The BottomsLine

SPRING 2018

TWO QUESTIONS – REMEMBER, IT'S ALL ABOUT YOU

BY **GARY BOTTOMS, CLU, CHFC,** PRESIDENT
gbottoms@thebottomsgroup.com

Years ago, when I graduated from Georgia Tech and began my career, I had a future vision of what my life would be like by now. That vision was naïve. My lifestyle back then was fairly simple. Time moved on and I have accumulated more people in my life that I love. I've developed more passions and causes where I want to have an impact. I've accumulated material resources that require my attention. While I have so many blessings, my life is more complicated than I once imagined it would be. None of this is bad but somehow I thought things would be simpler.

I'm convinced that it's wise to have carefully selected counselors, coaches and mentors. I have a lot to learn about golf and know it's nearly impossible to diagnose a flaw in my own swing, but the knowledgeable observation of a golf coach is valuable. It's not only valuable, but makes the whole experience more fun. *(Continued on page 4)*

HEALTH SAVINGS ACCOUNTS:
A KEY TO HEALTHCARE EFFICIENCY (AND TAX SAVINGS)

BY **DAVID BOTTOMS**

With the 2017 tax filing season behind us and the 2019 benefit open enrollment period just a few months ahead, now is an appropriate time to address the interplay of health savings accounts (HSAs), high deductible health plans (HDHPs) and the potential to use them to lower both healthcare premium costs and income taxes in the years ahead.

For decades, many Americans have become accustomed to "traditional" health plans which include a myriad of copays for services such as doctor visits, urgent care, and prescriptions combined with a deductible for more significant healthcare items such as imaging, surgery, etc. *(Continued on page 2)*

ABOUT TBG

The Bottoms Group, LLC, has for decades been listening to clients and developing employee benefits, insurance and estate planning solutions customized to their unique and changing needs. For more information about TBG, visit **www.thebottomsgroup.com**.

tbg the bottoms group
SINCE 1947 BENEFITS · INSURANCE · COMMUNICATION

HEALTH SAVINGS ACCOUNTS:

A KEY TO HEALTHCARE EFFICIENCY (AND TAX SAVINGS) CONTINUED FROM PAGE 1

While the comfort of knowing that copays are available for common services is appealing to many enrollees, the complexity of these plans combined with the expense of providing them has led many employers to explore a simpler, more affordable approach to health insurance: high deductible health plans paired with health savings accounts.

It is likely most readers are generally familiar with the terms "HSA" and "HDHP" however somewhat confused by how these two components work together so I will endeavor to outline the key factors that make use of these two plan elements an attractive strategic move.

First, it is important to understand that a prerequisite to establishing a health savings account is enrollment in an IRS-qualified high deductible health plan. For 2018, in order to be deemed a qualified high deductible plan, the health insurance plan cannot provide "first dollar" coverage, i.e., copays, for non-preventative care prior to the attainment of a minimum plan deductible of $1,350.

This means that the plan will require that enrolled members pay 100% of the cost of care up to the deductible limit after which time the insurance carrier will pay all or part of the remaining costs up to a specified out-of-pocket maximum.

Bear in mind that preventative care is still covered 100% by these plans and that enrolled members still benefit significantly from the network discounts that their insurance carrier has negotiated with healthcare providers for services rendered.

So, in practice, these plans are quite clean in their structure as they require the enrollee to pay a predefined amount, then clearly indicate what the carrier will pay after that without all of the tiers and buckets that often cause confusion in traditional, copay plans.

Following enrollment in an IRS-qualified high deductible health plan, individuals under the age of 65 are able to establish and contribute to a health savings account on a tax-preferred basis up to a 2018 limit of $3,450 for an individual and $6,850 for a family.

HSA contributions can either be made pre-tax through payroll or can be made directly by enrollees through their chosen bank and deducted when taxes are filed.

Funds contributed to an HSA plan are available for use for qualified health expenses such as deductibles for healthcare treatment and have the added benefit of being available for approved dental and vision expenses generally considered to be outside the scope of a medical plan.

