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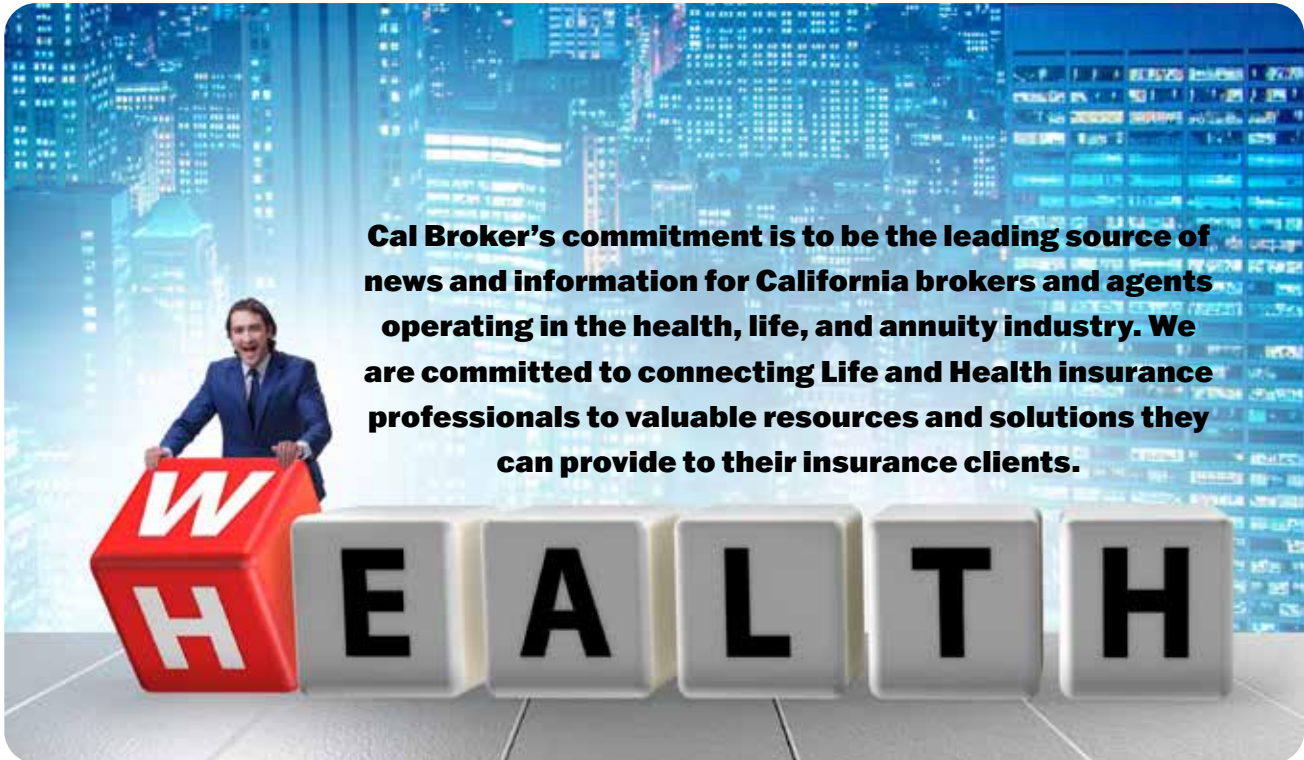
APRIL

CALIFORNIA BROKER

2023

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INDUSTRY/NEWS

CURATED NEWS FROM THE INDUSTRY



Elizabeth Blackwell, MD Rebecca Lee Crumpler, MD Nancy W. Dickey, MD

March was Women's History Month – let's celebrate 10 trailblazing women of healthcare history

Women have played an important role in healthcare for centuries. In celebration of Women's History Month and International Women's Day, we're honoring trailblazing women who made history in healthcare.

Elizabeth Blackwell, MD

The first woman in the U.S. to earn a medical degree, Dr. Elizabeth Blackwell paved the path for innumerable women to follow. Dr. Blackwell faced years of discrimination before graduating first in her class from Geneva Medical College in New York in 1849.

After moving to New York City to pursue a career in medicine, she continued to face hardships when looking for work – but that didn't stop her. In 1857, Dr. Blackwell opened the New York Infirmary for Women and Children with a mission to provide positions for women physicians. A true pioneer for women in the medical field, Dr. Blackwell also opened a medical college for women in New York City, where countless women followed in her footsteps.

Rebecca Lee Crumpler, MD

Dr. Rebecca Lee Crumpler was the first Black woman in the U.S. to earn a medical degree. Challenging the prejudice that stopped so many Black Americans from pursuing careers in

medicine, Dr. Crumpler graduated from New England Female Medical College in 1864.

Dr. Crumpler's focus was on helping others – whether it was medically or otherwise – and she was devoted to helping those suffering. Her strength, resilience, and bravery brought about a turning point in the history of women in healthcare.

Nancy W. Dickey, MD

The first woman to be elected president of the American Medical Association (AMA), Dr. Nancy Dickey is an educator, leader, and a passionate caregiver. When she started her relationship with the organization as an elected member of the AMA Council on Medical Services, she was 26 years old—the youngest to have ever held that position.

Dr. Dickey is currently serving as president of the Texas A&M University System Health Science Center and vice chancellor for health affairs. She continues to bring light to women in healthcare as she serves on the Board of Trustees of the Foundation for the History of Women in Medicine.

Explore all 10 women here: <https://hive.rochesterregional.org/2021/03/history-of-women-in-healthcare>

Are Movies With Moral Lessons Popular?

A new report finds that kids and teens prefer films that highlight people with good character.

If movies have the potential to shape children's and teens' character, how often do they elevate lessons about ethical and moral behavior? And do children and teens want to watch these kinds of movies?

Researchers at UCLA's Center for Scholars & Storytellers explored these questions in a recent report, "The Good Guys: How Character Strengths Drive Kids' Entertainment Wins." They analyzed over 1,700 movies for children and teens released in theaters after 2010 to see how many character strengths were featured in each film—qualities like compassion, empathy, gratitude, and integrity. Films could earn tags for 11 possible character strengths if the qualities were reinforced repeatedly and integral to the plot and characters, and helped characters succeed.

The results? Movies that prominently featured character strengths tended to make more money on opening weekend both within the United States and internationally compared to movies without character strengths. Dive in here: <https://bit.ly/3FkFR2g>



INDUSTRY/NEWS

CURATED NEWS FROM THE INDUSTRY

Living Longer: Quantity Doesn't Always Mean Quality

HOW SUSTAIN PEAK PERFORMANCE AS WE GROW OLDER

Life expectancy has been rising across most of the planet for centuries. Today, Americans live more than twice as long as they did in 1776, when the average person died in their mid-thirties. And thanks to advances in our



Photo Credit: IBEX.media / Adobe Stock

understanding of aging and longevity, we have continued to make big gains in life expectancy throughout the 21st century. But quantity doesn't always mean quality when it comes to years lived.

So how can you stay sharp and vital as you enter your "older" years? That's the main question Steven Kotler explores in his new book, "Gnar Country: Growing Old, Staying Rad," which shows that, with some dedication and hard work, you can indeed teach an old dog new tricks.

KEY TAKEAWAYS

- New research suggests we can sustain peak performance longer than previously believed.
- Key skills like critical thinking and creativity can be improved in later life.
- Search out ways to combine multiple training requirements into a single activity.

From Big Think: Read or listen here: <https://bit.ly/3ZPwBey>

THE SUPERPOWERS OF SENSITIVE PEOPLE

A new book explains how sensitivity can be an asset in life — as long as you learn how to manage emotional and physical overwhelm.

I'm the kind of person who absorbs the emotions of other people. If someone I know is stressed out or depressed, I feel it, too, resonating with their pain. Sad movies — heck, even sappy commercials — can bring me to tears. And I often complain about sounds, smells or tastes that don't seem to bother those around me.

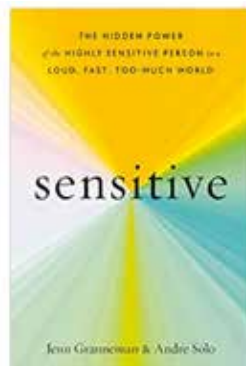
According to a new book, "Sensitive," by Jenn Granneman and Andre Solo, this suggests I may be a highly sensitive person (HSP) — among the 30% or so of the population with that characteristic. Granneman and Solo, who've created the website Sensitive Refuge for HSPs (highlysensitiverefuge.com) to

learn about their condition and connect with others, have turned their knowledge

into a book, explaining this trait in detail. By fusing research with testimonials, they hope to bring attention to the ups and downs of being sensitive, correct misunderstandings, and end the stigma that sensitive people sometimes face.

"Rather than seeing sensitivity as a weakness, we need to start seeing it for what it actually is — a strength," write the authors. "It's time we embrace sensitivity and all it has to offer."

Dive deeper here: https://greatergood.berkeley.edu/article/item/the_superpowers_of_sensitive_people



Sensitive: The Hidden Power of the Highly Sensitive Person in a Loud, Fast, Too-Much World Harmony, 2023, 272 pages.

Medicare Recipients Face Significantly Higher Projected Costs

An annual estimate of how much money a 65-year-old Medicare beneficiary should have in savings to cover healthcare costs in retirement jumped yet again in 2022, according to the Employee Benefit Research Institute.

The predicted health savings targets shot up by about \$17,000 for a 65-year-old man enrolled in a Medigap plan with average premiums and median prescription drug costs, assuming the goal is to have a 50% chance of holding enough liquid assets to cover all out-of-pocket care expenditures.

Continue reading here:

<https://bit.ly/3TiQ9pt>

The 2023 CHCF California Health Policy Survey

California is home to nearly 40 million people of different incomes, ages, and racial and ethnic backgrounds, and who live in different regions. Every year since 2019, the California Health Care Foundation has conducted a representative, statewide survey of residents' views and experiences on a variety of health care topics, some of which are tracked to detect meaningful shifts over time.

Key findings include:

Health care costs. Like prior years, half of Californians (52%) report skipping or delaying health care due to cost in the past 12 months. Of those who skipped or delayed care, half of them (50%) say their condition got worse as a result.

Medical debt. More than 1 in 3 (36%) report having medical debt, and of those, 1 in 5 (19%) report owing \$5,000 or more. Californians with lower incomes (52%) are more likely than those with higher incomes (30%) to report medical debt. View full report here: <https://www.chcf.org/publication/2023-chcf-california-health-policy-survey/#related-links-and-downloads>

EVOLVING CONSUMER EXPECTATIONS ARE DRIVING HEALTHCARE INNOVATION — FOR THE BETTER

Healthcare is seeing unprecedented innovation being spurred by post-Covid-19 momentum. This is long overdue, as we've witnessed the consequences of a broken system for years: untenable costs, poor patient outcomes, and a focus on reactive rather than preventative care in traditional healthcare systems.

