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SERVING CALIFORNIA'S ANNUITY, LIFE AND HEALTH INSURANCE PROFESSIONALS • DECEMBER 2023



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26 - 50	\$ 4,000 / \$6,000
11 - 25	\$ 2,000 / \$3,000
4 - 10	\$ 1,000 / \$1,500

Contact your local Covered California for Small Business sales representative to learn why we're growing and how we can help build your business! An increasing number of agents and their clients are glad they did.

**[CoveredCA.com/ForSmallBusiness](https://www.coveredca.com/ForSmallBusiness)
844.332.8384**

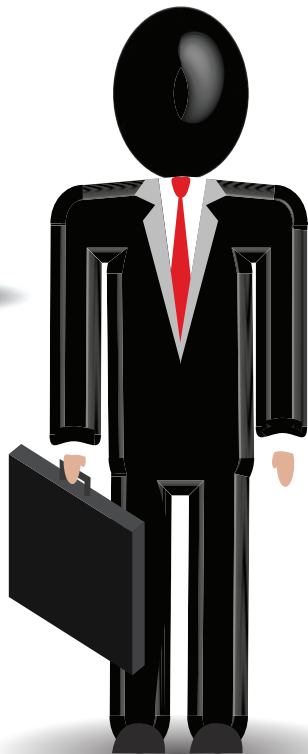
Some Key Rules:

1. Applies to new to Covered California for Small Business (CCSB) groups with initial effective dates of 07/1/23, 08/1/23, 09/1/23, 10/1/23, 11/1/23, 12/1/23 and 1/1/24
2. Agency must submit minimum of three groups to qualify for bonus program
3. Bonuses will be calculated on number of subscribers (employees) in effect for the first effective month of the policy as determined by CCSB.
4. No pro-ration of target values will take place.
5. Business written through partnering General Agencies qualifies.
6. Covered California will issue the second bonus (6+ groups) incentive payment forty-five (45) days following the conclusion of the incentive program so long as qualifying groups satisfy the ninety (90) day requirement outlined in Section (E)(2)(c) of Exhibit F of the Agency Agreement.

For a complete list of the program rules go to:

<http://www.coveredca.com/agents/PDFs/Agent-commission-schedule.pdf>





KEY PERSON DI

Key person disability benefits allow for funds that may be used however the company sees fit such as to scout, hire and train a replacement employee, or simply provide much needed capital to a business in transition.

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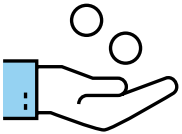


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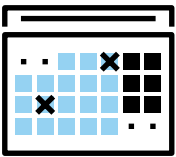
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CALIFORNIA BROKER

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The healthcare network that gives you more

When it’s time for your clients to choose their healthcare, selecting the right medical group matters.

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- ✓ Enjoy working with professionals who collaborate with you to resolve client planning needs

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When your client needs help outside of your area of expertise:

- **Tax and retirement income concerns** about running run out of money in retirement;
- **Legal concerns** such as estate planning, so their tax concerns are addressed; and
- **Business Owner succession planning** needs are professionally managed.

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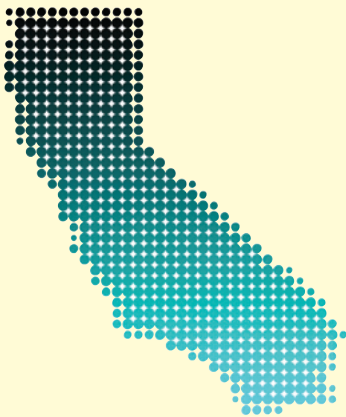
CALL: 657-229-2849

EMAIL: info@healthbrokercollaborators.com



California Business Facts & Resources

Chamber of Commerce Report on California's Competitiveness Identifies ways to stem the tide of businesses leaving the state



A recently released report by the California Chamber of Commerce

has found that businesses continue to choose to leave California, especially in Southern California, for more business-friendly states, because of the state's lack of affordable housing, cost of living, high taxes, and stringent regulatory environment. However, the report also sees an opportunity to mitigate this trend as it identifies the problem with the state's homogeneous approach to stem the exodus of businesses from one of the largest economies in the world.

The "California's Competitiveness: A Regional Approach" report outlines steps California (especially Southern California) must take to maintain its advantage over other states in the coming years. Some of the report's recommendations are to create innovation and improve competitiveness for the state's regions and, in turn, stem the outbound migration of businesses.

Highlights:

1. Develop an economic strategy which considers and supports regional differences.
2. Leverage the state's regional assets to compete for workers and firms. California can do so more effectively by addressing the state's high cost of living and ensuring community amenities are on par with those in other states.
3. Build entrepreneurial infrastructure and support, which will attract new firms while lowering the barriers to entrepreneurship for its homegrown talent.

"We wanted to look at why California-based businesses continue to leave and whether the state was doing enough to stem the flow of business outbound migration," said Maria S. Salinas, President and CEO of the LA Area Chamber of Commerce. "This report is unique because it examines the issue from a Southern California perspective and finds that to stay competitive, California's economy and its evolution over time are best analyzed and understood by looking at its regions. The report offers several recommendations to strengthen California's competitiveness among other states and suggestions to develop regional strategies to help businesses prosper."

Read more here:

<https://bit.ly/45yBhYj>

Sutter Health: Working to Help Californians Access Health Care

Dwindling access to health care is a nationwide issue with a big impact on California, and it is proving to be one of the toughest and most significant health policy issues we face. California has made great strides toward helping get most people access to health insurance; however, getting a timely appointment or receiving the right care at the right place and time remains a challenge for many.

As one of California's largest health systems serving more than 3.3 million patients, Sutter Health is committed to helping close the health care access gaps. When patients cannot access timely primary care services or can only access a hospital for simple or routine procedures, it can have a negative impact on individual health outcomes and contribute to the escalating costs of care. That is why Sutter Health is ramping up investments in solutions: addressing the critical health care clinician shortage, increasing the number of ambulatory care centers and bolstering Federally Qualified Health Care Centers.

Read more here:

<https://advocacy.calchamber.com/2023/10/23/sutter-health-working-to-help-californians-access-health-care/>

CMS releases proposed rule for 2025 Medicare Advantage prescription drug plans

The Centers for Medicare & Medicaid Services (CMS) proposed changes to the Medicare Advantage and prescription drug programs for contract year 2025 intended to improve access to behavioral health care; ensure that agents and brokers enroll individuals in the best plan for their needs and that MA plans offer appropriate supplemental benefits; streamline enrollment for individuals dually eligible for Medicare and Medicaid; and annually review MA utilization management policies for health equity considerations.

Among other changes, the proposed rule would streamline the appeals process for enrollees if their MA plan terminates coverage for certain post-acute care services; standardize the appeals process for MA Risk Adjustment Data Validation audit findings; limit out-of-network patient cost-sharing for certain plans serving dually eligible enrollees; and give Part D plans more flexibility to substitute biosimilars for reference drug products.

For more on the rule, see the CMS fact sheet.

How to report Medicare Fraud

If you suspect fraudulent activity on your Medicare account, have questions about suspicious charges or have been contacted by someone who tried to steal your Medicare number, you can report the problem in several ways.

Senior Medicare Patrol: 877-808-2468
<https://smpresource.org>

Medicare's helpline: 800-633-4227

U.S. Department of Health & Human Services fraud hotline: 800-447-8477

Part D fraud: 877-772-3379

State Health Insurance Assistance Program: 877-839-2675
www.shiphelp.org

THE #1 DESTROYER OF RELATIONSHIPS



by Bill Cates

<https://referralcoach.com/the-1-destroyer-of-relationships/>

Here is the perfect formula to hurt (or even destroy) any relationship business or personal:

1. One party has an expectation of the other.
2. That expectation goes uncommunicated.
3. That expectation goes unmet.

I'm confident that this formula has played out in your business and personal relationships more than you want to recall. Can you recover from this sort of situation? Sometimes. Not always.

Preventing this scenario with clients, your team members, and everyone else in your life is simple – but not always easy.

Strategy #1 – Discuss Expectations Early

Strategy #2 – Assess Expectations Over Time

One simple AND easy way to build trust and win the business of prospects is to discuss what your prospects expect from working with you.

You already know that a relationship that's had a problem and has been handled well, is almost always a stronger relationship than one that's never had a problem.

Prevent problems by getting clear on expectations.



Warner Pacific welcomes Janet Trautwein as compliance and government affairs executive

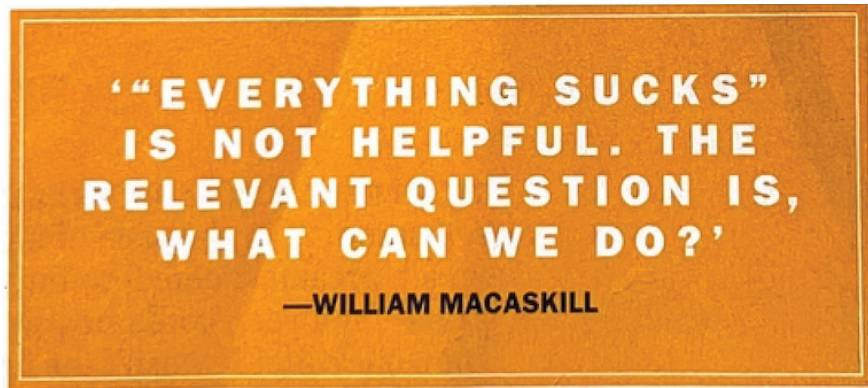
Janet Trautwein, former NABIP CEO, has joined Warner Pacific as its compliance and government affairs executive, providing hands-on guidance and insight to support brokers in navigating policies that impact the industry. Trautwein has a distinguished 35-year career in the insurance industry. Having served at the helm of the National Association of Benefits and Insurance Professionals (NABIP, formerly NAHU) since 2005, Trautwein is highly respected for her in-depth understanding of legislative and regulatory matters from an insider’s point of view.

“One of the key benefits of Janet joining the Warner Pacific team is that our brokers will have access to her extensive inside knowledge of health insurance compliance, empowering them to better serve their clients,” said John Nelson, co-CEO of Warner Pacific. “Janet has been on the inside and will bring an unprecedented understanding of future trends and a unique perspective of the industry.”

Warner Pacific is a leading health insurance general agency supporting health care brokers in California, Colorado, Oklahoma, Texas and Florida.

Warner Pacific is now featuring “Ask Janet!” on their website where brokers can ask questions and get input from a consummate expert.

**Access here: <https://go.warnerpacific.com/askjanet.html>
www.warnerpacific.com.**



“People who want to do good often prefer to directly tackle problems, since it’s more motivating to see the tangible effects of their actions. But what matters is that the world gets better, not that you do it with your own two hands. So people applying effective altruism often try to help indirectly, by empowering others. ...

For instance, some charities help 100 or even 1,000 times as many people as others, when given the same amount of resources.”