HSA funds not used for health expenses roll over year to year and grow on a tax-free basis. Additionally, HSA funds can be invested to enable long-term growth until such time as they are withdrawn on a tax free basis for qualified healthcare expenses.

As healthcare costs continue to escalate, the ability to leverage tax policy through the use of health savings accounts to lower premiums while concurrently building a healthcare nest egg may be just what the doctor ordered.

BY **DAVID BOTTOMS, REBC, RHU, CLU, CHFC,** SENIOR VICE PRESIDENT, BENEFITS
dbottoms@thebottomsgroup.com

BENEFIT PLAN MARKETING

BY **KELLY THOMPSON,**
SENIOR ACCOUNT EXECUTIVE, BENEFITS
kthompson@thebottomsgroup.com

With frequent changes occurring in the health insurance industry, medical carriers are often updating their proposal guidelines. These updated guidelines can affect all group sizes and it is important to prepare diligently in advance of the renewal date to ensure that all options are reviewed. Prior to Health Care Reform and community-rated plan options, all groups implementing a medical plan needed to complete medical underwriting requiring individual employee applications to obtain firm, underwritten rates. Now, the medical rates for groups between 2-50 eligible employees are community-rated and do not require employee medical applications.

While the community rates were age-banded originally, carriers have started offering composite community rates based upon a detailed census and a formula to create a 4-tiered rate. This 4-tiered rate can be a more efficient option for the employer to administer their group. The rates are determined by each enrolled employee's age and dependent's age as of the effective date and the rates at that time are in place for one year. The community rates for groups that are fewer than 50 eligible require that each dependent's date of birth be included in the calculation for a family's total. If a new medical plan is implemented, the final enrollment census is what determines the final premium, as it may have changed slightly upon final enrollment compared to the original quoting census.

There are some alternate funding options that are available for groups in the 2-50 market that would allow individual medical questionnaires to obtain firm rates which could result in lower premium. We often use an online portal to complete all medical questionnaires that we will use for medical carriers to obtain firm rates. Many employers prefer using these online medical questionnaires due to the accuracy of the information provided and the overall process of finalizing the rates. It also allows a seamless transition between the renewal decisions and open enrollment process.

Groups having 50-99 eligible employees would need to be medically underwritten by the carrier and would not use community rates. We now have a few options for obtaining firm rates from the carriers in this ever-changing process. Some carriers will allow a detailed census for these larger groups that provide even more dependent information and allows for review of their claims information. Others still require individual medical applications. The carriers then use these forms to complete medical underwriting for firm rates.

Groups with greater than 100 employees enrolled are typically rated with claims experience data from their current insurance carrier. There are times that data is not always available as it is contingent upon the guidelines of each carrier. In this area of quoting with 100+ employees, each medical insurance carrier has unique guidelines and preferences that we must follow in underwriting an employer group. It is important to always check with each carrier on each scenario. By staying informed of the fluid nature of the industry requirements, we are committed to finding the best options for each client as each situation is unique.

By staying informed of the fluid nature of the industry requirements, we are committed to finding the best options for each client as each situation is unique.

TWO QUESTIONS - REMEMBER, IT'S ALL ABOUT YOU

CONTINUED FROM PAGE 1

BY GARY BOTTOMS, CLU, CHFC, PRESIDENT
gbottoms@thebottomsgroup.com

Advice related to personal insurance and employee benefits can come from family, personal network, peers, or by reading books and surfing the Internet. But, advice from all of these sources may not be the best advice. A new Gallup poll found that 58% of Americans said the increase in news sources makes it harder to stay confidently informed. We have information overload. So, in what source do we place our confidence? My personal coach says that "your eyes only see, and your ears only hear, what your brain is looking for." Therefore, our personal mindset matters. An article about Mindset appeared in an earlier TBG newsletter.

In addition to us, the insurance advisor, we believe the advisory team should include an attorney, CPA, wealth manager and in some cases a psychologist. We have a deep network of capable advisers, and we are happy to assist and help others with the creation of a team.

