterinary costs that can really wreck a budget. Broken bones, hip dysplasia, or a cancer diagnosis (just to name a few) can easily cost in the thousands (or even tens of thousands) to treat. According to Datamonitor, one in three pets needs unexpected veterinary care every year—and when faced with the need for an expensive treatment, many pet owners must choose between financial ruin or euthanizing

their furry best friend.

It doesn't have to be this way—and that's why more and more pet owners are turning to pet insurance. By paying a monthly premium, which can be customized to fit most budgets, pet owners can enjoy the peace of mind that any unexpected ailment suffered by their pets will be covered.

Pet insurance has the potential to help millions of pet owners in the United States, and enrollment is rising. According to the North American Pet Health Insurance Association (NAPHIA), 2.07 million pets were insured in 2018, a 16 percent increase over 2017. Even so, that number amounts to less than 2 percent of the total number of pets in America. Many animal lovers have never heard of pet insurance, or don't understand how it works. As a result, there's a huge untapped potential for insurance agents to educate their clients and help to meet this demand.

What Is Pet Insurance?

Pets are considered part of the family, but they're protected like property (and are treated as such by law). Pet insurance falls under the category of property and casualty insurance. For this reason, though it's often compared to human health insurance, there are a number of notable differences.

Most importantly, pet insurance does not cover wellness expenses—it only covers the unexpected. Vaccines, dental cleanings, annual checkups, and spay/neuter surgeries (among other things) are considered routine care and, as such, are not part of pet insurance coverage. However, wellness plans are available through some veterinary practice networks and can be used in conjunction with a pet insurance plan to ensure complete coverage for all of a pet's medical needs.

Like most types of property insurance, pet insurance plans have a deductible and co-insurance. Most pet insurance providers allow customers to select their deductible amount and rate of reimbursement (pet owners commonly choose between 70, 80 or 90 percent reimbursement). Some pet insurance providers use a per-condition deductible, meaning that it will reset for every new illness or injury. Others, like Petplan, offer an annual deductible, so

that regardless of the condition the pet is being treated for, the bills will be reimbursed once the deductible has been met.

In another departure from human health insurance, pre-existing conditions are not covered under any pet insurance policy. Conditions that are considered curable (such as urinary tract infections, gastrointestinal issues, or ear infections) generally will be covered after a waiting period has ended. Pet owners interested in enrolling should carefully read the terms and conditions of each provider, and if it's offered, request a medical review—claims examiners will look at the pet's medical history and lay out exactly what would and would not be coverable under the plan based on veterinary records.

Pet Insurance in California

Insurance brokers in California have a special incentive to offer pet insurance to their clientele. Pet owners in the Golden State have the potential to save more money on their vet bills than anywhere else in the United States—and that's because they pay more for veterinary care than other Americans.

Did you know that the cost of veterinary care is not fixed, but fluctuates based on location? According to claims data from Petplan pet insurance, unexpected vet bills cost Californians an average of \$1,521.19 per year. Compare that to only \$769.56 in North Dakota! When a pet's emergency medical care poses the potential to take such a big bite out of pet owners' budgets, turning to pet insurance is a smart move for consumers looking to protect their finances and ensure the best care for their furry best friends.

Plus, the active lifestyles that many Californians enjoy sharing with their pets can put four-legged family member at heightened risk of accidents or injuries. Petplan received 5,231 injury-related claims in 2017 from California alone, at an average cost of \$680 per incident. The most commonly claimed injury, tears or ruptures to the cruciate ligament, cost an average of \$4,637 for treatment.

Injuries such as cruciate tears become so expensive because after the initial operation is completed, the pet will require extensive physical reha-

bilitation in order to regain strength and mobility. This can involve regular visits with a rehabilitative veterinarian over the course of weeks or months, and often alternative therapies such as acupuncture or laser therapy (which are coverable by Petplan). Pet insurance is especially helpful in such cases when vet bills add up fast.

Selling Pet Insurance

Offering pet insurance as part of a comprehensive insurance package is highly attractive to clients looking to safeguard and protect all the things that matter most to them in life. The option to bundle pet insurance along with home and car insurance offers clients convenience and complete peace of mind.

To solicit pet insurance, agents need to be P&C licensed in their state, as well as any other locations they may operate in. Agents interested in providing pet insurance to their clients should reach out to providers to learn more about the available compensation and perks. Petplan provides materials to help assist with promoting and explaining pet insurance. Additionally, a 24/7 call center offers customer service support, and internal teams communicate directly with agents' clients about premium collection, claims submissions and policy renewals.

Working with a supportive provider makes it easy for agents to add pet insurance to their portfolio of insurance offerings—pleasing clients and also helping to generate extra income for the agent. Petplan offers compensation for policies booked through agents, with commissions typically paid out on a quarterly basis. ★



Steve Shell is Petplan Pet Insurance Co-CEO. Interested in learning more about pet insurance—and helping your clients choose the best plan? Visit <https://insurance.gopetplan.com/agent-101guide> to download the Pet Insurance 101 Guide. The guide explains how pet insurance works and helps consumers weigh out the factors they must consider in order to purchase the plan that's right for their individual needs. For more information about partnering with Petplan, and to receive more marketing materials to share with your clients, please visit gopetplan.com/agents-brokers.

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