**Excerpt from an interview in Time Magazine article: “How to do the Most Good”
By Naina Bajekal, Oxford, U.K. with William MacAskill, one of the founders of the effective altruism (EA) movement**

**www.effectivealtruism.org
www.time.com/6204627/effective-altruism-longtermism-william-macaskill-interview/**



New California law raises minimum wage to \$25 for health care workers

What earlier this year seemed like a long shot is now a done deal: Gov.

Gavin Newsom signed a law

in October that will raise the pay for hundreds of thousands of California health care workers and set them on a path to a \$25 minimum wage.

Newsom's signing of the law means medical technicians, nursing assistants, custodians and other support staff will see a gradual wage hike that rolls out starting next year. He got behind the law on the same day that unions representing lower-paid Kaiser Permanente employees announced a new contract with a \$25 minimum wage for the health care giant's California workers.

Newsom's approval of the new minimum wage for medical workers follows his signature on a separate law mandating a new pay floor for fast-food workers. Starting next April, fast food employees will make at least \$20 an hour.

Between the two new industry-specific minimum wage increases, about 900,000 Californians are expected to see their pay climb thanks to new state laws.

<https://calmatters.org/health/2023/10/california-minimum-wage-health-care-law/>

CalMatters: Gavin Newsom Signs Law To 'Overhaul' Mental Health System

Gov. Gavin Newsom signed the first of a series of bills that aim to transform California's mental health system. Depending on who you ask, this transformation represents a long overdue humanitarian response — or a worrisome step backward on civil liberties. This loosens long-standing rules about who is eligible for involuntary treatment under the half century-old Lanterman-Petris-Short Act, the landmark mental health law that regulates involuntary civil commitment in the state.

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

Calendar

Dec 7 @ 11:30 am – 1:30 pm PST
WIFS-LA **"Tax Changes-This Year and Next"**

Register: Janet Fishman 213-359-0389
janet@wifs-losangeles.org

Dec 7 @ 11:30 am – 12:30 pm PST
Dickerson Insurance Webinar:

"What Advisors Should Know About Telemedicine & Virtual Care Benefits."

Register: www.dickerson-group.com

Dec 12 @ 5:00 to 7:45 pm PST
CAHIP OC Newport Beach Parade of Lights Harbor Cruise

Register: www.ocado.org

Dec 14 @ 4:00 – 7:00 pm PST
CAHIP GG Holiday party

Register: www.ggahu.org

Dec 14 @ 5:00 to 7:00 pm PST
WIFS & NAIFA LA Holiday Happy Hour

Register: Janet Fishman 213-359-0389
janet@wifs-losangeles.org

Dec 15 @ 5:00 to 8:00 pm PST
CAHIP-LA Annual Holiday Party

Register: www.cahip-la.org

2024

Jan. 22

CAHIP Innovation Expo

Sheraton Universal, LA.

Register: www.cahip-la.org

March 25-27

Ellevest Women's Leadership Summit 2024

JW Marriott Las Vegas

Register: www.ellevestfoundation.org

May 6-8

CAHIP Capital Summit

Kimpton Sawyer Hotel, Sacramento

Register: www.cahip.com

June 23-26

Society for Human Resources Management SHRM24 Annual Conference and Expo, Chicago

Register: www.annual.shrm.org



Level Funded health plans are catching on

Don't miss out on up to 17% potential savings for your California small business¹

In 2019, only 7% of small businesses offered a level funded health plan. Today, more than a third of them do.² Get in on UnitedHealthcare Level Funded and the advantages that come with it—like exemption from many ACA regulations and surplus refund potential,³ too.



Get the details at uhc.com/saveCA

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There for what matters™

¹ Average savings for UnitedHealthcare Fully Insured groups 2–50 nationwide migrated to UnitedHealthcare Level Funded, Jan. 1, 2021 – Dec. 31, 2022. Savings are not guaranteed.

² Kaiser Family Foundation Employer Health Benefits Surveys, 2019 and 2022. For the purposes of the surveys, a “small business” was defined as groups with 3–199 employees. 2019 survey available: <https://www.kff.org/report-section/ehbs-2019-section-10-plan-funding/>. 2022 survey available: <https://www.kff.org/report-section/ehbs-2022-section-10-plan-funding/>. Accessed: Feb. 17, 2023.

³ Please consult a tax and/or legal advisor to determine if, by receiving this refund, there are any restrictions or obligations. Surplus refund available only where allowed by law.

Administrative services provided by United HealthCare Services, Inc. or their affiliates, and UnitedHealthcare Service LLC in NY. Stop-loss insurance is underwritten by UnitedHealthcare Insurance Company or their affiliates, including UnitedHealthcare Life Insurance Company in NJ, and UnitedHealthcare Insurance Company of New York in NY.

A Note of Appreciation from the Publisher

2023 was a year of change for California Broker. On behalf of the Cal Broker team, I want to thank our subscribers for their commitment to Cal Broker — many have been with us since 1981 when Ric Madden started *California Broker Magazine*.

Our staff is grateful for you ...

We have a great “education first” focus led by our Editor **Linda Lalande**. Our monthly magazine is elegantly presented by our Art Director **Randy Dunbar** who makes the visuals strong and compelling each month, especially the cover. Our Production Associate **Zulma Mazariegos** has successfully led the digital transition all of our subscribers now enjoy. And our health insurance agency VP of Employee Benefits **Carmen Ponce**, has also led the way to organize and direct the operations of our publishing company, Health Broker Publishing.

As we celebrate 2023, some key events are highlighted below for your appreciation:

Conversion to a digital media company: This transformation saved trees and money, as well as better serving our expanding audience. Our digital media conversion was possible due to our acquisition of the California Department of Insurance list of ALL California resident licensed agents and brokers. With now over 125,000 Cal Broker subscribers receiving our monthly magazine and weekly eNewsletters, our content reaches more California health insurance professionals than any other media. These professionals cover nearly 75% of all insured persons in the state.

Paid print subscription: We appreciate those who made the purchase to continue to receive our monthly magazine delivered to their address. We plan to continue to offer a paid subscription for the print magazine while sending the eMagazine to all 125,000 e-Subscribers.

More advertising partners: Many of our advertisers make a continual annual commitment. We greatly appreciate their support and hope our subscribers show their appreciation as well by partnering with our advertisers. NEW for our advertisers is the fact we can now track the response to their content using digital technology. Digital subscribers can show their interest in the articles and ads by clicking on the hyperlinks placed in the content. When clicking on a hyperlink you open access to more resources. This digital

connection allows our subscribers to interact with our content providers. Subscribers can read both articles and ads and, if they choose, they can learn more by clicking on the links.

More articles featuring industry influencer input on trends in the health industry: 2024 will bring more advancements in healthcare and health insurance professionals will find and learn about these changes in our media.

Introduction of the Collaboration Center: The Center connects subscribers with subject matter experts (SMEs) committed to supporting health insurance professionals who want to help their clients with solutions that are outside the health insurance arena. Common issues supported by SMEs include planning for asset protection, wealth and estate planning, and retirement income risk management.

Professional association coverage: We will continue to provide news and updates from professional associations such as NABIP, CAHIP, NAIFA, WIFS and local Association Chapters who provide resources and information brokers need to help their clients with the best service possible.

*Best wishes for a prosperous and healthy
2024 from our staff to all our
authors, advertisers and subscribers.*

Phil Calhoun,
owner and publisher
Health Broker Publishing

Shine the Light:

ANNOUNCING FIRST ANNUAL CALBROKER HEALTH INSURANCE PROFESSIONALS OF THE YEAR RECOGNITION

Your nominations wanted for Health Insurance Professionals of 2023!

Please join Cal Broker as we launch our first annual recognition program called "Shine the Light" to highlight health insurance professionals who made a difference through their good work in the past year.

As you look back over 2023, consider nominating a colleague you feel best fits YOUR description of Health Broker/Agent of the Year.

Criteria: We are looking to honor professionals who are an example for others in the industry — those who shine by providing consistently excellent solutions for their clients, address their client's issues with collaborative partners, and demonstrate unfailing commitment to their work. Does that sound like a professional you know? Let them know by nominating them!

Email your nominee's name, their contact information and a brief reason for your nomination with concise examples.

Use the subject line: Shine the Light Nominee.

Send nominations for consideration by Jan. 15 to emma@calbrokermag.com

We will "Shine the Light" on selected Health Insurance Professionals of 2023 in our eNewsletter and in our February monthly magazine. Honorees will receive a free two-year annual print subscription (value \$24 annually) and a basic eDirectory list-ing for a year (value \$99).



COMPLIANCE



2024

Compliance Issues to Watch

By Misty Baker

As we ring in 2024, there are a number of healthcare industry legislative and compliance issues that brokers and employers need to be aware of. Yes, there's a presidential election later in the year and the potential for changes in the balance of power at the national and state levels. But before we get to November, there are plenty of other issues impacting the industry, from new IRS regulations and transparency requirements to parity compliance.

New IRS Filing Threshold for 2024

The Internal Revenue Service (IRS) recently released draft instructions for preparing, distributing, and filing 2023 Forms 1094 B/C and 1095 B/C. These instructions largely mirror guidance the IRS has published in previous years, except that the electronic filing threshold has been reduced from 250 forms to ten forms in aggregate.

Previously, employers could mail their Forms 1094 and 1095 to the IRS if their submission included fewer than 250 forms. For the 2023 ACA filing and beyond, employers that

cumulatively submit at least ten forms to the IRS (including W-2s, 1099s, ACA Forms 1094/1095, and other common form series), must file all of those forms electronically.

For example, if an entity issues four 2023 Forms W-2, five 2023 Forms 1095 B, and one 2023 Form 1094 B, then that sum of ten forms means they must file all of them electronically with the IRS when due in 2024. This change resulted from a final regulation the IRS issued earlier this year that officially reduced the electronic filing threshold for many form series.

Employers that have historically submitted their Forms 1094/1095 to the government via paper mailing will need to consider overall how many forms they will be filing with the IRS in 2024, not just Forms 1094/1095, to determine whether they can continue to do so.

Ultimately, the ten-form aggregate threshold will necessitate electronic filing for nearly every employer. Employers that have traditionally paper filed their ACA forms are urged to either register with the IRS as soon as possible so they can eFile themselves, or to contract with a vendor that can confidently eFile on their behalf.

Price Comparison Tools and Cost-Sharing Estimators

Finalized in 2020, the Transparency in Coverage (TiC) rule has a multi-year, phased implementation with a goal of helping health care plan participants make informed choices about medical procedures and services. Earlier phases of the TiC included requirements around accurate provider directories, prohibitions on balance billing, gag clause attestation, and more.

The latest phase of the TiC requires health plans or issuers to provide internet-based, self-service price comparison tools and cost-share estimators. These tools must provide real-time, personalized out-of-pocket cost information based on the member's plan for covered items and services furnished by a particular provider. In 2023, these tools were required to cover 500 specific healthcare services. For plan years beginning on or after January 1, 2024, all covered items and services must be included in the cost-share tool.