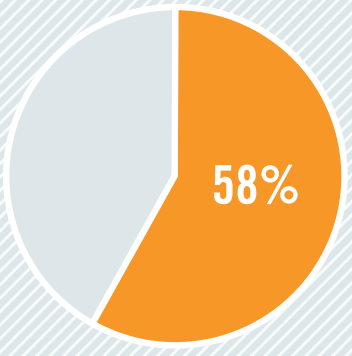
Early on in the relationship with our personal, as well as corporate clients, our first step is to understand what our client wants. We have a lot of products and services that we can easily talk about, but first we want to listen and learn how we can be useful and create value for them.

1

TO ILLUSTRATE, HERE'S A QUESTION THAT WE OFTEN ASK WHEN WE FIRST VISIT WITH A PROSPECTIVE INDIVIDUAL CLIENT:
"LET'S SUPPOSE YOU DIE TOMORROW (OR YOUR SPOUSE OR BUSINESS PARTNER DIES, BECOMES DISABLED, ETC.), WHAT NEEDS TO HAPPEN OVER THE NEXT FEW MONTHS?"

Question #1 does not need to be answered from a life or disability standpoint, we just ask that clients paint a picture of what they would like to have happen. Set the table, and visualize what needs to transpire. We listen.

Once we establish what they really want to happen, we can consider their current assets, insurance plans and other factors. We can then begin assembling routes to accomplish whatever it is they would like to accomplish. It's all about them. This is how we create value for our clients.



A NEW GALLOP POLL FOUND THAT

58% OF AMERICANS

SAID THE INCREASE IN NEWS SOURCES MAKES IT HARDER TO STAY CONFIDENTLY INFORMED.

As a means of practically illustrating the type of concerns many of our clients have, below are some of the dangers that our clients have communicated to us just over the last year or so:

- My spouse is 55 and I am 62. If I die now, she might live another 40 years. I don't want her to run out of money.
- All of my life insurance is group coverage through my employer. If for some reason I leave my employer, my life insurance coverage will be gone. I'm not in control.
- We own a small business and two of our children are active in the business, but a third child is not. We want to be fair to all three with regard to their inheritance and don't know how to do that.
- We have two children and they are both married. We're concerned that one or both of our children may get divorced, and don't want any assets we leave to them to end up in the hands of an ex-spouse. We want to keep all of our accumulated assets within our family's bloodline.
- I just learned that my employer's long-term disability plan only covers base salary and does not include bonus or commissions. Furthermore, the maximum monthly benefit is relatively low and subject to income tax. Also, if I'm disabled, my spouse may be unable to be employed because she would need to care for me.
- We have two young children and if both of us die, we're concerned about how our assets and insurance will be preserved and used to benefit our children.
- We have a business but have no possible successors in sight. I'd like to retire in five years but I'll need income from the business in order to make things work financially.
- We have beautiful lake house and would like to leave it to our two children to enjoy. One can afford 50% of the upkeep, but the other cannot.
- I am in a partnership and things are going well. But, if my partner dies I do not want to be in business with his surviving spouse.
- I own part of a successful business and one of our shareholders is responsible for 75% of the business development. If she dies, I'm afraid many of our existing clients will leave.
- My husband and I have two young adult children together and he has two older children from a previous marriage. He wants to leave a significant part of our accumulated assets to his two children when he dies. I'm concerned that if he does that I will not have enough money to last for my lifetime. I'm five years younger than him.

Question #1 and the list of some dangers that seem to surface frequently indicate what we might call the "softer side" of the estate planning process. The complexity of some of the issues routinely call for the involvement of additional team members. We want our clients to get where they want to be.

At some point in the process, we routinely ask Question #2. Once we establish what the client wants, we need to understand how they would like to proceed.

2

HERE'S THE QUESTION:

"IF WE WERE MEETING HERE ONE YEAR FROM TODAY - AND YOU WERE TO LOOK BACK OVER THE PRECEDING 12 MONTHS - WHAT HAS TO HAVE HAPPENED DURING THAT PERIOD, FOR YOU TO FEEL HAPPY ABOUT YOUR PROGRESS?"

The answer to this question will give us a sense for creating the timetable that our client wants.