More here:

<https://ramaonhealthcare.com/evolving-consumer-expectations-are-driving-healthcare-innovation-for-the-better>

Blue Shield of California Named One of World's Most Ethical Companies® for 11th Time

For 11 of the past 12 years – Blue Shield of California nonprofit health plan received designation as one of the “World’s Most Ethical Companies” in 2023 by Ethisphere, a global leader in defining and advancing the standards of ethical business practices. In 2023, Ethisphere recognized 135 organizations spanning 19 countries and 46 industries.

“Blue Shield of California’s ongoing commitment to ethical behavior is the foundation for our company’s values of being human, honest and courageous,” said Venetia Marshall, VP, chief risk, and compliance officer at Blue Shield of California. “It is how our more than 7,800 employees focus on ‘doing the right thing’ in serving our members, customers, and communities.”

More here: <https://bit.ly/3ySkFNn>

EVENTS

2023 INDUSTRY CALENDAR

April 10, 9:30 am PST

CAHIP Orange County 26th Annual Charity Golf Classic. Contact CAHIP-OC

(714) 441-8951, ext. 3, or orangecountyahu@yahoo.com

April 11-14

Virtual Fourth National Medicare Advantage Summit by Global Health Care, Virtual/Online Live

Video; Media Partners: Harvard Health Policy Review, Health Affairs and Inside Health Policy.

(800) 503-0078. Registration@hcconferences.com

April 21, 6 pm PST

Dancing With the CAHIP San Diego Stars

Register: <https://conta.cc/42bdBIY>

April 25, 7:30 am - 4:30 pm PST

LAAHU 2023 Annual Symposium

Register: <https://laahu-annual-symposium.constantcontactsites.com>

May 8-10

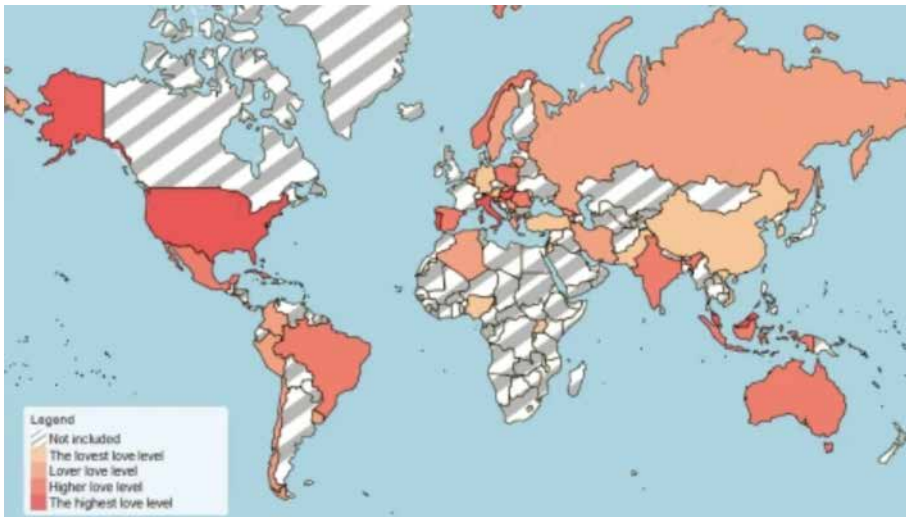
CAHIP Capitol Summit, Sacramento

Register: <https://www.cahu.org/capitol-summit>

June 24-28

NABIP's 2023 Annual Convention, New Orleans

Register: <https://bit.ly/3mNSUTs>



THE BIG STUDY

Americans are among the most loving, Chinese and Germans the least

An international team of nearly 100 scientists has conducted one of the largest studies on love of all time. Their work is published in the journal *Scientific Reports*. Americans are not shy about being loving in romantic relationships, if we can judge by public displays of affection, anyway. Of course, affection is more than that — it involves emotional intimacy, sharing, and mutual support. In a new study that assessed the nature of romantic relationships around the world, researchers confirmed a lot of stereotypes: Americans are, indeed, extremely affectionate, while the Germans are among the least affectionate. The Chinese and Turks didn't score well, either. Read or listen to the full story here: <https://bit.ly/3mZXs9h>



Work phones are making a comeback as offices ban more social media apps

There may be a new ringtone in your life — the urgent chime of a company-issued cell phone.

In a throwback to the BlackBerry era, telecom-service providers are seeing strong growth from companies handing out phones to employees. The phenomenon, which started during the pandemic, picked up recently thanks to new compliance policies around the use of WhatsApp and TikTok.

Read more: <https://bit.ly/3lcbNPs>

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Eye Breaks and Vision Coverage Help Keep Employees Engaged

Perks and benefits to improve eye and overall health are popular with workers

BY JONATHAN ORMSBY

When employers think about their workers overall health, both physical and mental, does vision always factor in? With “quiet quitting” and lower work productivity lingering in workforces, it’s more important than ever for employers and brokers to put forth positive, impactful benefits and perks for employees who may be struggling or checked out.

Many factors lend themselves to a term we’ve all heard for months – “quiet quitting.”

During the 2023 SHRM Employment Law & Compliance Conference, employment law expert James Reidy, an attorney with Sheehan Phinney in

Manchester, N.H., advised employers to look at other underlying causes rather than simply assuming employees are lazy. When it comes down to it, he adds, approximately half of the workforce are quiet quitters, and those employees think of themselves as setting healthy boundaries – a view very common among young workers. (SHRM. “Quiet Quitting May Raise Legal Issues.” February 27, 2023. <https://www.shrm.org/resourcesandtools/legal-and-compliance/employment-law/pages/quiet-quitting-legal-issues.aspx>)



How can vision benefits and eye health help workforce struggles?

With technology taking up a large space in our professional lives with all the different screens, virtual meetings and hybrid work models, eye care should be a fundamental benefit for every broker, employer and employee. Vision Impact Institute, a nonprofit organization that advocates for eye care, reports that the global economy is losing an estimated \$272

billion from uncorrected vision problems that hinder employees’ productivity and performance.

(HR Daily Advisor. “Eyecare at Work: The Eyes are the Windows to Employees’ Health.” Dec. 1, 2022. <https://hrdailyadvisor.blr.com/2022/12/01/eyecare-at-work-the-eyes-are-the-windows/>)

Employees need and desire eye breaks

According to Transitions Optical’s 2022 Workplace Wellness survey, people experience a multitude of eye related issues which impacts their work performance and productivity. This survey found that 78% of employees

VISION BENEFITS CAN HELP KEEP EMPLOYEES SATISFIED



OVER 7 IN 10

Employees who receive vision benefits said the loss of their health benefits would be a very important factor in their decision to resign



Millennials and Gen X are more likely than Boomers to say the loss of health benefits would be extremely important in their decision to resign from their job.

Transitions

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report their work productivity and performance has been impacted by either eyestrain/eye fatigue (50%), headaches (39%), blurry vision (36%), discomfort looking at bright screens (33%), and/or difficulty focusing on distance objects upon looking up from the screen (33%).

As we can see, employees' eyes need a break. When we think of “perks” that we can receive from our employer, we may be surprised to find out that, according to the Transitions study, 57% say regular breaks to rest the eyes and prevent eyestrain would be the best way to improve their productivity or quality of work over other workplace perks, such as financial assistance for fitness (47%), financial assistance for therapy sessions or mental health activities (36%), catered lunches with healthy food options (35%), meditation breaks (32%), and standing desks (28%).

The potential issues of “quiet quitting” and lower work productivity for employers cannot be fixed overnight, but a great way to start is to offer employees the time and space to take a break, for their eye health, to prevent the eye issues we can have from staring at a screen for 8 hours, and for mental and physical health as well.

FACTS FOR BROKERS

Vision Benefits Can Help Keep Employees Satisfied and Stay with Their Current Employer

One of the most important parts of the workplace is the ability to receive health benefits, and employees not only need these benefits, but they want them.

According to our survey, nearly two in three employees say they would be more likely to accept a job offering vision benefits. Further, a loss in vision and health benefits could also lead to an exodus of employees. Another 38% of employees are reporting they are likely to leave their current job in the next year. Additionally, 74% of employees who receive vision benefits say the loss of those benefits would be a very important factor in choosing not to resign.

Millennials and Gen X are more likely than Boomers to say the loss of health benefits would be extremely important in their decision to resign from their job.

Vision benefits that offer optical solutions are one of the most effective ways to protect our eyes from harmful light and aging. Based on the survey, 52% would seek eye care because of light sensitivity, 49% seeking eye care because of eyestrain from digital device usage, and 30% visiting their eyecare professional because of interest in blue light protection.

With seven out of 10 employees indicating that protecting their eye health is more important today than it was before the global pandemic — employers who offer premium vision benefits that cover both annual eye exams and eyewear options that employees both want and need can help catch the eye of employees.

The best part? Premium eyewear options can help alleviate the eye symptoms employees express having, and further impact employee wellness and productivity.

Popular photochromic lenses

The survey further revealed a growing interest in photochromic lenses. These lenses adapt to changing light, indoors and out, while helping to offer protection

from harmful blue light and ultraviolet rays. This option continues to influence employee interest in premium vision plans (“Harmful blue light” is calculated up to 455nm, with the greatest toxicity between 415-455 nm). In connection to this, brokers and employers should know that more than seven in 10 employees say that they would be more likely to enroll in a vision benefits plan that specifically covers Transitions® brand lenses.

By offering eye breaks and investing in vision benefits with protective lenses included, especially at a time when employees may be “quiet quitting,” brokers can assist their companies to ensure that their employees are receiving the top eye care and protection they need maintain or improve their eye health for many years and enhance their day-to-day work and life experience.

TOP REASONS EMPLOYEES SEEK EYE CARE



Half would seek eye care because of light sensitivity



because of eyestrain from digital device usage



More than a quarter would visit their eyecare professional because of interest in blue light protection

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Cross-generational Financial Planning Entrepreneurship

How a Millennial and Baby Boomer joined forces

Q&A WITH PATRICK “PJ” JOHNSON AND STEPHANIE DANNEBAUM

BY LINDA LALANDE

There has been an increasing trend in recent years for cross-generational partnerships to form, particularly between Baby Boomers (1946 to 1964) and Millennials (1981 to 1996). Many Baby Boomers are interested in transitioning out of their current roles and may be seeking a successor to take over their business, while Millennials may be looking for opportunities to start or own their own business. Boomers bring wisdom, years of experience, knowledge, and established networks to the table. Millennials often have strong digital skills, fresh perspectives, and a willingness to take risks. When combined these qualities can create a powerful partnership that can lead to business success.

Linda Lalande, Calbroker editor (CB): WHAT INSPIRED YOU TWO TO LAUNCH A BUSINESS VENTURE?

Patrick “PJ” Johnson (PJ): I hosted a long-term care (LTC) seminar to help educate financial planners and advisors about the importance of LTC as well as various strategies and products available for their clients. A colleague who attended the LTC seminar introduced me to Stephanie Dannebaum. She was the resident expert of all insurance needs for clients at a fee-only firm in the San Francisco bay area. At that point, we started working on various client cases together.