Employers will need to educate employees on how to access and use price comparison tools and cost-share estimators, but it may also be necessary to create incentives to encourage and remind employees to make use of these resources.

New Proposed Rule Impacting Mental Health and Addiction Coverage

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires group health plans and health insurance issuers to have parity between mental health/substance use disorder benefits and medical/surgical benefits. This includes financial requirements, as well as quantitative treatment and non-quantitative treatment limitations (NQTLs).

Group health plans and health insurance issuers must document their comparative analysis related to the processes, strategies, evidentiary standards, and other factors used to apply NQTLs to mental health or substance use disorder benefits. The analysis must show that the application of NQTLs is comparable to limitations on medical/surgical benefits and is not being applied more stringently.

In 2022, regulators released a report to Congress in which more than 200 NQTL analyses were reviewed, but none were

found to meet regulators' expectations. Failure to comply with the MHPAEA incurs a number of penalties, including corrective action, excise taxes, and potential litigation. Additionally, the Consolidated Appropriations Act of 2021 (CAA) requires regulators to identify by name all carriers and plans that are out of compliance, which can generate negative publicity for employers.

In July 2023, regulators released a new proposed rule to clarify requirements and strengthen enforcement around the MHPAEA. Once finalized, the new rule would likely take effect on Jan. 1, 2025 for group health plans and Jan. 1, 2026 for individual health plans. Brokers and employers will want to watch this area carefully to ensure compliance with the new rule when planning 2025 benefits.

IRS Changes to the Affordability Threshold

The Patient Protection and Affordable Care Act (ACA) Employer mandate specifies that applicable large employers (ALEs) must offer full-time employees affordable health coverage that meets minimum value requirements or face penalties. The IRS affordability threshold is updated annually. The cost of self-only health care coverage must be below the threshold to be deemed affordable.

In 2023, the threshold was 9.12%. However, for 2024, the affordability threshold has been reduced to 8.39%. Employers should review their compensation structures to ensure that they are in compliance with the affordability requirements for 2024.

When it comes to compliance, the new year brings new challenges and many unknowns. While some of the issues mentioned here require immediate action, they are just a starting point for 2024. Brokers and employers should remain vigilant to ensure they have a clear understanding of their responsibilities and key deadlines throughout the year.



Misty Baker, *director of compliance and government affairs at BenefitMall, is an Affordable Care Act compliance and agent advocate, specializing in ACA, ERISA, FMLA, COBRA, and legislative advocacy for over 20 years. She was a registered lobbyist in Texas for four years and is a strategic leader focused on compliance, agent knowledge, legislative advocacy, and ultimate client understanding of how to be*

successful in the changing world of compliance. Her passions include agent education, insurance advocacy inside and outside of the Capitol, and compliance.

www.benefitmall.com

LEGISLATION

BY PAUL ROBERTS

California Governor Signs New Bill Regarding Single Payer into Law

California Governor Gavin Newsom signed SB 770, a bill related to Single Payer health care in the Golden State in October 2023. **The bill does not create a Single Payer health system in California, and it does not detail any components of what the system would entail.** Instead, it focuses entirely on obtaining federal funding for a state-run single-payer health care system. It is intended to be the first of many steps toward financing such a system in California.

A California Single Payer health system would upend all existing health care operations and health insurance organizations within the state as we know them today. The system would replace all existing health care systems with one system to access, receive, and pay for health care. This means that everyone statewide would have health coverage through a single government-run program, with no other options.

Under a California Single Payer system, based on what has been previously proposed in prior, unsuccessful legislation, the state government would be responsible for negotiating prices with health care providers, establishing hospital and provider systems, and paying for all covered services, including doctors' visits, hospital stays, prescription drugs, dental care, vision care, long-term care, and more. It would eliminate and nullify all group health coverage, Original Medicare, Medicare Advantage plans, Medi-Cal (Medicaid), and the insurance professionals, agents, and agencies that support them. While full details of how the system would operate have not yet been vetted, costs of such a proposal are estimated to be around \$500-600 billion per year. For comparison, the current California state budget for 2024 is approximately \$330 billion.

SB 770 instructs the California Health and Human Services (HHS) Secretary to initiate discussions with

the federal government regarding waivers for Medicare and Medi-Cal (Medicaid) programs. The aim is to discontinue access to these programs within California and redirect allocated funds to the state, so it can finance part of its prospective statewide Single Payer health care system. According to the Kaiser Family Foundation's most-recent 2021 data, approximately 6.5 million Californians are covered by a Medicare plan. And approximately 14.2 million are covered by Medi-Cal in California, as of June 2023. The Medi-Cal number is expected to increase significantly beginning in 2024, when undocumented adults ages 26-49 become newly eligible for Medi-Cal regardless of immigration status.

The new law requires California HHS to develop its waiver proposal by June 1, 2025, which will be subject to a 45-day public comment period. The final waiver proposal is due by Nov. 1, 2025, at which point, the federal government may be approached for such waivers.

Word & Brown, the California Agents and Health Insurance Professionals (CAHIP) association, National Association of Benefits and Insurance Professionals (NABIP), and related groups and coalitions will be active participants in all related opportunities for engagement during the waiver creation process and for any subsequent legislation.

The Biden administration has been a loud proponent of preserving Medicare for seniors and has been vocal about building upon the Affordable Care Act (ACA). A Republican administration is also unlikely to entertain discussions for a Single Payer health care system in California. Even in the improbable event that the federal government grants the sought-after waivers, California would still need to find an additional \$300 billion per year to finance the rest of its Single Payer system – in addition to the taxes Californians are already paying.

As of this column's publishing,

there is a separate bill, AB 1690, which would detail the plans and operations for the Single Payer system in California. However, it is a "spot bill," which is a virtually blank placeholder bill that can be revisited in January. It merely states California's intent to create a "comprehensive universal Single Payer healthcare program," void of any details or financing mechanisms.

Furthermore, additional Single Payer health care bills may likely be introduced in January 2024. The long-term sponsors of Single Payer legislation in California have indicated further movement and legislation in January should be expected.

Word & Brown will continue its work with CAHIP, NABIP, coalition partners, industry partners, et. al., as these bills unfold when the California legislature reconvenes in 2024. Stay tuned for future updates.

California health insurance brokers, agents and insurance professionals are encouraged to get involved with CAHIP. The association works closely with the legislature on these proposals and advocates for alternate approaches to universal coverage in California, such as preserving private health care options for Californians – including group health coverage, Medicare, Medicare Advantage plans and Medi-Cal.



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With open enrollment in full swing, 2024 promises to bring a year of change in the health insurance market.

Nationally, Kaiser Family Foundation (KFF) is projecting an average 6% premium increase over 2023 and Covered California says marketplace rates in the state are set to go up a weighted average of 9.6%.

But premiums aren't the end of the story when it comes to health care in the coming year. From repercussions of the Medicaid unwinding to the changing nature of spousal coverage, and even the coming costs of the new breed of weight loss drugs, several areas bare watching in the coming months.

Medicaid rolls unwind

Prior to this year, Congress had frozen Medicaid rolls, meaning that thousands of people who no longer qualified for the program because of higher incomes stayed enrolled. Now that those restrictions have ended, states have been working to update their rolls.

About a quarter million Medi-Cal policyholders have been disenrolled since the COVID-19 restrictions have ended. Many of those people were struck from the rolls even though they still would have otherwise qualified. That is often because of procedural reasons, such as not responding to requests to update their information in a timely way, leading to horror stories of patients only learning that their coverage had ended when they were in the doctor's waiting room and their coverage was declined.

For patients who still have incomes low enough to qualify for Medicaid, they can re-enroll at any point because Medicaid has a rolling enrollment that is open all year.

But patients who got dropped because of their income qualified for a limited special qualifying period. That meant that they could have purchased a new policy outside of open enrollment. However, many didn't act in time and have been without a policy for months now.

For brokers and agents, that population represents a promising potential market as they need to have coverage according to the California Individual Mandate.

Spousal surcharges implemented

For some employee-sponsored plans, companies apply spousal surcharges when both spouses are employed and have access to subsidized coverage through their employers.

Most employers offer generous subsidies for their workers. Some also extend that subsidy to families, to the point that it is a better deal for both spouses to be on the more generous plan. That inevitably raises the health care costs for the employer with the more generous subsidy.

To combat this, about a quarter of employers charge a spousal surcharge, with another 10% saying they intend to do so.

These surcharges can run as much as \$250 or more per month, often eliminating the savings the family would have otherwise enjoyed by combining into a single plan.

2024 Heralds Cost Increases

Educate your clients on the details

By
Michael Giusti

In these cases, each spouse can opt for their own employer's plan. How to divvy up children between the plans should then be decided on a case-by-case basis.

From the perspective of a broker or agent, educating employers about whether adding a spousal surcharge makes sense presents a good conversation opportunity. In your advisory role, you can help your clients find personal solutions that work for them.

Family glitch addressed

When it was written into law, the Affordable Care Act included what critics dubbed the "family glitch." This was a limitation in the law that said if health insurance was available through one spouse's employer, the entire family would be ineligible for an Affordable Care Act policy subsidy.

What the family glitch failed to take into account was when an employer heavily subsidized the premiums for their workers but left the family portion of the plan unsubsidized.

Now, as a part of a revised interpretation by the IRS, families are eligible for subsidized ACA plans even if they have access to employer-provided plans, as long as those employer-provided plans were deemed unaffordable by the new formula, meaning they cost the family more than 8.3% of their income. (<https://www.cms.gov/marketplace/technical-assistance-resources/afford-employer-coverage-fixing-family-glitch.pdf>)

Again, as an advisor, you can assist your clients in determining who is affected in their employee population, and find cost-saving alternatives as explained below.

Do the math

To calculate the affordability formula, subtract the cost of the family coverage from the cost of the employee-only coverage. Then multiply that difference by 12 and divide that number by 8.3%.

For example, if an employee-only policy cost \$100, and a family policy cost \$1,200 a month, then the formula would show that policy would be considered unaffordable for any family earning less than \$157,330 per year.

For agents and brokers, it makes sense to educate companies on how to let their employees potentially cash in on those savings, and at the same time, roll off potentially costly claims from their employer-sponsored plan. You can assist in creating options for employers to offer their affected employees.

Weight loss drugs impact costs

One of the biggest cost drivers in the coming years promises to be the new wave of weight loss and diabetes drugs that are hitting the market.

These new drugs often cost more than \$1,000 per month, and many analysts worry they will greatly drive-up insurance costs.

While their adoption has been limited

thus far because of supply chain shortages, production is being ramped up continuously. Many policies refuse to cover the drugs merely for weight loss, but most of them are instead labeled for use as a diabetes treatment, meaning many more will be pressured to adopt them to their formulary.

The big picture question now being asked in insurance circles is whether those monthly drug costs might be outweighed by patients avoiding costly chronic diseases associated with obesity, such as diabetes over the long-term.