Simply put, we believe most people are oriented towards protecting themselves and those they care about. This means physically, but also financially. Helping others protect themselves financially is what we do.

KNOW YOUR NETWORK

Are employees covered under your company benefits plan aware of in-network and out-of-network providers? In order to utilize the most cost effective benefits of their plan, members must always confirm that their doctor is still contracted and in-network on the day of his or her appointment.

Recently, a member of one of The Bottoms Group's group clients reached out to our HelpDesk with concerns about her upcoming doctor's appointment. Her employer group was in the process of switching insurance carriers due to open enrollment. Prior to changing insurance carriers, she set up an appointment with her regular physician for after her new coverage became effective. Once she received her member ID card prior to her coverage becoming active, she verified her benefits using the details on her member ID card and learned that the doctor was no longer considered contracted or in-network with the new plan due to negotiations between the provider's office and insurance carrier. She decided to cancel the appointment.

When the member reached out to our office with this dilemma, our HelpDesk suggested that she may find it helpful to keep the appointment until negotiations between the provider's office and insurance carrier were finalized. Fortunately, the negotiations were finalized in time for this member's new insurance coverage effective date and prior to her appointment with her physician. This was a favorable outcome since the member could continue to see her regular physician as the physician would continue to be contracted and in-network with the new insurance carrier.

This situation could have negatively impacted claims if different events occurred. For example, if the member was unable to update her appointment due to a provider concern and/or if negotiations did not work out between the doctor and insurance carrier, the claims could have been subject to and processed under out-of-network benefits. If the provider was considered out-of-network on the day of the member's appointment, the member may have received invoices greater than expected; claims processing out-of-network would certainly not be considered most cost effective for the member.

Additionally, it is very important for members to update their doctor's office with any new insurance information especially at open enrollment as that can impact claims as well. When claims are filed with the wrong carrier, it can create frustration and confusion in working with both the insurance carrier and the provider to figure out what steps to take to resolve any issues.

On the whole, it is always beneficial for employer groups to encourage their employees to confirm with their provider on the day of their appointment that the provider is still contracted and in-network. Unfortunately, contracts between carriers and providers can change at any time. Thankfully, this situation worked out in the member's favor since her provider was still considered participating and in-network once the negotiations concluded. Employers and employees can always feel free to reach out to The Bottoms Groups HelpDesk with questions or concerns as we are always willing to help in any way we are able.

BY **BETTY MCGINNIS,**
SENIOR CLIENT ADVOCATE
bmcginnis@thebottomsgroup.com

TERM INSURANCE:
THERE'S MORE THAN MEETS THE EYE

We are frequently approached to run term quotes for prospective clients. We believe that each prospective client is more than just a quote but an opportunity for a long-term relationship. Therefore, it is our goal to shift these "quote requests" into a deeper conversation about what the client wishes to accomplish. It is a common misconception that all term insurance products are the same and that it's just a matter of finding the "cheapest." It is our responsibility to advise our term insurance clients on what exactly they are getting in the long-run.

After survivor needs goals have been discussed and term insurance is determined as a solution, we begin assembling our recommendations for insurance. Currently, we have the capability to quote 198 term insurance products in the marketplace, so it is vital to have strict criteria for narrowing down the options.

CARRIER FINANCIAL RATINGS

We are first able to narrow down the results based solely upon carrier financial ratings. We take a look at an insurance company's ratings from four credit agencies (AM Best, S&P, Moody's, and Fitch) as well as the Comdex score. Since credit agencies do not use a universal ratings scale, the Comdex score is an easy solution to clear up confusion on a company's financial health. Since the Comdex is the average percentile of a company's ratings, we are able to quickly eliminate companies with poor scores.

CONVERSION PRIVILEGES

Next to the financial standing of an insurance company, the most important criteria for our term recommendation are the conversion privileges of the policy. Conversion is a necessity when the need for permanent insurance past the term period arises but medical underwriting on new insurance might not be favorable.