In 2020, Stephanie decided to step

back from her role as a junior advisor to start a family. We stayed in touch and about a year ago decided to team up to help fee-only Registered Investment Advisory (RIA) firms provide risk management strategies for clients. We became strategic partners of fee-only for RIA firms and now provide insight and strategies that align with the client’s financial and estate plans.

CB: WHAT’S BEHIND THIS UNUSUAL PARTNERSHIP?

Stephanie Dannebaum (SD): We decided to become partners because we saw an opportunity to provide fee-only financial planners risk management education and expertise from an unbiased, independent position. We see the RIA space as open, free, independent and unrestricted. We form relationships with these firms and build trust with their clients.

CB: WHAT ARE YOU ACTUALLY DOING? DESCRIBE THE BUSINESS ITSELF.

PJ: We are doing actual retail sales to the client. We have access to hundreds of products through CPS Sacramento, our general brokerage agency. This allows us to bring independent product solutions to the client. We handle the case start to finish. From the first client conversation to case design, proposal generation, presentation, application, underwriting and case management to delivery of the

policy and placement. As a partner to financial planners, we work also with the client’s CPA, estate planning attorney, and of course their children.

CB: HOW IS IT WORKING?

PJ: Our approach is working really well. We hold educational seminars to train financial planners on the importance of risk management strategies to align with a client’s financial and estate plan. We conduct these training seminars to meet new RIA’s and then follow up with a visit to their office to get better acquainted. We also are active in the local FPA associations and estate planning councils and the Next Gen movement — more informal social events hosted by young financial planners, like Stephanie.

Once a financial planner identifies a client that has a risk management need, they connect with us to discuss their needs. We then speak with the clients to learn more about them and review their goals.

When we receive basic information from the client, we review and initiate an application with the provider selected. We walk the client through the whole process and ensure transparency.

CB: WHAT ARE THE PAIN POINTS AND MOMENTUM POINTS OF THE VENTURE?

SD: Our business model is focused on providing education to fee-only RIF. We decided to initiate our venture during

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the height of the pandemic, therefore our in-person seminars did not receive the attendance we were anticipating. Thankfully, we have seen more participation in this post-pandemic era to show our value. Once we show RIA firms our five core strategies to mitigate risk in a client's life, we are able to show them that we do not focus on products, but solutions. In 2023 the focus on training will be around estate tax planning for high net worth clients and planning around the new Secure Act and required minimum distribution (RMD) planning using life insurance.

CB: IS THE SUCCESS BECAUSE OF THE COMING TOGETHER OF TWO GENERATIONS?

PJ: I believe the experience each of us brings to the table is our strength. My experience with Transamerica, Smith Barney, City Bank and Met Life for over 30 years in the estate planning department combined with Stephanie's experience with financial planning with RIA firms is a perfect blend to provide clients the best solutions to achieve their risk management strategies. We approach insurance through the lens of estate planning and achieving a client's goal and by not pushing products. We also love the idea that once I retire, Stephanie will be the agent of record to help the client with any policy holder service needs in the future. We split the commission on all

applications 50/50.

CB: WOULD THIS BE A MODEL FOR OTHERS TO FOLLOW?

SD: Yes — we believe our business model aligns with a financial planners holistic and fiduciary responsibility to provide clients with transparency and the best solutions to achieve their financial goals. We view our strategic partnership as a way for both of us prosper by providing value mutually to the financial planner and the client. Our intergenerational approach appeals to clients, and illustrates how professionals can work together to support consumers and thrive in a challenging economic environment.



PATRICK "PJ" JOHNSON is an independent life insurance agent and does sales and marketing for CPS Sacramento. PJ has been a NAIFA member since 1984. He is a past

board member of the Greater East Bay chapter and past board member of the Sacramento FPA association. He has CLU and CLTC designations.

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STEPHANIE DANNEBAUM

is the founder of Stephanie Dannebaum Consulting, a CRM Implementation consulting firm. She helps Registered Investment Advisory

(RIA) firms successfully implement customized client services. Stephanie spent nine years in the financial services industry in operations, investment management, and financial planning for fee-based and fee-only advisory firms.

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There is a major change in long-term care planning in the works. A new, mandatory tax which would provide minimal long-term care benefits for California's citizens has now been recommended to the legislature by the California Task Force for Long Term Care. There's no guarantee that this tax will become law, but passage is likely. It could impact all citizens who pay either a payroll tax in California — no matter where they live — or pay California income tax.

What would this mean? It's too early to tell with any certainty. We can only guess what the most likely outcomes will be. But if you want to protect

California Task Force history

The California Task Force for Long-Term Care was established “to explore the feasibility of developing and implementing a culturally competent statewide insurance program for long-term care services and support.” The task force is comprised of a committee of some fifteen members, consisting mostly of California Department of Insurance (DOI) employees and representatives of caregiving organizations.

The California Task Force has met many times over the past year and has submitted its recommendations to the legislature. It has tried to improve on the imperfections of the recently enacted Cares Act from the State of Washington. The Cares Act will be funded beginning this July through a mandatory payroll tax of 0.58%. It will give workers a lifetime benefit of \$ 36,500, adjusted annually by Washington's Consumer Price Index. California and some thirteen other states, including the large ones of New York and Pennsylvania, are also considering adopting an improved version of the

Washington Cares Act.

The concept is to provide a small long-term care benefit and to encourage citizens to buy wrap-around private long-term care insurance. This would protect citizens and save the state many millions of future

Medi-Cal dollars.

In my view, this is a noble effort to provide a public program to solve the pressing long-term care conundrum. The committee meetings showed how pervasive, threatening and growing long-term costs are. But the more one examines the details of a public program, the more complex the issues are that emerge.

The Tax Amount

Let's discuss the most critical issue: how large is the tax going to be? The task force members formed into three distinct

WANT TO OPT-OUT OF THE LONG-TERM CARE TAX?

Consider this ...

**BY
LOUIS H. BROWNSTONE**

your clients that have fairly substantial incomes, get them covered with private long-term care insurance now. They would then have the ability to opt-out of paying the tax.

This article will first discuss the background of the Task Force and estimate the amount of the tax. Then it will discuss the role of the insurance agent in advising prospects as to who should buy private long-term care insurance merely in order to opt-out of the tax.

groups which differed on the size and cost of the benefits:

1. Caregivers group wanted the maximum benefit designs at the greatest cost. These designs could increase payroll or income taxes by as much as 20% over the huge 9.83% or more that many Californians currently pay;

2. Two insurance actuaries favored the least expensive designs. This could cost roughly the same as the 0.58 % Washington Cares Act

3. Members of the Department of Insurance said little but were concerned with cost issues and to what extent an expensive a plan could pass in the legislature and be signed by Governor Newsom.

The result was that the task force provided the legislature with five recommended designs, not just one, which are widely different from each other, both in cost and in benefit structure. It has hired the actuarial firm of Oliver Wyman to provide a cost analysis no later than December 31, 2023.

Members hope to get employers to pay up to half the cost. This would be counterproductive in my view. Corporations already pay an 8.83% income tax in California, and would strongly resist any increase. They would have an even greater incentive than they do now to switch their domiciles to more friendly states where they would pay no income tax at all. Their flight to other states would decrease tax revenues in California. I don't think the legislature will allow this to happen.

If California's citizens have to bear the full cost burden, what size of a tax rate would the legislature consider? Washington's payroll tax rate is 0.58% for a program far smaller than that the California Task Force is considering. How robust can California's program be and still be accepted by the legislature and its citizens? There would have to be many compromises in proposed benefits to keep the tax rate under 1%. I don't believe that the legislature would enact a tax rate of 1% or higher.

Insurance agent's role

It is almost certain that citizens won't be able to opt-out of the program and avoid the tax once the law is enacted. In addition, it's almost certain that they

will be able to opt-out if they have an acceptable long-term care insurance plan in place before the opt-out opportunity expires. Keep in mind that if one opts-out of the program, one also opts-out of the benefits in the plan.

What plan would likely satisfy any minimum opt-out requirements?

A traditional long-term care insurance plan could well contain a benefit of \$100 per day for a two-year benefit period with a zero or thirty-day elimination period with 3% compound annual inflation. Other non-traditional products with similar long-term care benefits which come under section 7702(b) of the Internal Revenue Code might also satisfy any requirements. Of course, these plans would only offer partial coverage.

Would life insurance and annuity products with chronic illness riders under section 101(g) also qualify? We don't know at this point.

Which of your clients should you prospect? Not those in the lower 50% in income, as the public program would be an inexpensive partial long-term care solution for them. The higher the income, the more advantageous an opt-out decision.

At what income level should you advise prospects to buy private long-term care insurance merely to opt-out of the public plan?

You have to project income of a prospect over many years and strike an average of what that income would be. The tax for the public program rises with income, but rates for private plans may remain relatively stable. For example, if a man were forty-one years old, making \$80,000 per year, and his income grew by 3 % per year, by age 65, he would be making \$160,000 per year. His average compensation over the twenty-four-year period would be \$120,000. If the tax turned out to be 0.9 % of income, the public program average premium would be \$1,080 per year.

For that person, a private long-term care insurance program could well be less expensive than the public program, especially if that person were a male and could take advantage of separate gender rates. One carrier currently has a very comparable rate for that forty-one-year-

old male. For females and those who would be subject to unisex rates, the income level to merit an opt-out decision would be somewhat higher.

For a person whose current income is in the \$100,000 to \$150,000 range, it might be a wise decision not to opt-out of the public plan and purchase wrap-around private long-term care insurance in order to obtain robust protection. But for a person whose income is above \$150,000 now, I would recommend opting out of the public plan and purchasing private coverage.

Timeframes for opting out

In Washington, only several months were allowed to opt-out of its program. An amazing 1/7th of eligible citizens opted-out of the Washington Cares Plan. There's going to be more time to opt-out of the California plan. Legislation will probably not happen for at least another eighteen months, and for at least a year, you can take advantage of this unique opportunity to help protect California's citizens. There's going to be a great deal of discussion in California about long-term care in the coming months, and as an agent, you need to be well informed on the issues and ready as the situation clarifies to execute a specific marketing plan.



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This series will give you the resources you need to provide insurance solutions, supported by valuable collaborative partners. Helping your clients determine what coverage they need to manage the risk of unpredictable life events at any age, helping loved ones prepare for life events or managing expenses in retirement. And of course, we will demonstrate how to be paid for this work.

It's all about process

The management of client education and marketing — to lead management to presentation and then the closing sale — is about process. When you build your process you effectively develop a response to these concerns, with a solution that addresses the need for asset protection.

In most cases health insurance professionals already know they can select new insurance products that require no additional license and which have proven to naturally fit their current customers. They just need a process to get started and consistently maintain success.

Offer your clients more solutions

BY PHIL CALHOUN

This is the first in a series of articles about how to expand your business and increase your success through cross selling. Why this series? Our readers know that cross selling is an ideal way to generate more revenue but many do not have a process to get started or maintain momentum. In all business endeavors, success is assured when we use an organized process.