How those long-term results play out will likely inform how they will be covered in the future. For agents and brokers, being aware of how this affects clients can give you a head start on advising them how to incorporate plans that will help address these factors. It takes a savvy advisor to use foresight and help evaluate and potentially mitigate the high cost of these new drugs. It's a great opportunity to demonstrate your worth.

For brokers and agents, that population represents a promising potential market as they need to have coverage according to the California Individual Mandate.



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<https://www.insurancequotes.com/>

Current and Future Power of AI to Improve Care and Elevate the Member Experience

By Dr. Arta Bakshandeh

The article describes how artificial intelligence (AI) has improved patient care and member experience at Alignment Health over the last decade, and the potential for AI to do even more to help improve care for all people in the future. While we include examples of how we are using AI at Alignment, the broader message is how AI can be integrated into the insurance industry with beneficial results.

Over the last decade, artificial intelligence (AI) has elevated the member experience and dramatically improved the level of patient care we can deliver. As Alignment Health’s chief medical informatics officer, I can say I’m a true believer that it will only get better from here.

Let me share a story to put into perspective just how far we’ve come as an industry, with the integration of AI.

In December 2018, a member called into our 24/7 concierge care line with dangerously low blood sugar levels. As a senior medical director for Alignment at the time, I took the call and the member began describing his current situation and symptoms. As he spoke, I could click into our AI-powered platform — AVA®—to gather important context around his situation. According to AVA, this member lived in a low-income area with no nearby family or access to urgent care. He was on his own, and I needed to give him immediate guidance on what to eat and how to adjust his insulin pump. But like many seniors, this member was dealing with food insecurity, and unfortunately that night, there was no food in his fridge.

Acting quickly to gain control of his blood sugar levels, I ordered the member a large pizza, and it arrived while we were

on the phone.

By 9 a.m. the next day, Alignment’s care team was in the patient’s home, and by the end of the day, he was set up with appropriate nutrition from Meals on Wheels.

A \$20 pizza prevented a potential \$2,000 ER visit and, more importantly, serious health consequences for our member. None of that would have happened without the context provided by our AI-powered clinical care model. The “pizza prescription” is just one of many examples of how AI technology can empower both care teams and members across the industry.

Over the last decade at Alignment, AI has evolved into a powerful tool that collects thousands of real-time, actionable data points and, in turn, presents us with a “whole person” picture of our members. In moments where we have traditionally been confined to reviewing lab work, we now see the other 80% of the “picture” that really contributes to health outcomes: Did our member pick up a prescription? Is our member at risk of a hospital visit? With AI, we can make things that used to be inevitable, avoidable.

Here are a few of the most powerful AI impacts I’ve witnessed over the last decade that are applicable to many situations and not exclusive to Alignment

Enabling a proactive stance in our most vulnerable populations

With greater data visibility comes a more focused, proactive care delivery. In Alignment’s case, AVA enables exponential efficiencies for our physicians and their care teams. AVA

delivers real-time insights and access to a more complete picture of a patient's health at any given moment. Instead of reacting to an emergency, we are acting before early warning signs turn into a true emergency. Other companies using AI can expect similar positive integrations.

What does that look like in practice? Physicians can stratify members based on health status and instantly know which of their patients have multiple chronic conditions. Physicians can also see how social determinants of health such as transportation and food access are negatively impacting patient compliance and outcomes. They know who is frail, who needs medication, and who may just need some extra companionship. This 360-degree view of the patient population enables physicians and care teams to stay proactive with the most vulnerable members, providing efficient, coordinated care at just the right time.

Improving measurable health outcomes for seniors

Beyond enabling a more proactive care stance with the most vulnerable, AI can help improve accuracy in the ability to predict health outcomes. AVA operates on 170 machine-learning algorithms and hundreds of thousands of rules across 35 modules. That enables us to predict a patient's risk for hospitalization, readmission and mental or physiological disease propensity with a model that is typically 20% to 25% more accurate than traditional methods.

Compared to 2019 Medicare fee-for-service benchmarks, with the assistance of integrated AI, Alignment members had:

- **48% fewer ER visits**
- **37% fewer member hospital admissions**
- **26% lower member 30-day readmission rate**

For those affected by chronic conditions like diabetes, AVA empowers members with the tools to manage their health proactively, from kidney disease monitoring to blood sugar control. For example, proactive diabetes care resulted in more than a 1.5-point average reduction in Alignment members' average blood sugar levels (HbA1c) after 12 months of enrollment in the company's *Care Anywhere* programs. According to the BMJ, a high-impact peer-reviewed medical journal, a 1-point reduction in HbA1c leads to a reduction in health risks, including a 21% reduction in death from diabetes.

What does that look like in practice? It can look like AVA flagging a fall risk after an in-home caregiver report mentions the words "loose area rug" or "uneven floorboards." It could look like AVA flagging a pharmacy alert for a missed insulin prescription. It could look like AVA flagging an increase in calls for transportation or to a mental therapy hotline.

Creating an empowered, personalized experience for today's seniors

Seniors are consumers. Just like for other consumer products, they have higher expectations for personalized, timely services. Today's seniors are more tech savvy than past generations and they want the ability to better manage their health

care. To that end, they are more comfortable using digital tools to get what they want.

What does that look like in practice? AVA allows us to predict member needs and personalize their experience accordingly. For example, our Asian or Hispanic members may want to see physicians and care teams that understand their customs and speak their language. AVA allows us to make the most relevant recommendations based on patient history, location data and more.

The future of AI in Medicare Advantage looks bright

AI has elevated the member experience and dramatically improved the way providers care for patients and achieve better outcomes. I'm optimistic that the trends in value creation, efficiency and quality outcomes will continue. The ability to reduce provider burnout alone is priceless. AI can alleviate healthcare burnout by automating repetitive and monotonous administrative tasks, offering diagnostic insights, and streamlining administrative duties. AI chatbots can handle routine inquiries, allowing healthcare professionals to concentrate on patient care and more complex tasks.

However, as AI continues to get smarter, so must the data scientists who feed it. We will need to invest more time in understanding the negative potential of biased data, and how to keep empathy and compassion for patients at the center of what we do. Having a human in the loop is important to bringing context to AI and helping it understand causality versus correlation, which is important in medicine.

We as humans need to continue to be part of the team developing AI tools to ensure guardrails are in place and checks and balances are measured to provide the highest quality outcomes we can. As we push forward, we must remember that high tech will never replace high-touch quality care.



Dr. Arta Bakshandeh, D.O., is chief medical informatics officer for Alignment Health, a Medicare Advantage company championing a new path in senior care. He joined the Alignment team in 2014 to help build Alignment's clinical model and clinical command center.

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Nine Questions Women Asked Us About LTCi

Long term care challenges impact women both as caregivers and recipients of care. In a recent webinar titled “Women and Long-Term Care,” we reviewed these challenges with a panel of female long-term care experts. They offered solutions for ways that women could navigate the complexities of caring for a loved one and planning for their own care.

After we presented the challenges, it was clear that creating a personalized long-term care plan could provide women with much deserved peace of mind. We were thrilled to receive as many questions as we did about the topic and many of them centered around long term care planning. We’ve provided some of the top questions in this article.

The long term care planning process is personal and it’s important to understand what options are available to your female clients and what the long-term care planning process involves. Here are highlights from the webinar.

At what age should I purchase long-term care insurance?

A: This is always one of the questions we are asked the most and the answer is not as simple as the question may sound. Many people wait to purchase LTCi until the ages of 40 to 65, and some purchase after they have had a personal experience with a family member who required care. However, the younger your client is when they plan for long-term care, the more options they generally have and the more affordable the coverage. That’s not to say that older people don’t have options. A good long-term care specialist can help your client determine what is available.

How do we pick the right insurance company?

A: The best approach is to advise your client to speak with a long-term care specialist about their needs and their budget. The specialist will make recommendations about products that might be a good fit for your client and they can provide information on the carriers. Insurance companies are regulated by each state in which they do business. They are also rated by independent agencies such as AM Best. Encourage your client to do their own research on any company that they might be considering. Better yet, offer to partner with a specialist to advise your client as part of building their long-term plan.

Would you explain the difference between hybrid and traditional or standalone long-term care insurance?

A: Long-term care insurance was created with the specific purpose of providing a pool of funds that can help pay for long-term care costs. Traditional long-term care insurance typically works like auto or home-owners insurance — you pay a recurring premium with the objective of getting the maximum risk protection in the future. You hope to never use the policy, but if you do, most of your premiums go toward the LTC coverage. Your client generally doesn’t receive money back if they don’t need long-term care services.

Hybrid or Linked Benefits plans provide long-term care benefits that are usually linked to a life insurance policy or an annuity. Premiums are often paid as a lump sum or over a specified number of years. Hybrid products have become popular as more options have emerged to fill gaps in the standalone market. Pricing and insurance leverage has become more competitive in the Hybrid market over recent years. Hybrids may offer guaranteed premiums, guaranteed LTC benefits, cash indemnity benefits, and even significant life insurance or annuity benefits if long-term care is not needed. Hybrid plans can be appropriate for people with health issues but may also be used in some cases together with a traditional plan. Seek out more information on planning for LTC when your client has a health issue.

Sometimes all of these extra features do not cost significantly more for the same level of LTC benefits as a standalone policy. As usual, a specialist can help your client shop the market to find the best value for their situation.

What does it mean to self-insure?

A: Self-insuring is also known as self-funding. It means that the person receiving care will cover some or all long-term care costs out-of-pocket through income or savings. One of the challenges with this approach is that the cost of care in the future can quickly drain savings. Once you exhaust savings, your client is left with few options outside of Medicaid. Insurance can offer a larger pool of funds that can protect their savings, relieve their family members of the burden of caregiving, and provide your client with many more options that may include home health care.

What is the minimum and maximum policy you can purchase?

A: That depends on your client’s situation and what they want to achieve with their long-term care plan. As a general rule, you will first want to do a needs analysis and the cost of care today and in the future with inflation. There are cost of care surveys available. Most people choose a plan that pays between \$3,000-\$9,000 per month as a starting point (\$100-\$300 per day) depending on their budget for insurance and the cost of care. Then, they determine if they want the benefits to grow and how many years of coverage they desire. Often, these choices are based on how attractive the insurance price is, along with personal experiences in their own family with long-term care needs and the quality of care they desire. For those willing and able to pay out of pocket, insurance can be a supplement to self-funding. The best insurance plan for your client is one that they can afford over the long term.

Is there protection against inflation?

A: Yes. Many policies offer compound inflation protection as an added rider to the policy. Inflation protection options may be higher or lower depending on what the carrier offers and what your client feels they can afford. Inflation growth is important because given the shortage and cost of quality care providers, we expect that the cost of care will continue to increase faster than general inflation.

My husband and I are 50 but concerned about keeping up with the premiums. What type of monthly or annual premiums can we expect in the future?