For example, a client has a 20 year term policy that was issued with a Preferred Non Tobacco risk class. His term policy has conversion privileges that allow him to convert to any permanent policy offered by the company by the end of term period before age 65. At age 60 in the 10th policy year, he unfortunately is diagnosed with a disease that would render him uninsurable. He realizes that he doesn't want his policy to stop at the end of the term period. He converts his term policy to a permanent policy without medical or financial underwriting and is able to keep his Preferred Non Tobacco risk class.

The danger in not paying attention to conversion privileges can limit the insured in a variety of ways:

- Does your policy have the ability to convert to any permanent policy available by the company or only conversion to one specified permanent policy? Another consideration is if the company has a strong portfolio of permanent options available. A company could very well state that you can convert to anything but they might only have two or three permanent plans that aren't competitive in the marketplace anyways.

- Does your policy have the ability to convert until the end of the term length or does it limit the timeframe for conversion? Additionally, the maximum allowable age at conversion should be considered in conjunction with the timeframe. The most common maximum ages for conversion are 60, 65, and 70.

UNDERWRITING LEVERAGE

Insurance policies, term or permanent, are not one size fits all. No two people have the exact same medical history so it is important to consider any underwriting hurdles when considering the carrier to formally apply. Many carriers have similar underwriting guidelines but they all vary slightly in how strictly they consider certain criteria such as tobacco use, height/weight, family history, etc. Therefore, it is important for us to know of any potential underwriting issues during the recommendation phase so that we can be sure to recommend the best carrier for each individual. Due to our ownership in Lion Street, we have dedicated underwriting teams at partner carriers that allow us to have underwriting leverage and guidance that most insurance advisors do not have. This allows us to avoid surprises during the underwriting process to ensure that our client's expectations are properly met.

BY **LAURA BOTTOMS HIGGINBOTHAM,**
VICE PRESIDENT, INSURANCE SERVICES
lbottoms@thebottomsgroup.com

the bottoms group
SINCE 1947 BENEFITS · INSURANCE · COMMUNICATION
180 CHEROKEE STREET NE, SUITE 200
MARIETTA, GA 30060-1610
770-425-9989

BY **JAMIE MOODY,**
SENIOR ACCOUNT EXECUTIVE, BENEFITS
jmoody@thebottomsgroup.com

EMPLOYEE ASSISTANCE PROGRAMS

We all face problems in life, but when we cannot handle them ourselves it is important to have the appropriate outside resources to support, guide, and help us find solutions to the issues we have encountered. Employee Assistance Programs (EAP) provide meaningful benefits that are designed to help employees and their family members deal with a wide variety of matters that might adversely impact their health, well-being, and job performance.

Most employer sponsored life and disability policies include an embedded Employee Assistance Program at no additional cost to employees, but there are also stand-alone programs that can be implemented as well. While all Employee Assistance Programs can vary from employer to employer, some of the most common and typical issues addressed by members may include but are not limited to the following:

- Grief or loss of a loved one
- Stress Assessment
- Work Related Difficulties
- Wellness Coaching
- Relationship/Marital Issues
- Legal & Financial Services
- Personal Counseling
- Adoption Resources
- Pet Services
- Academic Planning
- Child & Elder Care
- Alcohol & Drug Problems

Employee Assistance Programs are there to support Human Resources with known topics, and make available the appropriate level of resources to better assist and guide employees to those provided services. When an employee reaches out with a specific area of concern, introducing them to the Employee Assistance Program is as simple as providing them with access to the EAP website and telephone number, where they are able to contact experienced counselors and consultants at their own leisure for confidential assistance. Just like medical insurance is intended to address employee's physical health, the Employee Assistance Program is an added component to the benefits package intended to assist with emotional and mental well-being. While all information is private between the employee and the counselor, employers are still able to use the program as a management tool to obtain utilization and impact reports showing the usage of the program by the employees individually and organization as a whole.

In today's culture, balancing work and personal life problems are more challenging than ever before. Not only does the Employee Assistance Program provide quality service to employees, it is also an important adjunct to the internal HR staff by focusing on internal solutions to help minimize costs and maximize productivity. As a result, the EAP is there to ward off potential issues to help maintain a happier and more productive workplace.