We will share tips from experts to address situations that health insurance alone will not solve for business owners and individual clients. There are many ways health brokers can add new lines of insurance that will increase their value and add to the good work already perform for their clients.

The average California insurance broker makes \$98,252 (as of October 27, 2022), but the range typically falls between \$84,927 and \$120,053. Adding new insurance lines within your license scope can bring from \$10,000 for one case to well over \$100,000 for several cases — all new income for the health broker.

For many health insurance professionals, it's a smooth transition to include life, long-term care insurance, or annuities. For group health clients, many product solutions fall under a life and health license. As a trusted group insurance professional, you can provide these solutions on a group sponsored basis only, but also offer interested employees more coverage and buyup options. Your relationship with employees opens the door for more work and referrals.

Turning back the clock to the 1960s, when life insurance brokers were first able to offer medical plans for clients, it was a natural transition to offer health insurance. Customers already experienced the benefit of life insurance and with a good relationship with their life insurance broker, the move to medical insurance was natural. It is a similar natural fit to offer life, annuities and long-term care products today.

Where to begin: start with your existing clients

Carriers and general agencies suggest the first step in cross selling is to look at your relationship with your customers.

LIMRA states that 80% of your new sales revenue will come from 20% of your existing base of customers. This significantly lowers the cost of new business acquisition.

Introducing new insurance products to your clients is easily done when you have an outreach process. Success will come from implementing that process: determine how to get information out, how to move to further education, and how to move to a personalized quote and finally complete the application.

The most popular first step to build is a client communication process

When emailing to a large number of clients, it's common practice to use Constant Contact or Mail Chimp. Client focused newsletters can educate and surveys can identify needs or risks expressed by your customers. From these outreach efforts, you can develop solutions related to insurance products you can offer.

Build your customer retention process to include multiple touches

The Golden Rule is the more touch points you make in a year the greater your client retention. Make each contact as valuable as possible. Focus on ways to educate your clients to improve their knowledge of their benefits. This demonstrates you are concerned about their health and wellness. When you focus on a process to introduce coverage options and cost saving tips in addition to health insurance, you open the door to saving your clients money and improving their financial situation. With a consistent education efforts, you will become a trusted advisor and advocate. With a process in place, you will have a disciplined approach to close the sale.

Asset protection is top of mind

Retirement income concerns are very common, and usually center around secure savings. Both annuities and permanent life insurance are often a good fit. Long-term care insurance also addresses these concerns since expensive levels of care required are not covered by health insurance. These solutions allow savings to grow and be used for other expenses.

Health brokers using a combination of tools to educate their clients will see many opportunities to address these concerns. Working with marketing or general agencies that offer a proven process centered on client education-based campaigns can be highly profitable.

As one example, Medicare brokers often have hundreds of clients aged 65 and over. While some of insurance products are clearly more affordable for people in their 50s, many policies with the right coverage can be written for those over 65. Also with group benefits brokers, you have the opportunity to work with business owners and their employees to address the same issues.

Consider building a process to address these lifetime events, which all clients experience directly or through loved ones.

- Dealing with the birth of a child/grandchild
- Finding safe investment options built for both current needs as well as longer lifetime needs
- Covering the costs of medical care in older age
- Providing funds to cover expenses and debt at death

These realistic needs and concerns can be addressed with insurance products all health insurance professionals are licensed to offer.

Cross selling often happens in one of three ways. Health brokers:

- Learn about products and offer them as a natural part of their business. They enjoy some sales and product support with a carrier or general agency.
- Partner with another broker/agency who supports the broker marketing and sales efforts.
- Handle owner policies and work with a few friends but don't actively work with clients.

In summary

In future cross selling articles, we will focus on the process to offer your health insurance clients life insurance, annuities and long-term care insurance as a natural cross sell. We will hear from experts about the steps to grow your business in these insurance lines. We will explain your options to include collaborating with experienced advanced planning professionals on a per case basis and/or working to build your product expertise through general agencies who provide the resources health brokers need to either get started or expand.

We will outline the professional assistance available for quoting, case design and implementation and how as a health broker you can exercise these options to meet your client's needs. You will also see how a disciplined process will help you close sales to increase your income.

BOTTOM LINE: We will help you help your clients build a defense against the risk of expensive personal health issues. When you add value to your clients by bringing new solutions for their concerns beyond what health insurance covers, it is a Win-Win. All in all, your success is enhanced when the new products build on current client relationships and needs.



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Commissions" is available free at www.healthbrokersguide.com. He offers complementary 15-minute coaching sessions.

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NABIP Members Visit with the 118th Congress

Shaping the Future of Healthcare

BY MAGGIE STEDT

Representing our association, agents and our clients, members from over 200 chapters of the National Association of Benefits and Insurance Professions (NABIP) that was formally known as NAHU, visited with their elected representatives from Feb. 26 to March 1 in Washington, D.C. Chapter representatives flew in from all over the country for leadership training, to discuss key legislative issues and hear outstanding speakers. And, they visited the many D.C. sites, enjoyed great meals with friends and shared ideas. Members celebrated the 80's at a fundraiser for NABIP's Political Action Committee (PAC).

Members meeting with their respective congressional representatives and senators discussed the role of the insurance agent and shared following talking points that addressed a variety of issues and concerns:

Association Name Change

For nearly a century, the National Association of Benefits and Insurance Professionals (NABIP), formerly NAHU, has advocated on behalf of benefits and insurance professionals. The health insurance and benefits landscape has evolved, and so has NABIP's role in supporting our members and their clients. Over the years, our membership has grown to encompass professionals who sell traditional health insurance products and those who offer non-traditional coverage options. The association has expanded its capabilities to respond to new marketplace dynamics, offering

its members a growing selection of professional-educational opportunities, network-building conferences and business-development tools.

NABIP and our new tagline, "Shaping the Future of Healthcare" protect the association's legacy of leadership while representing our current role in the modern healthcare industry.

While our name has changed, our mission and vision remain the same:

We believe that all Americans should be empowered to make wise healthcare and benefits decisions and have access to high-quality, affordable healthcare and related services.

Addressing the Cost of Care

NABIP supports site-neutral rules to deter location-based gaming of coverage. One of the single most important things Congress could do is ensure that the cost of a service does not vary based on the site where it is delivered. The price of the same X-ray, MRI or physician's visit should not differ if it is delivered in a free-standing facility versus an outpatient hospital setting.

Preserving and Strengthening Employer-Sponsored Health Coverage

NABIP strongly opposes capping or modifying the individual tax exclusion of employment-based coverage. For decades, employees and employers have benefited from the preferences in the Tax Code that exclude the employer's contribution toward employment-based health coverage from being considered

compensation for tax purposes, allow for the pre-tax payment of an employee's premiums for employment-based health coverage, and enable employers to deduct the cost of health coverage as a business expense. A cap on the exclusion does not address rising medical costs or limit utilization of medical services, and will stifle private-sector innovation of benefits and delivery designs. To tamper with the current tax treatment of employer-sponsored coverage would be especially devastating to businesses and American workers, which could lead to the highest increase in taxes to middle-class Americans in decades

The Commonsense Reporting Act

This act enables employers to report employer-sponsored health plan information to the IRS prospectively, before annual fall open-enrollment season in the state and federal exchanges — instead of 14 months after that open enrollment period and an entire coverage year has ended.

The Reporting Act:

- equips consumers and exchanges with information to determine if an individual is eligible for a tax credit based on their employer's offer of coverage
- reduces the likelihood that an individual will have to pay back a premium tax credit incorrectly received
- protects employers from having to incur additional accounting and legal costs and business worries, on top of the requirement's compliance costs, to appeal an IRS Letter 226-J tax penalty notice
- uses the current IRS IT reporting

WHAT YOU NEED TO KNOW ABOUT MEDICARE

Generally, Medicare is available for people 65 or older. It has four parts: Part A, Part B, Part C and Part D.



ORIGINAL MEDICARE
Includes **Part A** and **Part B**.

MEDICARE ADVANTAGE
Also known as **Part C**.

Part A is hospital insurance. It has a deductible and copay. It may have a premium.
Part B covers medically necessary services and supplies. It has a deductible, premium and coinsurance.

+
Medigap
Medicare Supplement insurance can cover copayments, coinsurance and deductibles that are not covered by Part A or Part B.

Part D is prescription drug coverage.

Part C plans cover all of the services included in Original Medicare, have a cap on the annual out-of-pocket costs and include Part D at no additional cost. Medicare Advantage plans are administered by **private insurers**. They feature co-pays, low or no monthly premiums plus additional benefits.



Ready to Enroll?

Talk with a certified health insurance agent who is a member of NABIP. NABIP members can help you make an informed decision. Visit www.nabip.org to find a certified agent in your area.





National Association of Benefits and Insurance Professionals

WHO WE ARE

Founded in 1930, NABIP is the premier trade association representing over **100,000** health insurance agents and brokers across more than **200** state and local chapters. Our members help millions of Americans purchase and effectively use health insurance.



WHAT WE DO

DEDICATE OURSELVES TO CONSUMERS

Fortune 500 companies, mom-and-pop shops and individuals all turn to NABIP members to find policies that meet their needs. NABIP members' work continues after the sale. They help clients with claims issues, compliance matters and coverage questions.



2 in 3 small businesses and **1 in 3** individuals count on agents or brokers to help them pick a policy.



STAY INFORMED ABOUT INDUSTRY TRENDS

NABIP members read NABIP publications and NABIP email communications to learn about industry trends, current legislation and more. NABIP members also take NABIP courses to receive the most up-to-date training and obtain certification in topics like Medicare.



3 in 5 agents and brokers spend some or most of their time helping clients resolve claims issues.



Most agents have more than **10 years** of experience in the healthcare industry.

ADVOCATE ON BEHALF OF CONSUMERS

NABIP members have firsthand knowledge of industry trends, employer challenges and the economic reality of the health insurance market. They apply that knowledge to advocate for responsible market solutions that promote access to affordable health insurance.

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system and Exchange Data Hub, thus does not require additional federal resources

- provides employers with two compliance choices: prospectively report streamlined information authorized under the Commonsense Reporting Act or continue to utilize the current end-of-calendar-year reporting process.

NABIP supports initiatives to innovate HSA-eligible plans

We support the modernization of the definition of an HSA-qualified high-deductible health plan (HDHP) to allow primary care visits before application of the plan deductible. HSAs were created nearly 20 years ago, but regulations that define a qualified high-deductible health plan that can be used with an HSA have not kept pace in today's changing benefits landscape.

NABIP opposes cost-shifting alternatives to end stage renal disease coverage

There have been efforts in Congress to shift the cost of coverage for end stage renal disease (ESRD) from Medicare Secondary Payer (MSP) to employer plans. MSP covers ESRD for individuals entitled to Medicare based on ESRD for a coordination period of 30 months. Proposals to limit this timeframe and shift the cost to employers would create an unnecessary coverage mandate for the care of a specific disease, which could lead to an expansion of mandates for employers beyond what is already required for qualified health plans (QHPs), further driving up the cost of care.