A: The beauty of creating a long-term care plan is that the cost of insurance can be tailored to your client’s budget. That means that long-term care insurance may be more affordable than your client thinks. The key is to understand the premiums paid for the total insurance benefits available in the future when they are most likely to use the coverage.

We find many clients paying as little as a few hundred dollars or less per month in premiums. However, more often clients will buy more coverage if the product value is expected to cover the cost of care more fully. It even makes great financial sense to pay higher premiums now but pay over fewer years with a limited pay policy, so that you can pre-pay or lock in the rates.

The best way to understand what is best for your client’s situation is to calculate their total premiums and compare to your client’s total policy benefits in the long run.

What if I move or I’m traveling? Are policies good in every state?

A: Yes. Private long-term care insurance offers national — and in some cases, international — portability of your benefits. Be sure to let your client’s long-term care specialist know if your client has plans to move out of state or travel extensively, and make sure they find a plan that will follow your client.

What is the process for filing a claim?

A: Your client can file their claim with the insurance company as soon as it is determined that long-term care assistance is needed. That requires a physician determining that the covered person cannot perform two out of six activities of daily living (basic physical needs, including personal hygiene or grooming, dressing, toileting, transferring or ambulating, and eating.) Make sure your client goes through the policy to determine if there is an elimination period (deductible) which is commonly 90 days or less. Advise your client to respond promptly to all

requests for information completely and accurately when they speak with a claims representative.

BuddyIns has relationships with community partners who are long-term care claims advocates.

We would love to provide more information and resources about long-term care planning, caregiving and tips on healthy aging.

Learn More: www.buddyins.com/calbroker

The beauty of creating a long-term care plan is that the cost of insurance can be tailored to your client’s budget. That means that long-term care insurance may be more affordable than your client thinks.

PUBLISHER’S NOTE:

California Broker is pleased to have a collaborative relationship with Buddy Insurance, a leading long-term care insurance education, marketing and technology company. CEO Marc Glickman and his specialists will collaborate with health and life insurance professionals to help design LTCi options. Learn more about LTCi and refer clients — or learn how to write your own LTCi policies using Marc’s system.

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5

Ways to Use Short Stories to Attract Ideal Clients

How many times have you heard that using short stories in the client acquisition process is an effective strategy? Probably a lot. So, are you using stories? Have you developed a small inventory that you can apply to the right situation? Here's more information to help you get started.

By Bill Cates

Two Benefits of Using Short Stories

They bring your value proposition to life. If your value positioning statement isn't crystal clear and/or filled with jargon, your prospects may be a bit lost. A good short story adds context and clarity.

Your prospects' brain loves stories. Thanks to a process called Neural Coupling, a story activates parts in the brain that allows the listener to turn the story into their own ideas and experience. The benefits you offer as told through stories become more relevant to your prospects.

Five Places Stories Can Be Used to Boost Client Acquisition

I've identified five places in your client acquisition process where an interesting and relevant story can help you seal the deal.

1. Client Focused "Why" Stories

This is a quick story that brings to life why you believe in your value. It could be why you got into this business or something you observed with one or more of your clients after being in the business. It could be why you're with your current firm, why you went independent, or why you believe what you do is more important now than ever before.

We recommend using this story with prospects in your first or second meeting. It will help them engage with you, win their business, and become more referable.

Here's more information on the Client-Focused "Why": <https://bit.ly/3sKMI1R>

2. Differentiation Stories

Creating differentiation that is meaningful in the eyes of your prospects and clients is not always easy to do. Whatever you choose to hang your differentiation hat on, you will gain more traction if you bring it to life with an example — a short story.

Remember — Only differences that matter... matter. In other words, when you talk about your differences make sure to tie it to specific benefits that are relevant and desired by your ideal prospects and clients.

3. Benefit Stories

Most financial professionals talk in terms of features and rarely translate those features into clear advantages and tangible benefits that their prospects want. You should never assume that when you talk about any aspect of your business that your prospects and clients will automatically understand the benefits to them.

Here's a simple example. The fact that you do financial planning is a feature of your business. The clients having that plan gives them an advantage — with that plan they make better decisions. The benefit is better decisions, more clarity, confidence and peace of mind.

Having one or more stories that paint this picture will help your prospects and clients fully understand the benefits you can bring to them.

4. Transformational Stories

If you bring a robust suite of services to your clients — not just one or two products — you have the ability to transform their lives — financially and in other ways.

For example, I just interviewed a successful advisor that helps his clients accomplish items on their bucket list. He learns about their dreams and then supports them in various ways. Sometimes he'll make sure they set aside money to fund a dream. Sometimes he just keeps nudging them to get them into action.

And since money intersects all aspects of one's life, when you transform their financial life, you transform other parts of their life.

What short stories can you share that demonstrate your ability to transform their life?

5. Recommendation Stories

I could have called this "Closing Stories," i.e., stories you use to close the new business. But I just don't like the word "closing" when it comes to bringing on new clients.

I've found that one technique that works quite well is to make a recommendation that asks them to make a decision.

Here's an example:

"George and Martha – Based on all that we've discussed today, here's what I recommend we do next. Let's get started on your financial plan. You are going to learn so much in the process and through implementation of the plan, you're going to gain a huge amount of clarity and confidence toward your financial future. Do you see any reason why we shouldn't get this started right away?"

So where does a story fit into this context? You can tell a story of a prospect who did exactly as you had recommended and share the benefits of that experience. I suggest you tell this story before you make your next-step recommendation. They will be inspired by the story and, therefore, more likely to follow your lead.

ACTION STEPS

- With your team, start building an inventory of these short stories. Write them out in just enough detail so you can remember them. Keep them on the short side. No long and rambling stories allowed!
- To support your efforts, grab my 1-Minute Case Study Guide here:
<https://referralcoach.com/wp-content/uploads/2021/07/Cates-The-Minute-Case-Study.pdf>



Bill Cates, CSP, CPAE, is president, *Referral Coach International*. He is the author of "Get More Referrals Now," "Beyond Referrals" and "Radical Relevance." Cates is a highly sought-after coach, consultant, international speaker, and virtual presenter.

CalBroker readers can get valuable free tools here:
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Looking to free up time for other insurance lines or to semi-retire?

Sell some of your commissions

A growing trend for many health insurance professionals is to build new revenue by adding new lines of business. To be successful in this effort, you can learn to build referrals, including using tips we explain in articles featured in CalBroker. It is also common practice to carve out time to pursue other insurance lines by selling some of your commissions (and unburdening yourself of the required client support). Either way, when you want to add new lines, it will likely take time to become knowledgeable and then more time to find leads.

First, determine value

For many active health insurance professionals, the first step is to look at the value of their book of business and how much time is spent retaining clients. Time saved spent on the service work required to retain clients needs to be calculated and then compared to the opportunity to sell some of their book of business — but not all. It may become evident that selling the commissions for a less profitable line of health insurance would make sense to gain the time to build revenue with new product sales. Another aspect to consider is the time required to prepare annually for renewal season for certain business. And, finally if any staff or other expenses can be reduced with a partial sale, this may also help lead to a decision.

When selling some commissions, brokers desire to either spend time enjoying other pursuits in partial retirement or gain the “new” available time to build other lines of insurance business.

Case studies illustrate solutions

The cases presented involve three actual situations where health insurance professionals evaluated how to best use their time. One broker made the decision to sell only their Medicare Advantage book. Another decided to make a complete exit after looking at the options. Still another broker decided to only sell their MAPD/PDP business and keep their Medicare supplement clients. Finally, our third broker decided to sell part of their small group business while keeping the small groups that required the least amount of service effort.

Health insurance professionals are individuals. When offered only ONE solution, it is often not the best solution. Health brokers should shop around for more input and develop multiple options.

Case #1

Becky has a Medicare only practice with a 50/50 split between MAPD and Medicare Supplement. She realized if she could avoid going through the annual AHIP process, the time saved would be significant. Becky decided to keep her Medicare Supplement commissions. These clients would need little service each year. She would also avoid the time it takes to complete the annual certification process and address clients during the annual election period (AEP). With this change, she would win back time in the fourth quarter while gaining income from the sale of her MAPD and PDP book of business.

With this decision, Becky realized her goal to have the option to travel more in the fall and begin selling long-term care insurance to her clients. A key to the final decision was the fact she found a buyer for her MAPD clients who could successfully manage her Medicare Supplement client’s drug plan review process every annual election period. She settled on a buyout that was based on a split of commissions over a period of a few years. Another key for Becky was her buyer also agreed to protect her Medicare Supplement commissions. Now she has a succession plan in place to protect the Medicare Supplement commissions she kept.

For the MAPD and PDP commissions, she had a written agreement to get paid 50% of her commissions annually for several years. She now also has this same arrangement for her Medicare Supplement clients. She added to her agreement that her buyer would manage the annual PDP work in a friendly role with her Medicare Supplement clients who needed to shop for a drug plan during AEP. Her formal Commission Protection Agreement with the buyer includes all the essential work required to protect her commissions earned from Medicare Supplements clients in all life events.

Becky liked the idea that she could stay actively licensed and enroll people in Medicare Supplements and her commissions are now protected 100% in all life events. Becky also knew if a lead wanted an MAPD plan she would get paid for referring them to her buyer.

Tax implications

Becky realized the tax problem with a one-time payment and realized she would get a higher payout than one-time payment offers is she chose to be paid over time — a better option than a one-time payment due to the reduced net payout amount and the severe tax intensiveness that results in a lower after-tax amount for her.

Case #2

Another broker, Randy, moved into health insurance sales after a long and successful career building businesses in other industries. He was able to sell two businesses and then moved into full retirement. As a retiree, Randy turned sixty-five and enrolled in Medicare and immediately explored giving the Medicare business a try. Since he was active socially with friends and enjoyed helping solve problems for people, he was natural. Fast forward ten years and Randy's Medicare book of business was large enough to be attractive to buyers. With plans to relocate coming soon, he decided to retire and sell all his health commissions. When he shopped around, his prior experience in selling businesses led him to a desire to collaborate with a buyer who had experience and a proven track record. After finding a couple options, it came down to personality and professionalism. Randy's final decision was based on his "must have" deal points and the fact the buyer he selected had delivered on the same points for several other brokers. Randy sold his Medicare business and was able to move to another state with his wife. Today they enjoy their retirement together.

Case #3

Jennifer had a group book of business and wanted to find time to sell more annuities and life insurance. She knew there would be a learning curve to be an expert and by selling some of her more service intensive group cases she would pick up the time needed.

It is always a tough decision to sell any business. Thoughts about life expectancy and also boredom after the sale surface. Many sellers spend time giving the decision a great deal of thought and look for outside input to gain objectivity in the decision process.

Many never consider they could sell part of their business, keep a portion and then have the time to add new lines of insurance. With health insurance commissions, one has the freedom to keep going for a long time or take cash out and retire partially or fully retire.