NABIP opposes civil monetary penalties on employers for network requirements

NABIP supports the need for adequate mental health networks. However, efforts to penalize employers for noncompliance with network-adequacy standards for mental health parity aim to penalize an entity with no control over the network. Employers use networks from carriers or third-party administrators (TPAs) and do not have control over the contracted network. Therefore, we oppose any proposals that would penalize employers for noncompliance with these standards.

Instead, Congress should focus on ways to encourage mental health providers to enter into networks, which would truly support network adequacy.

Improving Medicare NABIP supports excluding licensed agents and brokers from burdensome marketing restrictions

NABIP supports legislation to explicitly exclude independent agents and brokers from the current requirement to record calls with beneficiaries, in addition to any future regulations that relate to recording calls with beneficiaries. NABIP recognizes the increase in unscrupulous actors in the Medicare market; however, the CMS regulations released last year do not adequately address these entities and inappropriately target licensed and certified agents and brokers committed to acting in the best interest of Medicare beneficiaries.

NABIP supports allowing COBRA to be treated as creditable coverage

Seniors who are enrolled in COBRA coverage but are eligible for Medicare face financial penalties for not enrolling within the mandated timeframe. However, seniors who are enrolled in similar employer-sponsored plans are not penalized, as their coverage is considered creditable for Medicare. Switching from a COBRA plan to Medicare could be disruptive for beneficiaries' care and may come with financial consequences for terminating their COBRA coverage early to meet the Medicare enrollment windows. Seniors should be able to remain on their COBRA coverage without penalty, the same as seniors who remain on similar employer-sponsored coverage. We urge Congress to support forthcoming legislation that would allow seniors enrolled in COBRA coverage to transition to Medicare Part B without a penalty.

NABIP supports observation status to be treated as inpatient status

Many Medicare beneficiaries are classified as being on "observation," which can result in significantly higher claims and prevent Medicare coverage from being applied for nursing home care

for patients who do not have a three-day inpatient hospital stay. We urge Congress to support legislation that would allow observation stays to be counted toward the three-day mandatory inpatient stay for Medicare coverage of a skilled nursing facility (SNF).

NABIP supports a new Part D open-enrollment period

Many Medicare beneficiaries enroll in their plan during the Annual Enrollment Period (AEP) and are locked into their Part D coverage. Once the plan year begins, however, they are no longer able to switch to another plan if they discover they are not in the right plan for their needs. Medicare Advantage offers a three-month open-enrollment period (OEP) at the beginning of every year to allow beneficiaries to switch between plans if needed. We urge Congress to enact similar consumer protections during the OEP for Part D plans to allow beneficiaries to access the plans that best fit their prescription drug needs."

For more information, please contact the NABIP Government Relations Team at legislative@nabip.org



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C.S.A., LPRT is an independent contractor/licensed agent and consultant. She is a certified senior advisor and lifetime member of NAHU's Leading

Producers Roundtable at the Soaring Eagle Level. She has over 40 years of experience in essential areas of the insurance industry including sales and sales management, product development and product management. A dedicated leader, Maggie currently serves on the NAHU Medicare Advisory Committee. Founder of the annual Senior Medicare Summit, attendance grew from 200 in 2010 to close to 1,000 attendees in 2022. She served as past president of CAHIP; NAHU Region 8 Membership Chair 2014 – 2018 and past president of OCAHU, serving two terms.

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Protect Your Company Against Phishing Attacks

Brokers can protect themselves, and advise clients

BY CHUCK BURBANK

While ransomware attacks and organized hacking operations may grab headlines, malicious operators often gain access to company networks in mundane ways that don't earn attention so aren't talked about as much. While this information may seem basic, it bears repeating. We are seeing a significant increase this year in cybercrime, so though you think you and your clients, employees and colleagues are wise to the multitude of scams out there, there are still scammers succeeding in hooking us in.

Email is an easy mark

Despite the growing number of communications options available to businesses, email remains the number one tool of business communications. The flexibility, reliability and convenience of email means it's not going away any time soon.

But for all its benefits, email is also the primary target of serious cyberattacks. Social engineering attacks, like phishing, can lead to data breaches, malware and

ransomware attacks, and millions of dollars in losses for businesses.

Know what you are up against

Phishing is a social engineering attack that tries to trick the recipient into clicking a link or opening a file that downloads malware or reveals sensitive information, such as user names and passwords. Phishing emails appear to come from trusted senders, such as personal or business contacts. Such emails many times have generic introductions (such as "Dear valued customer"), grammar and spelling errors (although this is harder to detect with grammar and spell check — although it may be obvious that English is a second language in the structure of the communication). Some have email addresses that do not match the website of the sender's company, or do not actually match the name stated, include unrequested attachments, or requests to click a link and enter a User ID and password in order to confirm information.

Brokers and healthcare info are prized targets

According to the FBI and several data breach-tracking websites, the value of healthcare data can be significantly higher than other types of financial records. According to Experian, a single patient record can sell for upwards of \$1,000 on the Dark Web, depending on how complete the record is. That's nearly 50 times higher than the value of standard credit card records.

In addition to Protected Health Information (PHI), brokers also have access to large amounts of Personally Identifiable Information (PII) — sensitive information that can be used to identify a unique individual, such as Social Security Numbers, full names and financial information.

Why is PII/PHI so valuable?

When credit card information is stolen, it can only be used until the theft is discovered and the card is shut down by the issuing institution. For those of us who work in health insurance, the

information we deal with has a potentially unlimited lifespan. For example, Social Security Numbers don't "expire" and are very rarely reissued — generally only under the most extreme circumstances.

Additionally, fraudulently-obtained PII enables a number of illegal activities, such as identity theft, tax or healthcare insurance fraud, or extortion.

As I said, at BenefitMall, we have seen a continual spike in phishing attempts in the past year. Each month, we block 22,000 attempted phishing emails and our Security Operations teams respond to more than 2,000 user-reported phishing emails. Of those reported emails, half contain malicious attachments.

What's concerning is that phishing emails often appear to be coming from trusted sources, hoping that recipients will click on links and open files believing that they came from known contacts with legitimate business needs. Sometimes, those emails are coming from broker partners whose email has been compromised, allowing cyber attackers to use those email accounts to send out phishing attacks to other organizations.

What should you do if your email system has been compromised?

There are a number of regulatory and contractual obligations that brokers must comply with in the event that an email network is compromised and a data breach may have occurred. In addition to notifying the applicable State Attorneys General, some states have additional reporting requirements. For example, in New York, the Department of Financial Services must be notified, and in Maryland, the Department of Insurance.

In California, you should report the incident to the California Department of Justice (DOJ) through their Cyber Crime Center and to your local law enforcement agency. If the cybercrime involved a breach of personal information, such as Social Security numbers or financial account numbers, you may also need to notify the affected individuals and relevant government agencies, such as the California Attorney General's office or the Federal Trade Commission (FTC). You should also report the incident to the Internet Crime Complaint Center (IC3).

If you have entered into any Business Associate Agreements (BAAs) with

carriers, they must be notified. Also, the U.S. Department of Health and Human Services Office for Civil Rights must be contacted regarding any HIPAA violations.

There are also steps that employees should take if they are victims of phishing attacks. Employees should immediately change their passwords for all email accounts and critical websites connected to those email addresses. (While it's not a good practice to reuse passwords, we know that many people do. Remind clients and employees that if they are using the compromised password for other things — such as personal banking or online shopping — they should create unique passwords for those sites as well.)

Anyone who may have received a compromised email from the affected employees should also be notified to prevent additional phishing attacks. This includes not only other employees and contractors within the company, but contacts at other companies.

How to prevent email phishing attacks

Fortunately, there are a number of proactive steps that brokers can take, and recommend to clients to protect the integrity of their email networks.

- **Enable Multi-Factor (MFA) or 2 Factor Authentication (2FA).** This is an electronic authentication method in which a user is granted access only after presenting two or more pieces of evidence ("factors") that they are who they claim to be. Factors may be knowledge (something only the user knows, like a password), possession (something only the user has, like a barcode on a badge), or inheritance (something unique to the user, like a fingerprint or iris scan). Your email provider can help you set up MFA.

- **Use encryption across all parts of your network.** Email encryption should be used when sending PII/PHI via email, but workstations (laptops and desktops) should use full disk encryption as well.

- **Select and install an antivirus solution — and keep it up to date.** Schedule signature updates and monitor the antivirus status on all equipment. Deploy SPAM/phishing filters in your email settings as well.

- **Auto-install all software upgrades and patches for your**

operating system (Windows or Mac OS). The patches will have up-to-date security protocols and address security flaws as they are discovered. Many malicious software attacks exploit known security issues for which updates have been made available, but were not deployed.

- **Educate your employees AND your client!** Network security can only do so much. Phishing attacks work not by tricking the network, but by fooling individual users by exploiting their trust. Your employees and contractors need not just a one-time training, but periodic reminders on how to spot a suspicious email and what they should — and more importantly, should not— do when they receive them. Training doesn't have to be expensive or created in-house. The security industry has a number of free resources, such as Stop, Think, Connect (stopthinkconnect.org) with videos, as well as downloadable tip sheets, posters, and graphics that can be distributed easily to employees. Your email provider may also have a library of resources for your use.

While we can't stop bad actors from attempting to breach our email networks, or committing other cybercrime, taking these steps will greatly reduce their ability to target us, our employees and our valued clients.



CHUCK BURBANK
joined BenefitMall in 2019 as chief information security officer. A certified HIPAA professional and HIPAA Security Specialist, Burbank has more than three

decades of experience in healthcare and is a recognized Privacy and Security expert and sought-after industry speaker. A Navy veteran, Burbank's information security experience includes both military support and private industry. He oversees BenefitMall's overall Information Security Program, which includes cybersecurity and compliance with data security regulations.

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Virtual Care Technology Focuses on Prevention

Additional Trends to Expect in 2023:
Technology + Innovation Supports the Virtual
Care Industry

BY MICHAEL GORTON

The virtual care industry is on a mission: to enable patients, providers and payers throughout the healthcare ecosystem to make smarter decisions about utilizing digital technology and virtual care solutions to improve access to care that results in better outcomes at lower costs. This change is especially important for brokers as they continue to advise clients about selecting the highest quality organizations for serving employer workforces.

Part II of this series captures additional key trends in virtual care that will impact brokers in their processes to make the best recommendations 2023.

Continued Shift to “Virtual-First”

Analysts confirm that virtual care use has stabilized at levels 38 times higher than before the pandemic: 40% of individuals believe they will continue to use virtual care going forward and 40–60% of individuals express interest in a broader set of virtual care solutions such as virtual-first health plans.

a) Anticipate rapid expansion of virtual care to dramatically reshape how healthcare is delivered, with trends showing that it’s no longer enough for virtual care to provide individuals with a convenient way to access care for acute conditions.

b) As the COVID-19 pandemic accelerated, the healthcare system strained to respond appropriately. The dilemma for private practices was less about emergency care and more about how to continue providing services for patients when clinic doors were suddenly closed to in-person routine visits.

c) New research from providers illuminates bright spots and areas for improvement that make telemedicine attractive, productive and profitable for both providers and patients. They report that 15% of all visits were done virtually, 89% of patient feedback was positive and 76% of patients would recommend telemedicine and to a friend.

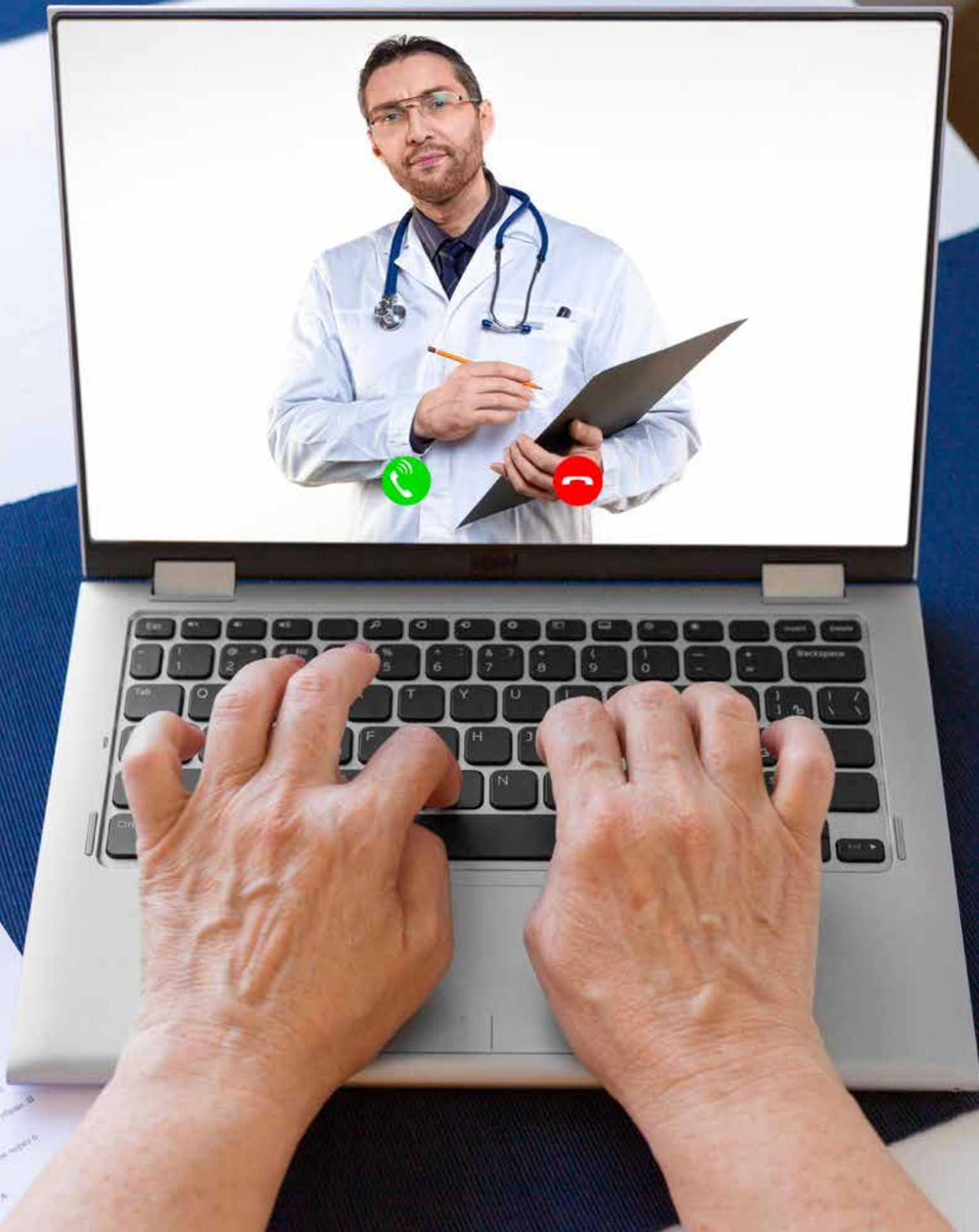
d) Among more traditional healthcare organizations, leading analysts believe we will see a focus on optimizing virtual care delivery models, enabling enhanced access to virtual care and building up the underlying infrastructure.

e) Expect to see even more innovation in how those providers are accessing virtual care, integrating it into their care models and integrating it with value-based care models. In this environment, two types of virtual care model archetypes are emerging: a model will focus on specific conditions or offerings and be direct-to-consumer; and another will be an integrated hybrid care focused on chronic, primary, and behavioral healthcare services.

Additional industry guidance says that while the direct-to-consumer space will remain popular for smaller players, larger organizations will move toward centralization. They predict that all the big health plans and health systems are going to centralize their telehealth investments with emerging technologies coming from the tech vendors and perhaps, the leading retailers.

Solidifying the medical cost value of telehealth services will be a primary focus to demonstrate that these solutions are actually reducing the consumption of acute care services or replacing them with telehealth services rather than adding on more line-item costs.

As employers become more reliant upon brokers for credible, trusted advice, these industry data points can be woven into the suggestions that brokers make in order to further build client relationships. Self-insured companies are continuously searching for opportunities to improve employee health outcomes, enhance the member experience and lower the total cost of care. This is particularly important for employer direct contracts with providers where quality and cost are the arbiters for decision-making.



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Healthcare transitions to the home

Better telemedicine solutions are giving healthcare organizations a greater competitive advantage in a highly saturated market. The telehealth industry is quickly becoming a quarter-trillion-dollar sector, with some of this revenue that was once attributed to utilization at acute facilities now moving toward healthcare in the home.

Leading analysts point out:

A. When patients enter a healthcare facility, their primary aims are to become well again and to go home. While increasing disease burden and rising healthcare costs in the United States have already contributed to a boost in Care at Home services, the COVID-19 pandemic has created a catalyst to truly reimagine their future.

B. Based on a survey of physicians who serve predominantly Medicare fee-for-service (FFS) and Medicare Advantage (MA) patients, it is estimated that up to \$265 billion worth of care services (representing up to 25% of the total cost of care) for Medicare FFS and MA beneficiaries could shift from traditional facilities to the home by 2025 without a reduction in quality or access.

C. Emergence of new technologies and capabilities are making care at home possible for more people. Remote patient-monitoring devices, for example, allow providers to monitor patient progress remotely and receive alerts if there is an issue. In an April 2021 poll, more than one in five healthcare leaders said that their practice offers remote patient monitoring. Stakeholders are exploring ways to provide higher-quality care, especially for an aging population, including home-based services that include primary-care visits via telehealth, self-administered dialysis at home, and skilled nursing-facility services at home with remote patient monitoring and support for activities of daily living.

To better serve their clients, brokers should be cognizant and knowledgeable of this shift to “Care at Home,” a trend that creates value for employers and their workforces. Empowered with this knowledge base, brokers can better assess the capabilities of healthcare facilities, physician groups, home care providers and technology companies to meet payer expectations. It also could improve patients’ quality of care and experience.

Growth in virtual care is palpable

In February 2021, the use of telehealth was 38 times higher than pre-pandemic levels and some estimates predict that 70.6 million Americans will use remote patient monitoring tools by 2025. About 40 percent of surveyed consumers said that they expect to continue using telehealth going forward. This represents an increase from 11 percent of consumers using telehealth prior to the COVID-19 pandemic. Integrated digital solutions are likely to shed their focus on siloed, add-on telehealth or remote monitoring solutions that mirror the fragmentation and unreliable care transitions of our existing system.

Patients with post-acute and long-term care needs will be evaluating their options. As baby boomers age and families contend with the ongoing impact of the COVID-19 crisis, a growing number of patients and families may be considering their options for post-acute and long-term care. Ideally, eligible individuals would receive care in the most appropriate setting, whether that is at home or in a facility for rehabilitation, assisted living, skilled nursing, or long-term care. A combination of remote monitoring, telehealth, social supports, and home modification may enable more patients to receive some level of Care at Home.

Greater focus on care coordination

Telehealth has the potential to improve transitions of care, through enhanced connections among patients and their clinicians, during a vulnerable period such as after hospital discharge. To achieve triple aim objectives, reducing unnecessary hospital readmissions is desirable for payers and patients alike.

As employers become more reliant upon brokers for credible, trusted advice, these industry data points can be woven into the suggestions that brokers make in order to further build client relationships. Self-insured companies are continuously searching for opportunities to improve employee health outcomes, enhance the member experience and lower the total cost of care. This is particularly important for employer direct contracts with providers where quality and cost are the arbiters for decision-making. Several key studies have shown the values of telehealth in reducing avoidable hospital readmissions.

Telehealth interventions using primarily communications and surveillance technologies show the most promise in counseling and enhancing patient compliance with treatment and the patient's transition to the home while managing multi-comorbid diseases.

Thoughtful industry stakeholders will increasingly implement an integrated digital technology approach that supports every step and every transition in the care journey, creating the connective tissue that makes patient-centered, team-based care a reality.

At the nexus of employer healthcare benefits decision-making, brokers are well positioned to not only be aware of the digital/virtual trends, but also knowledgeable about the industry players that have a track record for meeting company expectations.

Convenience factor drives increased consumer preference for at-home lab and genomic testing

Stakeholders that may have the greatest say in how quickly home testing becomes common is patients themselves. They value the convenience of taking a test at home and receiving the results digitally afterwards.

While at-home lab testing has been available for decades, it is now clearly on the rise and these tests have become increasingly utilized during and following the COVID-19 pandemic. The issues of quality, access and cost-savings inherent to at-home lab testing should send an important signal to brokers who may be tasked to evaluate these options.

The notable increase in at-home testing may be attributed, in part, to the widespread availability of COVID-19 tests, school and employer-mandated testing, and the desire to avoid exposure to the coronavirus. An April 2022 report from a trusted source at the CDC suggests that at-home COVID-19 test use peaked in January 2022, with 11% of the surveyed population reporting at-home test use within the previous 30 days.

According to a February 2022 report, the at-home test industry is projected to be worth over \$2 billion by 2025. Moreover, a recent market research analysis suggests that the global at-home testing kits market will grow at a compound annual growth rate (CAGR) of 6.1% from 2022 to 2029.

An estimated 26 million consumers have sent DNA samples to the four leading commercial ancestry and health databases to decode any mysteries in their genetic pool. Patients also prefer to conduct other tests at home, such as Cologuard or rapid oral HIV testing. In a study based in San Diego, California, 62% of survey participants selected home as their preferred location for a rapid HIV test.

Higher utilization of telehealth advances health equity

Access to quality, affordable health care is a fundamental human right, regardless of patient location, economic status or race. The American Medical Association says telehealth has the potential to become an important tool to address longstanding health inequities in the historically marginalized racial and ethnic groups that have been disproportionately affected by the COVID-19 pandemic.

The World Economic Forum asserts that virtual care

technologies, such as telehealth, have the potential to significantly improve global health equity. They forecast the ultimate result of this predictive and personalized healthcare will be earlier medical interventions that prevent medical crises and lead to better outcomes across countries of all sizes, locations and stages of economic development.