Jennifer consulted with personal coaches and colleagues in the industry and arrived at the decision to sell the groups that would free up the most time. The sale of some of her group clients and all of her individual and family plan (IFP) clients was executed with a qualified buyer who paid her over time and split commissions during her buyout period of time. After the sales, Jennifer retained two thirds of her total commissions and picked up two full days a week to build her life and annuity business.

Summary

Many health insurance professionals love the annual cycle of open enrollment and the annual commitment to the client management process. They like how client's require them to be available for service and support when needed. Conversely, when the fire to work through the annual cycle of renewals fades, it makes sense to look to either exit soon or protect your commissions while active to eliminate the risk of losing them. When either a Group Benefits broker or a Medicare specialist

decides to explore what it would be like to have an exit plan for some or all their commissions, it pays to research the options. Our experts are at your service to put the best practices to work for you to protect and/or sell your health commissions.



Phil Calhoun is owner and publisher of *California Broker Magazine*. He is an active member of several insurance associations including the California Association of Health Insurance Professionals (CAHIP) and local chapters in Orange County, Los Angeles, San Diego and Inland Empire Health Insurance Professionals.

Phil's book, "The Health Broker's Guide: To Protect Grow and Sell Commissions" is available free@ www.healthbrokersguide.com. For a free 15-minute consultation, call 714-664-0311 or email phil@commission.solutions.

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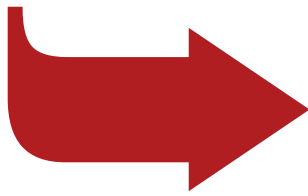
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SOCIAL MEDIA MARKETING



Made...Easier

6 tips for your social media marketing strategy

BY SANDRA GEBHARDT

When we think about social media marketing it can be overwhelming. Watching others marketing their insurance agency online with great success can give us a bit of a bump in swagger and bravery. So, we go all in.

Listen to podcasts, watch YouTube videos, buy a course or two, copy what others are doing, post on all the platforms we have an account on. Then we sit back and wait for all the leads to come in. The sun sets and rises. We wake up and rush to our computers to see all the new leads we have generated just to find there are none. Defeated, we wait a few days... watch more videos, listen to more podcasts and try it one more time. We find the same results. Frustrated, we go one of two ways. We give up completely or invest more time and money into trying to find the secret sauce others have seemingly found.

The Secret Sauce

Well, here is the secret sauce. Grab a pen or highlighter. Here is it *there is no secret sauce*. Write it down. No matter the amount of money you spend, podcasts you listen to... you will not be able to “cheat” the work that goes into building a foundational social media marketing plan. Yes, you can put up a viral video and end up with a larger following quickly. However, nothing is done in social media marketing strategies only once with success. It’s a constant feed of rich content that works.

So, what do you need to do? Look at social media as a tool to create small talk.

I’m going to give you six content tips that have helped thousands of insurance agents. First, we have to get our mindset right. Social media marketing is very much like networking in real life. You are creating relationships with other people. Remember that these are real followers, customers, referral partners.... real humans on the other side of your keyboard. Treat them as such. Build trust with them. Let them get to know you, your business, your family, your likes and dislikes, hobbies. This is the same stuff that you talk about in a real-life networking situation.

Content is a huge part of your success.

Content means the information, pictures and stories you are sharing on your social media platforms. Content seems to be one of the biggest hang ups people have when starting, or continuing, a social media journey. It can feel overwhelming to try to find something to say every day. People often will let their own mindsets talk them out of posting great content. Thinking things like “I don’t want to be too salesy, too braggy, too annoying.” Rest assured you are not the only person thinking these things.

We all struggle with this but we have to push through. When you are really struggling with these mindset blocks, think about what in person conversations you are having.

Create a content plan

Having a solid content plan helps overcome mindset blocks as well. So, here we go!

1. Educational Posts

One of the cornerstones of a successful content strategy is educational blog posts. These articles offer valuable insights, tips, and information related to your industry. By providing helpful content, you can position your business as an authority in your niche and attract a loyal following of readers seeking expert advice.

Life and health agents have been extremely successful with educational posts.

The secret here is to not try to over educate your audience. Often when agents go to make an educational post they focus on the ins and outs of policy information. Or they over-correct and try to use shame to guilt people into getting the correct coverages. Neither of these techniques will work for you.

Rather you want focus on the “why.”

Why should people reach out to you to get life insurance or health insurance? What makes you unique as an agent? Why should they work with you rather than a website or a call center?

Educate your audience on the importance of working with someone who can educate them on their policy...in the right ways.

Sample post: A post done correctly will look something like this:

“Did you know I spend at least 40 hours a month educating myself on the ins and outs of _____ insurance? This means that I am here to help you with any situations you may run into with your policies. Reach out to me today to discuss your insurance options!”

Or another example is:

“We started our office here locally because we love our community! We want to be part of the insurance solutions for our neighbors, family and friends. Trust that we have your best interest in mind when you are doing your insurance shopping. Don’t let big websites or call centers come in and confuse you. We are here to help!”



2. Customer Testimonials and Success Stories

Nothing speaks louder than satisfied customers. Share real-life success stories and testimonials from clients who have benefited from your offerings. These stories can build trust and serve as powerful social proof.

Ask your friends and customers to leave feedback on their experience. Often agents are worried about inconveniencing customers. Usually you will find they are happy to leave feedback. Try shooting quick videos on your cell phone with them. Post pictures of families you protect on your office wall. Their success and happiness are a direct result of your hard work and caring...be proud of that!

3. Behind-the-Scenes Content

People love to see the human side of businesses. Offer a behind-the-scenes look into your daily operations, introduce team members, and showcase your workplace culture. Such content humanizes your brand and makes it relatable.

This is an incredible opportunity for agents to highlight staff, referral partners, success stories and to not just talk about — but show — your audience what you do.

Examples:

- Your outreach in the community
- Your office and how welcoming it is
- Referral partners that you trust

Share your day-to-day workings and you will be amazed at the increase in direct messages you will receive and increased foot traffic.

4. Interactive Content

Engagement is key on social media. Host polls, surveys, quizzes, or contests to actively involve your audience. These interactive elements can also provide valuable feedback and insights.

Engagement posts will always get the most interaction or a very close second to pictures of yourself. When we post an engagement post we are asking a very easy question encouraging our followers to give their opinions.

Examples of engagement posts that work really well this time of year are:

- Do you open Chanukah presents every night, or just on the last night?
- Do you wrap your Christmas presents from Santa?
- Which is better: Hot Cocoa or Hot Apple Cider?
- Do you like a live Christmas tree or a 'packaged' one?

This type of post allows people to interact with you and your business without having to burn too many brain calories. It is important to interact with each comment you get on these posts. Pay attention to who is commenting. This will show you who is seeing your posts on a regular basis but may not be commenting.

5. FAQs and Q&A Sessions

Address common questions and concerns from your customers in a dedicated FAQ section or through live Q&A sessions. This demonstrates your commitment to transparency and customer service.

Bonus points if you do this in a video format. If you're not at the point of feeling comfortable on videos that is okay too. Just simply take your main FAQs and answer them. Remember insurance is an extremely confusing industry. When sharing information, work to use simple language, not industry jargon. Explain one question and one answer in the simplest way possible.

6. Infotainment

Mix information with entertainment to capture your audience's interest. Share interesting facts, trivia, or humorous anecdotes related to your industry. This helps keep your content engaging and shareable.

We build relationships with our followers when we share our likes, interests, hobbies, family and other personal. Infotainment allows us to mix in our swagger and personality into a combined business and personal post. Keep these posts fun and light.

Examples that have worked wonderfully for agents are:

"This weekend we had a great time as a family attending soccer games. I was able to also help two of our soccer families with their insurance needs right there at the event. I saved them time, got them into the best policies and we ended up winning the tournament! Woo Hoo!"

- Trivia Question: Do you know when the first life insurance policy was issued (invite everyone to guess)
- Trivia Question: How many jelly beans are in this bowl? (with a photo a jar of countable jelly beans)

Next steps

Pick some of your favorite suggestions from this list. Add to your calendar an appointment to post on your social media. Make it part of your daily routine. This should not take more than twenty minutes a day. There are services like **HootSuite.com** where you can schedule posts that will feed all your social media outlets at once, and report on responses.

When you feel discouraged — remember that we have a huge opportunity to reach many people. Traditionally we would have to attend multiple in-person meetings to get in front of prospects. Now we can generate leads, referral partners, advertise and build a solid marketing foundation for free and in a fraction of the time.

Rules of the road

Don't compare your social media journey and results with others. That is the fastest way to lose your own momentum.

What you are building is foundational. Built correctly it will generate leads and referrals for years to come. Realize some people have entire content teams working on their brands. For others, posting content is their full-time job.



Sandra Gebhardt is a digital marketer with years of experience. She is famous for being a power connector and helping small business owners fix advertising and marketing issues. She has worked with thousands of small business owners, trained in high ticket consulting groups, spoken at multiple events including TEDx, been featured in two documentaries, runs a top-rated podcast called

Binding Authority — all while being a wife and keeping the world's cutest 4-year-old entertained, happy and safe from falling off tall things he climbs.

Known as the "Queen Bee of Organic Social Media Marketing," Sandra is passionate about teaching agents to build their own personal brand. She also runs a group consulting course where she focuses on coaching and helping agents build smart marketing plans!

Find more information about this complex, sarcastic, fun-loving gal at:

sandra@sandragebhardt.com

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Gebhardt was a 2023 Ellevest Foundation Women's Leadership Summit Keynote Speaker



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Dispelling the Myths of Life Insurance

Dave Ramsey and the “Buy Term and Invest the Difference” Fallacy

Dave Ramsey is the founder and CEO of the company Ramsey Solutions, where he’s helped people take control of their money and their lives since 1992.

He’s also an eight-time national bestselling author, personal finance expert and host of The Ramsey Show.

**By
David McKnight**

Unless you’ve been hiding under a rock, you’re well aware that Dave Ramsey hates permanent life insurance. Here’s what he has to say about it on his website.

“There are two main kinds of life insurance (with a few other varieties we’ll deal with later). But the basic types are term life and permanent life insurance. Even though all the different forms of permanent life insurance are way more expensive and confusing than term life, that doesn’t mean they’re not popular. We believe that’s because many people just lack the info about these rip-offs.”

In other words, the only reason someone would enter into a permanent life insurance policy is because they haven’t done enough research. They’re gullible, and they simply don’t have enough information. Once a consumer gets fully educated, however, they’ll readily conclude that term life insurance is the only cost-effective way to

go. You’re much better off, Ramsey insists, taking the money you were thinking about contributing to your permanent life insurance policy, buying a term life insurance policy and investing the balance into a more traditional tax-free account like a Roth IRA or Roth 401(k). This approach has come to be known as “buy term and invest the difference.”

In an effort to buttress the claim that permanent life insurance is a rip-off, Ramsey will show you a comparison that looks something like this. Let’s say that you’re 35 years old and you contribute \$26,000 per year for the next 30 years into an Indexed Universal Life insurance policy growing at 6.24% per year. Let’s also say that Indexed Universal Life (IUL) has a \$500,000 death benefit. By the time you retire at age 65, your cash value will only be \$1,944,145.