Next-generation technologies, such as remote patient monitoring and management, which include real-time and continuous data collection and analysis from medical-grade biosensors worn in the home, enable clinicians across the globe to address the health inequities and social determinants of health in ways never before possible.

Achieving health equity is quickly becoming a priority for many employer groups, and brokers are well-advised to learn how they can help their clients advance this step forward.

Telehealth increasingly serves all age groups and demographics

About a third of older Americans say they plan to use telemedicine in the future, a number that has remained steady throughout the pandemic, according to a new AARP study. Thirty-two percent of adults 50 and older said they were extremely or very interested in utilizing telehealth services for themselves or a loved one, the poll of 1,149 older adults found.

Women and non-Hispanic Blacks were the groups most likely to express a keen interest. More than half (51 percent) of older adults said they or a family member had used telemedicine during the past two years, with women being more likely to have done so than men. The report concluded that telehealth is likely to continue to remain an important tool in the health care delivery tool kit — at least for those with computers and high-speed internet access.

Behavioral telehealth provides a safety net for millions of parents that have been faced with skyrocketing rates of mental and behavioral health issues among their adolescents and teens. Pre-COVID, 12.8 million children between 3 and 17 years old had been diagnosed with anxiety disorder, depressive disorder, and ADD or ADHD, according to the Kaiser Family Foundation. A growing problem before, COVID wreaked havoc on an already vulnerable group and behavioral telehealth offers immediate support.



MICHAEL GORTON is a quintessential entrepreneur and company builder. As CEO of Recuro Health he leads a team which includes several leaders from Teladoc, where he served as the founding CEO and pioneered an industry-changing health care model that created a new efficiency paradigm in healthcare.

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LEVERAGING NEW TOOLS TO CONTROL HEALTHCARE COSTS

BY JOHN THORNTON

H **healthcare costs** have been steadily rising for over three decades. According to National Health Expenditure (NHE) data analyzed by the Kaiser Family Foundation (KFF), U.S. national health spending in 1970 totaled \$74 billion. It increased to \$1.4 trillion in 2000, and by 2020, health expenditures tripled to \$4.1 trillion or 19.7% of the Gross Domestic Product (GDP).

These steady increases can be attributed to many factors, including an increase in per-person healthcare spending, consolidation of hospitals and physician practices, and consolidation among health insurers. The aging of America, increased incidences of chronic diseases, and the wider spread use of high-cost specialty drugs are other primary contributors to rising healthcare costs. Unfortunately, employer-sponsored health plans have had to bear the brunt of these high costs.

Leveraging advanced technologies and services is proving an effective way to control spiraling healthcare costs. **For brokers, presenting these technologies and services to their clients can generate new revenue streams and further establish oneself as trusted advisors continually seeking new ways to help clients.**

Healthcare cost trends

In its analysis of healthcare expenditures from 2019-2020, KFF found these to be the primary contributors to an increase in health spending:

- Federal and state/local public health 32.5%
- Hospital expenditures 20.9%
- Administrative costs 18.0%
- Physician and clinical expenditures 11.4%
- Long-term services (i.e., home health care, nursing facilities and continuing care communities) 9.1%
- Other health (i.e., other health, residential, personal care and services from other healthcare practitioners (e.g., physical therapists, chiropractors, etc.) 5.3%
- Prescription drugs 2.8%
- Medical goods (i.e., durable and non-durable medical goods and equipment) 0.7%

The NHE projected national health expenditures to grow, on average, 1.1 percentage points faster than the GDM per year from 2019 to 2028, with the healthcare portion of the economy projected to increase from 17.7 % in 2018 to 19.7% in 2028.

The consultant Aon projected that for large, self-funded U.S. employers, healthcare costs will increase, on average,

5% to over \$13,000 per employee in 2022. Its projections were based on the healthcare costs and benefit programs of more than 700 large U.S. employees with a total of 5.6 million employees. They took into account any health plan changes and vendor negotiations. It would not be unusual for a similar pattern to exist among other self-insurers which, according to the U.S. Department of Labor's Annual Report on Self-Insured Group Health Plans, March 2021, totaled 25,500 in 2018; a number that has likely increased over the past four years.

COVID-19 and other drivers

At its peak, the COVID-19 pandemic caused increased healthcare spending. And, while today COVID-related costs are more predictable, there remains uneasiness regarding its variants and what may be in store for the nation. Consequently, some commercial insurers may adjust their 2023 rates.

Other factors driving rate changes include:

- changes in the small group market due to the continued shift of small employers to self-fund or adopt other risk-rated coverage
- changes in the individual market composition fueled by changes in premium tax credits; increased utilization of telehealth and mental healthcare
- changes in provider contracting and related impacts of medical inflation.

Next-Gen Telehealth

One bright spot in the nation's healthcare landscape has been telehealth. Up until the COVID-19 pandemic struck, telehealth was not widely used by either providers or consumers. Of course, when it became challenging to have in-person visits, many had little choice but to use telehealth to virtually meet with their providers. What they learned was that virtual doctor appointments weren't such a bad thing and that telehealth actually gave them access to a broader network of providers. What plan sponsors found out was that telehealth resulted in lower costs. Still, up until recently, telehealth has relied largely on phone visits, which subsequently led to video conference visits. Now, next generation telehealth solutions are proving to be the most convenient, cost-effective alternative.

The most leading-edge telehealth solutions provide an integrated nurse help line with a telemedicine program accessible on a 24/7 basis.

In addition to adopting advanced telehealth solutions and specialty drug cost management programs, and considering forming coalitions similar to these groups, other measures plan sponsors can also benefit from include instituting robust employee wellness programs which, in addition to offering on-site health screenings and exercise and nutrition programs, also provide educational seminars to help educate employees regarding their behavior and lifestyle choices and the impact on their health, and how to make fiscally-sound healthcare decisions.



Here’s how they work.

An individual with a medical problem calls a dedicated toll-free line staffed by experienced registered nurses (RNs). An RN conducts a virtual patient intake and records all pertinent information including the patient’s contact information, symptoms, and reason for calling. This information is entered into the patient’s electronic health record. Then, based on the RN’s exchange with the patient, the RN would either address the individual’s situation directly or triage the call by transitioning it to the next level of medical care; which could be a physician, health advocate, behavioral advocate or other professional.

As a result of this option, unnecessary visits to a physician’s office, hospital emergency department or urgent care facility can be avoided, and the associated costs saved. Plan sponsors reduce their medical claims’ costs, while plan members have lower co-pays or no co-pays at all.

One employer of 1,000 employees saw telemedicine effectively transition 44% of urgent care visits and 35% of physician visits. The 140 telehealth calls its plan members made over the winter season resulted in a \$15,000 savings with similar savings projected in subsequent seasons.

The most advanced next-gen telehealth platforms feature user-friendly dashboards that can be accessed from any device — a PC, laptop, tablet or smart phone. Some of the most progressive providers of these advanced telehealth solutions customize their pricing based on the demographics of each group.

Taming the beast — specialty drug costs

The Centers for Medicare and Medicaid (CMS) reports that specialty drug costs have been rising at an estimated rate of 18% annually since 2014. According to the AMS 2020 Specialty Drug Trends Report, high-cost specialty drugs comprise 51% of total drug expenses and are responsible for driving 80% of all medical trend increases. This is despite the fact that only 2% of the U.S. population uses specialty drugs.

Two reasons for the high costs of specialty drugs are the lack of competition among specialty drug manufacturers

and the lack of legislation to curtail their high, rising costs, although efforts to enact legislation are underway. For instance, the AARP has called on Congress to remedy the problem by establishing a law that enables Medicare to negotiate drug prices, place a cap on out-of-pocket costs, particularly those incurred by older individuals, and levy penalties on drug manufacturers that increase their prices at a rate faster than inflation. While there has been significant progress in the development of biosimilars to offset current specialty drugs, the fact remains that the large majority of high-cost specialty drugs are still needed and used by many individuals to treat chronic and/or catastrophic illnesses such as cancer, arthritis, multiple-sclerosis, Crohn’s disease, psoriasis, hemophilia, and cystic fibrosis.

To provide an example of just how expensive these drugs are, GoodRx Health reported that these are the annual costs based on length of therapy for some of the most expensive specialty drugs:

- Zolgensma - which treats spinal muscular atrophy- \$2,125,00
- Zokinvy - which treats a rare disease that causes premature aging - \$1,073,760
- Danyelza - which treats neuroblastoma in the bone or bone marrow - \$1,011,882
- Kimmtrak - which treats metastatic or surgically untreatable uveal melanoma (eye cancer) - \$975,520

On a lesser scale, the Commonwealth Fund reports that Tretinoin, which helps manage some leukemia complications, cost \$6,800 per month per patient. However, it is not unusual for many specialty drugs to cost over \$100,000 per year per patient.

Some of the ways that insurers are tackling the high-cost specialty drug problem is to implement plans which require plan members/employees to first try less costly drugs before going on a high-cost specialty drug. They are also asking plan members to adhere to their overall treatment plans and offering incentives. Other measures include using a combination of a specialty drug cost management program

with a specialty drug prior authorization service that works to identify alternatives to the most cost-effective specialty drugs. Using this approach, an average of 40% savings on specialty drugs can be achieved.

New Pharmacy Benefit Administrative Services

Newer to the drug cost management landscape are advanced pharmacy benefit administrative (PBA) services. By giving patients access to a national network of retail pharmacies with mail order capabilities, these services are also driving savings upwards of 40% when used with a specialty drug reimbursement cost management program and a prior authorization policy. They also have been effective in driving lower medical stop loss costs.

Like advanced telehealth platforms, PBA services leverage online technologies that feature user-friendly, easy to navigate platforms with intuitive functionality. The PBA services' portal can be accessed 24/7 and provides helpful drug and healthcare information, as well as drug videos on demand. Real-time alerts remind patients when to refill their prescriptions. The portal can be accessed from a PC or any mobile devices and also use quick response codes (QR) on select specialty drug prescription labels.

Other successful measures

Along with deploying advanced telehealth platforms and specialty drug cost management services, plan sponsors, largely self-insurers, are banding together to drive lower healthcare costs through various measures. Many of these initiatives are state and/or regional based alliances.

Among those which are already making strides are:

1. Employers' Forum of Indiana, comprised of 154-self-insured employers including larger employers such as Eli Lilly, Fiat Chrysler, Cummins, Indiana University and Purdue University. To address the high prices in Indiana, due in large part to the declining number of independent providers with approximately 70% of physicians in Indiana now employed by hospitals and health systems, the group commissioned RAND Corp. to conduct several studies over the past five years (2017-2021). The studies revealed patterns relating to prices negotiated by specific Indiana hospitals with Medicare for inpatient and outpatient services. Specifically, the 2017 study, relying on claims data analysis, found that employers were paying 358% of Medicare rates, on average, for outpatient services and up to three-and-one-half times the Medicare rates for inpatient services. Further uncovered was that hospitals aligned with large health systems had higher costs than smaller health systems and independent hospitals. The 2019 report revealed that Indiana's hospital pricing was the nation's highest. Some of the outcomes of these and the Forum's other commissioned studies led to the release of pricing from specific hospitals, altering of negotiations between hospitals and health plans, the Indianapolis-based insurer Anthem's demand of concessions from Parkview Health, and the pursuit of legislative measures to facilitate price transparency.