Now, let’s instead take that \$26,000 per year and fully fund your Roth 401(k) at \$20,500 and put the remaining \$5,500 into your Roth IRA. For

comparison's sake, let's also grow those Roth accounts at the exact same rate of 6.24%. By the time you reach 65, you'd have \$2,304,271. That's \$360,126 more than you'd have in your permanent life insurance policy! In other words, by going the permanent life insurance route, you just made a \$360,126 mistake! "See, I told you that permanent life insurance was a rip-off!" Ramsey concludes.

Now, is the comparison that Ramsey's making here truly apples-to-apples or is it just a bunch of fruit salad? Let's break it down. What Ramsey's comparison fails to account for are two major expenses. The first expense is the cost of term life insurance.

If the IUL has a death benefit of \$500,000, then to be fair, you have to account for the cost of an equivalent amount of term life insurance in the "buy term and invest the difference" scenario. For a 35-year-old in good health, a 30-year term insurance policy for \$500,000 would cost \$804 per year. We'd have to subtract that amount from the \$26,000, leaving us with \$25,196 to invest in the Roth accounts.

The second expense that Ramsey fails to account for is the expense ratio inside those Roth accounts. An expense ratio is the cost you pay for the third-party investment management. Since \$20,500 of the total amount to be invested is going into the Roth 401(k), let's take a look at what its typical expense ratio might be.

According to the 401(k) Book of Averages:

"A company with 2,000 employees can expect to see an average 0.78% total expense ratio. In comparison, small business plans with 50 employees have an average expense ratio of 1.26%."

For our comparison today, let's assume a medium-sized company with an average expense ratio of 1.0%.

So, to be clear, if we're truly after in an apples-to-apples comparison, we can only invest \$25,196 per year into an account that's earning a gross rate of return of 6.24%, but a net rate of 5.24%. And what we find is that at the end of 30 years the "buy term invest the difference" scenario only produces \$1,649,036. Compare that to the \$1,944,145 you would have in your permanent life insurance policy!

What's more, at the end of those 30 years, that \$500k term life insurance policy expires. You have no life insurance coverage left. Conversely, at that same point in time the IUL has a total death benefit of \$2,444,215. So, your heirs would get the \$1,944,145 of cash value, plus about \$500,000 of life insurance for a total death benefit of \$2,444,215. Moreover, should you end up needing long-term care somewhere along the way, you can receive that death benefit in advance of your death for the purpose of paying for LTC.

In summary, when making his claim that permanent life insurance is a rip-off, Ramsey doesn't tell you the entire story. He omits key details that would otherwise vindicate permanent life insurance over time.

Now you may be saying, hey, I think I can do better than a 6.24% gross rate of return in my Roth and Roth 401(k) accounts. That may be the case. But you could also do better than 6.24% in your permanent life insurance. This is just the maximum amount the federal government allows to be illustrated. But guess what, if you can get a 6.24% gross rate of return without taking any more market risk than what you're accustomed to taking in your savings account, that's a pretty safe and productive way to grow at least a portion of your portfolio.

That said, let's assume that the best we can do with our IUL is 6.24% and we can grow our Roth accounts at 10%. Wouldn't the Roth accounts far outstrip the IUL over time? This is the other big fallacy that Ramsey perpetuates. No one's really suggesting that the IUL take the place of our traditional stock-heavy retirement plans. At least I'm not.

What I suggest instead is that you make your IUL the bond portion of your overall investment portfolio. Reach into your current investment portfolio, take out your bond allocation, and replace it with permanent life insurance. If you do so, you'll increase your return, lower your risk, lower the standard deviation of your entire portfolio and experience a better outcome over time. What's more, you'll be getting a death benefit that doubles as long-term care along the way.

Here's the bottom line: I'm not trying to make the case that you put all your money into Indexed Universal Life insurance. What I am suggesting, however, is that Dave Ramsey has taken a disingenuous approach in his claim that "buy term and invest the difference" is the only way to go. When you do a true apples-to-apples comparison, you'll find that permanent life insurance is a much more financially viable alternative than Ramsey makes it out to be.



David McKnight

graduated from Brigham Young University with honors in 1997. He has been featured in Forbes, USA Today, The New York Times, Fox Business,

Bloomberg Radio, MarketWatch, CBS Radio, CNBC, Yahoo Finance, Nasdaq.com, Reuters, Investor's Business Daily, Kiplinger's and numerous other national publications. David was a Focus Speaker at the worldwide annual meeting of Million Dollar Round Table (MDRT) in Toronto, Canada and is a multiple Top of the Table qualifier.

His bestselling book "The Power of Zero" has sold over 400,000 copies and the updated and revised version was published by Penguin Random House in 2018. This book was recently made into a full-length documentary film entitled "The Power of Zero: The Tax Train Is Coming." When his follow-up book "Tax-Free Income for Life" launched in November of 2020, it finished the week as the #3 most-sold business book in the world. He and his wife Felice have seven children.

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The Present State of Prescription Drugs and Health Insurance

How brokers can help clients save cash • By Emma Peters

In this article, we will explore the current state of the industry and highlight key innovations that can empower insurance professionals to better serve their clients. A survey produced by Kaiser Family Foundation shows that 61% of American adults currently take prescription drugs. According to another survey completed by Value Penguin,

- persons under 65 pay for 48% of their expenses for prescription drugs out-of-pocket
- but persons aged 65 to 79 pay 56%
- those age 80 and older pay 67 % of their total drug expenditures out-of-pocket.

The greatest impact of these statistics is the fact that almost a third of Americans under and over 65 have skipped filling a prescription, mainly because they couldn't afford it, or because their insurance wouldn't cover the cost. (<https://www.valuepenguin.com/prescription-costs-survey>)

Although these statistics may seem dismal, there are practical strategies that health insurance professionals should be aware of to best help their clients who are dealing with the high costs of their prescriptions.

Discount Drug Options

Discount drug programs have emerged as a cost-effective solution for patients struggling with high prescription drug prices, most often for brand name medications. These programs often offered by insurance providers, pharmaceutical companies, or third-party organizations, allow patients to access their medications at reduced prices.

Brand Name Drugs	Good Rx	Optum Perks	Single Care	Script Save Well Rx	Blink Health	Rx Saver
Januvia	Retail Price: \$614.89 Ralphs: 513.34	CVS/Target : \$545.33	Retail Price: \$708.29 Rite Aid: \$335.47	Rite Aid: \$509.30	Participating pharmacies: \$550.72	Ralphs: \$513.34
Oxycontin	Retail Price: \$249.54 CVS: \$51.98	CVS/Target : \$295.74	Retail Price: \$117.89 Walgreens: \$82.32	Rite Aid: \$87.77	Participating pharmacies: \$399.62	CVS: \$51.98
Ozempic	Retail Price: \$1,027.78 Ralphs: \$872.50	Walmart: \$469.3	Retail Price: \$1,199.32 CVS: \$774.27	Rite Aid: \$869.58	Participating pharmacies: \$18, 637.48	Ralphs: \$872.50

Here is a table that shows three popular drugs prescribed to people 65 and older, and a comparison of top discount cards that are available.

SingleCare is a prescription savings card available to all U.S. residents over the age of 13 for free. It is accepted at major pharmacies and can be used to save up to 80% on prescription prices.

> Medicare Extra Help is a discount drug plan for people already receiving Medicare. It is charged annually, and helps clients pay the monthly premium for Medicare's prescription drug coverage, yearly deductibles, coinsurance, and copayments.

Programs like these and more can be recommended by health insurance professionals to help guide their clients towards options that align with their specific medication needs but are lower priced.

Patient Assistance Programs and Manufacturer Discounts

Pharmaceutical companies have started to offer patient assistance programs and manufacturer discounts to make their medications more affordable. These programs span many different kinds of prescriptions for various medical needs.

Here is the website for the Asthma and Allergy Foundation where they provide resources explaining Drug Company Assistance Programs for these illnesses.

(<https://aafa.org/advocacy/advocacy-resources/patient-assistance-medicine-drug-programs/>)

These discounts can significantly reduce out-of-pocket expenses for patients. Health insurance professionals can play a critical role in educating their clients about these opportunities and ensuring they take advantage of any available savings.

Drug Tiers and Pharmacy Networks

Many health insurance plans employ strategies like drug tiers and pharmacy networks to control costs. Prescription drug tiers categorize medications into different levels of cost-sharing within health insurance plans.

Tier 1 typically includes the most affordable generic drugs, with the lowest patient copayments. As you move up the tiers, costs increase, with specialty drugs in Tier 4 and potential additional tiers for high-cost or exclusive medications requiring the highest cost-sharing from patients. If you would like more information on the different stages of coverage within Medicare for 2024, this video provides a comprehensive review of changes that are coming in 2024.

(<https://bit.ly/47nUuux>)

Value-Based Insurance Design (VBID) is an innovative approach that tailors insurance coverage to the clinical value of certain medications. VBID encourages the use of high-value drugs, often by lowering copayments for these medications.

Professor Mark Fendrick, director of University of Michigan's Center for Value-Based Insurance Design and the originator of VBID, explains the concept of VBID in practical terms. "Over a decade ago I told CEOs that their employees pay the same out-of-pocket for life saving drugs that they pay for drugs that make their hair grow back or their toenail fungus to go away," he shared. "A typical response to this would be 'tell me this isn't true, how did it happen, and how can we fix it?' To those three questions I answered: I don't know, I don't know, and value-based insurance design."

The Centers for Medicare and Medicaid Services (CMS) are testing out the Medicare Advantage (MA) Value-Based Insurance Design (VBID) Model. This model is designed to reduce Medicare program expenditures, enhance the quality of care for Medicare beneficiaries (including those with low incomes such as dual-eligibles), and improve the coordination and efficiency of health care service delivery.

Blue Shield has also implemented a VBID system to cut unnecessary costs. They have partnered with five companies to deploy the new value-based insurance

model, which is expected to save up to \$500 million in annual drug costs after the multi-year strategy is fully implemented. These companies include Amazon Pharmacy, Mark Cuban Cost Plus Drug Company, Abarca, Prime Therapeutics and CVS Caremark.

Telepharmacy

The COVID-19 pandemic accelerated the adoption of telehealth services, including telemedicine and telepharmacy. Companies such as TelepharmRx and Telepharm work with insurance providers to offer virtual doctor visits and prescription delivery services. These companies and others provide services such as virtual medication consultations, medication therapy management, prescription verification, and more. Insurance professionals can inform their clients about the convenience and cost savings of these virtual healthcare options and resources.