2. The Alliance, a nonprofit cooperative comprised of

over 300 self-insured employees from Wisconsin and adjacent counties in Illinois, Iowa, Michigan and Minnesota. It applies data to convey the benefits, both fiscal and quality of healthcare, derived from directing employees to high-value providers, some of which consented to accepting bundled payment for select high-cost procedures.

3. Peak Health Alliance, a healthcare purchasing coalition covering seven counties in Colorado and comprised of self-insured employers, as well as local government and individuals who purchase health insurance on the state exchange. Like Employer's Forum of Indiana, it too relied on the capture and analysis of claims data to uncover that insurers were paying the local hospital, St. Anthony Summit Medical Center (part of Centura Health Network), almost 850% of Medicare rates for emergency department services and some employers, who believed that had negotiated great deals with the hospital for outpatient visits, were actually paying 550% of Medicare rates.

In addition to adopting advanced telehealth solutions and specialty drug cost management programs, and considering forming coalitions similar to these groups, other measures plan sponsors can also benefit from include instituting robust employee wellness programs which, in addition to offering on-site health screenings and exercise and nutrition programs, also provide educational seminars to help educate employees regarding their behavior and lifestyle choices and the impact on their health, and how to make fiscally-sound healthcare decisions.

Brokers as catalysts

With a full understanding of rising healthcare costs in America and the use of cost-savings measures such as advanced telehealth platforms, specialty drug cost management and administrative services, plan sponsors can gain some financial relief. Brokers can be valuable catalysts in helping to bring these next-gen solutions to their clients.



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Financial Wellness Solutions that Offer Immediate Support: A Win-Win Situation

Address today before planning for tomorrow

BY MIKE WILBERT

The macro-economic landscape for working Americans today is at best uncertain. Rising costs of everyday needs, speculation of a recession, and headlines about layoffs are pushing employee financial stress to an all-time high. And while wages have risen over the past year, inflation has outpaced those wage increases — forcing many to dip into their retirement, forego contributing to their savings or juggle which bills to pay.

And it is not just low-income earners who are feeling the pressure. Many

middle-income families say their earnings are not keeping pace with the cost of living, and a rising number say they are unable to save for the future.

We are increasingly having conversations with brokers, benefits professionals and senior human resources leaders about the importance of immediate financial wellness solutions and how to leverage them to work with more traditional and long-term financial benefits.

Traditional long-term financial wellness solutions such as retirement

planning and 401k contributions have an essential place in employer sponsored financial wellness strategies; however, it is the **immediate, inclusive solutions** that are top of mind for many working Americans right now.

When financial stress becomes prolonged it can have tangible effects on workers and employers alike. For employees, financial stress leads to physical and emotional stress, which can impact productivity, overall wellbeing and happiness, and ability to communicate. The impact of this stress negatively affects job performance and satisfaction.

From the employer's perspective, workers who are experiencing prolonged financial stress negatively impact workspaces by altering the company culture and overall productivity. When people are stressed about their financial situation at home, businesses may see greater absenteeism, lower levels of productivity, and higher levels of turnover.

Addressing today before planning tomorrow

Over the past three years, we have

seen the spectrum of wellness solutions and benefits packages expand from a purely health and wealth focus to include a focus on security and personal needs.

Brokers have an essential role to play to

empower employers with tools to help their people address more immediate challenges such as legal needs and identity theft, but they are also adding popular personal benefits such as pet insurance, tuition reimbursement, and subscriptions or stipends to mental health tools.

We believe that brokers can help their clients expand that personal focus by providing tools, resources, and information to help their workers address today's challenges. The reality is that financial wellness solutions need to span the spectrum — from long-term to immediate. They need to be flexible and need to accommodate the whole person who may be struggling to make ends meet today.

As trusted advisors, brokers can arm business owners with financial wellness solutions to help the employee get through today, and it will also put them in a better position to contribute to and participate in the critical long-term financial wellness benefits.

One of the most important things businesses can do when evaluating their financial wellness solutions approach is to listen to their employees. **Brokers who suggest this approach —**

and perhaps provide tools for their clients to do — show they are invested in their client's long term success. Surveys are a terrific way to understand the financial challenges employees are facing — meeting them where they are — and tailoring solutions that will work best for them.

Easing financial burdens now

Our research shows financial wellness solutions are important to employees

We are increasingly having conversations with brokers, benefits professionals and senior human resources leaders about the importance of immediate financial wellness solutions and how to leverage them to work with more traditional and long-term financial benefits.

and that they will gravitate to companies that provide access to these valuable offerings. A recent survey we conducted revealed that one in three working Americans said one of the top five reasons

they accepted a job at a new company is their desire to secure financial wellness solutions. Such benefits might include low-interest installment loans, medical deductible financing, early-wage access solutions, an employee purchase program, or bill-payment programs.

In addition to these more immediate solutions, **brokers can help** companies develop strategic partnerships with organizations to provide additional resources and education opportunities. This includes partnering with firms that offer financial literacy and planning, counseling or resources to connect employees with immediate needs like groceries or housing. **When brokers take the time to research and suggest resources to their clients, it gives them another opportunity to build a valuable ongoing partnership.**

According to an article in BenefitsPro (<https://www.benefitspro.com/2023/02/02/2023-ushers-in-a-new-era-of-employee-wellness-6-top-priorities/>) Millennials and Gen Z have been vocal about wanting their employers to care about them and their needs, not just a well-paying job. Offering solutions

to help support workers financial wellness is a fantastic way to prove an employer's commitment to its workforce.

During the "Great Resignation/Great Reshuffle" people left jobs because they did not feel valued, or they were not earning enough to make ends meet. Having financial wellness solutions can address both issues by helping workers with their personal finances, reducing their financial stress, and showing them their employer genuinely cares about their wellbeing.

Deliver effective solutions

Long-term financial wellness solutions are still essential, but many working Americans are struggling to pay their bills and need help in the short term. Today's economic environment has reinforced the need for immediate financial wellness solutions beneficial to working Americans of all income levels.

Brokers can play an indispensable role by educating employers about what's available and offering clients tools and resources they can use for their workforce.

When employees receive these valuable resources to support their personal financial wellness from their place of work, the benefits not only impact their personal life, but also their ability to maximize productivity for their employer as well. **That's a win for the broker, the client, and the employee!**



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A white piggy bank is positioned in the upper center of the frame. A black stethoscope is draped across the lower half of the image, with its chest piece resting on the left and its earpieces on the right. The background is a solid teal color.

Reference-Based Pricing in Self-Funded Health Plans

A key to cost savings

DOROTHY COCIU INTERVIEWS OMAR ARIF AND MIKE SIGAL OF CLAIMDOC

What should employers know about reference-based pricing?

The most important thing that employers should know about reference-based pricing (RBP), according to Omar Arif, SVP of Growth for ClaimDOC is that “it can be a wonderful tool to unlock transparency and price controls for your organization. RPB can also make health benefits much more affordable for your employees.”

However, brokers should prepare employers that in order to be successful with an RBP plan, you need real expertise to help implement it. It’s not as simple as a PPO plan. It takes a tremendous amount of up-front education, training and constant education to the employees and plan participants; it’s not a one-and-done type of plan. It requires participants to relearn the health insurance system. That is not an easy task. It takes a high level of understanding, and a lot of tools, including written materials, videos, and other educational vehicles. But if done right, it can save your health plan considerable money over the long run.

“You need a consultant that is an expert to help you through the process,” Arif explained. “Don’t think you can get it done with your brother-in-law or golf buddy. You need an expert, not a friend.”

If you want to help your group clients save 20-30% or more of your PPO self-funded health plan, you should look at RBP. But remember, it’s not simple and it’s a long-term process.

Many good vendors offer RBP repricing and services. Some of the major players include ELAP, ClaimDOC, HST, AMPS, 6 Degrees and Payer Compass, to name a few.

Any employer currently in the RBP space will tell you — the level of service, advocacy and negotiation abilities of the RBP vendor is critical. You need a vendor who is on the employer’s side, and works with the plan participants to resolve claim disputes. Member success is the way to grade your RBP plan. All RBP vendors can reprice the claims to an RBP rate. The difference is in how they work with the plan members and resolve their issues.

What to look for in an RBP vendor

- **Provider Balance Billing:** A provider may bill the patient a balance after receiving the reduced payment from an RBP health plan. In this phase, it’s imperative that the employer work with a skilled RBP vendor that has a robust patient/member advocacy program dealing with providers who balance bill, to avoid collections actions by the provider which could impact the plan participant’s financial situation and credit scores. How this works and how successful it is can make all of the difference to the plan participant.

- **Legal assistance to settle claims:** Sometimes, on rare instances, the employer/plan sponsor may need legal

assistance to resolve a claim. RBP vendors need to have expert legal support on their team.

- **Co-Fiduciary role:** One particular difference that only a small number of RBP vendors can claim is that they have taken a co-fiduciary role in the plan. For those of you familiar with ERISA, a plan fiduciary has decision-making authority over the plan, and therefore has liability. They are required by law to make plan decisions based on the best interest of the plan and its participants. Often, RBP vendors avoid fiduciary liability.

- **Provider communication skills:** RBP vendors need to establish open communication with providers — doctors, hospitals, clinics, etc. — to make sure they understand and agree to all the nuances of RBP.

So, if you’re a broker representing group employers who want to keep health benefit costs down and potentially save a substantial amount, consider self-funding with RBP. It doesn’t work for all plans, but it does work for a lot of them. Whether we’re in a recession or a booming economy, most employer plan sponsors are open to claim savings. But remember, you need experts to make it successful.

To find out if your health plan or your clients’ plans are good candidates, reach out to ClaimDOC.

Of Note: *ClaimDOC would like to thank health benefits broker and self-funded and RBP expert and plan consultant Dorothy Cociu, president of Advanced Benefit Consulting, for her assistance with this article. For more information on this topic, you can listen to Dorothy’s weekly podcast series, Benefits Executive Roundtable, Season 4, Episode 12, where she interviews Sigal and Arif on Reference-Based Pricing, available on all podcast platforms, or at: <https://advancedbenefitconsulting.com/s4e12-examining-reference-based-pricing-in-self-funded-plans/>*



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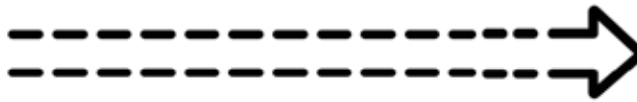
Exit Planning Strategy for Health Brokers

STAYING ACTIVE

Build and Grow Phase



Moving from ACTIVE to Plan to Retire



PLANNING TO EXIT



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3. FINDING BUYER
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5. NEGOTIATING
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