Specialty Medications

The management of specialty medications is a crucial area of focus in the insurance and prescription industry. Insurance providers increasingly offer programs to assist patients in managing complex, high-cost medications for conditions like cancer and autoimmune diseases. ProAct Pharmacy Benefit Management (PBM) offers help in navigating the specialty drug prices and in creating robust strategies for clients with their PBM partners. According to ProAct, a handful of mega-PBM vendors control 80% of the market. If health insurance professionals have clients in mid-market sized employer groups, ProAct and other businesses can provide partnerships that these vendors simply don't have the ability to reach. For individuals who work for smaller employers or have individual insurance, they must rely on local pharmacists, discount drug programs, and online shopping as PBMs only work with large employers.

It's no secret that the U.S. has some of the most expensive prescription drug prices in comparison to the rest of the world.

Brokers should be aware of companies such as The Canadian Medstore (www.drugstoreunlimited.com). They can help your clients find the best

prices on their prescription medications. This company started by sourcing prescriptions from Canada in 2003, and over the last few years have gained access to more world markets with affordable prices. They successfully source supplies from the United States, Canada, the United Kingdom, Australia, New Zealand, Germany, Turkey and India.

Biosimilars and Generic Drugs

The introduction of biosimilars and generic drugs can significantly reduce the cost of prescription medications. Health insurance professionals should encourage their clients to explore these alternatives whenever possible, as they offer similar therapeutic effects at a fraction of the cost. Generic drugs are approved only after a rigorous review by the FDA and after a set period that a brand product has been on the market. This is because new drugs, like other new products, are usually protected by patents that prohibit others from making and selling copies of the same drug for a defined period.

According to the Association for Accessible Medicines, "The amount patients pay at the pharmacy counter is where concerns lie. The average copay for brand-name drugs is more than nine times higher at \$56.12 than a generic drug for the same prescribed use. Fortunately, 93% of generic prescriptions are dispensed under \$20 (as compared to 59% of brand-name drugs)."

Although your clients may be overwhelmed by prescription drug prices and the complicated ins and outs of pharmaceuticals, there are practical ways to reduce these high costs that aren't often taken advantage of. Health insurance professionals can educate their clients on the strategies listed above, and effectively lower expenses for consumers.



Emma Peters is a media intern at California Broker Magazine. She recently graduated from Point Loma Nazarene University summa cum laude, with a Bachelor of Arts in Literature and a minor in Humanities.



Travel Medical Insurance

Why global telemedicine is now an essential benefit

By Don Van Scyoc

When it comes to travel medical insurance, the focus is often on major services not covered by domestic insurance. By “major” services I mean things like medical evacuation, emergency surgery and extended hospitalization — complicated services that require a lot of coordination and care and cost a lot of money. People envision injuries sustained by travel-related activities like snorkeling, hiking or driving cars or scooters on unfamiliar roads. The fear of these worst-case scenarios coming true is often what drives people to purchase an international healthcare plan.

But what about all the other, more everyday ways we use our domestic plans?

Reasons for accessing care often don't change when you leave the U.S.

Chances are the same types of concerns and illnesses that prompt you to contact your doctor in the U.S. would be the same things that would push you to see a doctor in another country.

Sinus infection, swimmer's ear, urinary tract infection, forgotten prescription refills — these are the everyday yet very important ways we're using our health insurance. While they're not “major” as compared with a medical evacuation, they certainly aren't minor. And in recent years, many of us have started relying on telemedicine as the most convenient way to seek treatment for these and other types of issues.

Telemedicine: an important benefit at home

Telemedicine has become an essential feature of our domestic plans. Rather than spending hours driving to an office, sitting in a doctor's waiting room and eventually meeting with the doctor in person, telemedicine allows us to speak with our doctors from the comfort of our homes, our cars or wherever we happen to be at the time.

We can have medications prescribed via telemedicine (and then even filled and delivered to our doors). The efficiencies it offers — in terms of both time and money — cannot be understated. And that's when we're close to home.

And an essential benefit overseas

Now, think how much of a difference telemedicine can make when you're in another country. You likely aren't familiar with your surroundings, don't have any local doctors and don't even know how healthcare works outside of the U.S. Where do you begin? Seeking medical care in other countries can feel so overwhelming that we may forego care for issues that would have us dialing up our doctor at home. Let's look at two different travel experiences.

Scenario 1: Traveling internationally without telemedicine

A family traveled to Europe for spring vacation. They did not purchase travel medical insurance. While on the flight, one of the children started experiencing a headache, cough and congestion. After arriving, he developed a fever and wasn't well enough to leave the hotel. His mother was up all night on her phone, researching the closest care facilities, but she was unsure where to turn. To make matters worse, it was a weekend, and many offices were closed.

Fortunately, when the child awoke the next morning, his symptoms began improving. But the mother was left shaken and exhausted. She spent the rest of their vacation feeling nervous that her child's symptoms would return. If the same situation had occurred at home, she would have called the pediatrician without hesitation.

Scenario 2: Traveling internationally with telemedicine

On the flip side, here's the story of someone who purchased travel medical insurance with a telemedicine benefit. She was in Cambodia and grew concerned with a bite that wouldn't heal. Although she visited a local pharmacy and was offered antibiotics, an allergy to penicillin prevented her from taking the recommended medication. Despite treating the wound with doxycycline and iodine, and taking anti-malaria drugs, her condition wasn't improving.

She accessed telemedicine via an app and had a remote consultation with a high quality, English-speaking physician. He advised her on the appropriate antibiotic to request from the pharmacy (taking her penicillin allergy into account) and instructed her on how to watch for side effects. A few days later she followed up via the telemedicine service to report that her condition had improved.

How people are using telemedicine when traveling abroad

Utilization data from our GeoBlue® telemedicine app shows that 80% of our telemedicine visits are for short-term travel, and an overwhelming majority of users are requesting a general medicine doctor. Furthermore, the top countries where members are accessing telemedicine include Italy, Spain, France, Canada and Germany. That's a little surprising, isn't it? These are countries where telemedicine may not seem necessary, given they have relatively easy access to care and highly qualified medical professionals, many of whom likely speak English.

What does all of this tell us?

People are using telemedicine from wherever they are because it's convenient. Once they become accustomed to using telemedicine with

their domestic plan, it's hard to envision being without it. It's like a safety blanket, and it's become an essential benefit to your customers wherever they are in the world.

Make sure your customers are covered by global telemedicine services

To be blunt, domestic plans likely won't cut it. Even if your client's domestic plan offers telemedicine and your customers are familiar with how to access it, they may not be able to use it. Why? Telemedicine providers have licenses that may prohibit them from practicing outside the U.S. This may come as a surprise to your customers, so be sure to explain the limitations of domestic telemedicine services.

Also, when discussing options for international health insurance plans, emphasize the importance of looking for a plan that includes **unlimited global telemedicine services as a standard benefit**. Not all plans offer it standard (i.e., at no additional cost), so that can be a deciding factor in choosing one plan over another.

New to travel medical insurance?

If you don't already sell international medical insurance, it's a great time to start! Here are some things to look for when choosing a carrier:

- Simple broker appointment
- Competitive commissions
- Marketing support
- A team staffed by industry experts to support your sales
- Easy, digital enrollment process with no medical underwriting and immediate approval (your customers will thank you!)

Even if you typically focus on domestic plans or Medicare plans, your customers ARE traveling. By including travel medical insurance (with telemedicine!) in your offerings, you're helping your customers by presenting a complete package of solutions that meet their needs. And you're helping your business, too.



Don Van Scyoc, VP of Individual Sales leads the sales and retention teams for GeoBlue's individual short-term travel and long-term expat sales through direct and brokered channels.

GeoBlue is the trade name for the international health insurance programs of Worldwide Insurance Services, an independent licensee of the Blue Cross and Blue Shield Association. For 25 years, GeoBlue's purpose has been to simplify the international healthcare experience for the globally mobile. Members have access to one of the largest care networks in the world, coupled with high-tech, high-touch services that enable them to fulfill their international aspirations.



**To learn more, go to:
[about.geo-blue.com](https://www.geo-blue.com)**

**Sign up to offer GeoBlue to clients of ALL ages who may be traveling in 2024:
www.geo-bluetravelinsurance.com/signup_landing.cfm**



Inland Empire Health Plan (IEHP) to join Covered California health care exchange

Inland Empire residents looking for health insurance through Covered California will see a trusted name on the list — Inland Empire Health Plan (IEHP).

The Rancho Cucamonga-based not-for-profit health organization will be among the list of options on the exchange for those seeking coverage in 2024. IEHP will offer four levels of coverage to consumers — including the lowest-cost silver plan option in Region 17 — when open enrollment begins November 1 and continues through January 31, 2024.

To help spread this exciting news, the IEHP sales and outreach team will work with external broker and navigator partners across the state to introduce IEHP and its new IEHP Covered plans. With over 27 years of expertise and care in serving the residents of Riverside and San Bernardino counties, and currently serving more than 1.6 million members, IEHP hopes to bring quality health care services to residents of the IE.

“Joining the Covered California exchange allows us

to expand our services to ensure that even more Inland Empire residents can enjoy optimal care and vibrant health at a more affordable price,” said Wayne Guzman, director of sales and outreach strategy for IEHP. “We are excited about our new partnership with Covered California and the dedicated certified agents and navigators who are vital to fulfilling our IEHP mission by serving our communities throughout the region.”

Known as the plan with a heart, IEHP is one of the top 10 largest Medicaid health plans and the largest not-for-profit Medicare-Medicaid public health plan in the country. To learn more, go to iehp.org.

IEHP’s sales and outreach team will be hosting webinars about IEHP’s transition into the Covered California market periodically throughout the rest of the year. If you are interested in attending or learning more about becoming an IEHP broker, send an email to brokerservices@iehp.org or call 844-264-IEHP (4347).

About IEHP

With a mission to heal and inspire the human spirit, Inland Empire Health Plan (IEHP) is one of the top 10 largest Medicaid health plans, the largest not-for-profit Medicare-Medicaid public health plan in the country, and for the third year in a row, certified as A Great Place To Work®. In its 27th year, IEHP supports more than 1.6 million Riverside and San Bernardino County residents enrolled in Medicaid or IEHP DualChoice (those with both Medi-Cal and Medicare). Today, IEHP has a growing network of nearly 6,800 providers and more than 3,000 team members who are fully committed to the vision: We will not rest until our communities enjoy optimal care and vibrant health. To learn more, go to iehp.org.

Join Us!

THE HEALTH PLAN WITH A HEART



IEHP enters Covered CA.

Lowest cost Silver Plan in Region 17 | Extensive quality-focused provider network

IEHP is entering Covered CA, offering the lowest cost Silver Plan in Region 17, Southern California's rapidly growing Inland Empire – and we want to partner with you! A trusted name in Medi-Cal and Medicare coverage for 27 years, IEHP is known as “the Health Plan with a Heart” in San Bernardino and Riverside counties, where it serves nearly 1.7 million members.

Join our growing network of Covered California broker partners today!



Email brokerservices@iehp.org
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The **HEALTHCARE** network that gives you more

When it's time for your clients to choose their healthcare, selecting the right medical group matters.

At Regal Medical Group, Lakeside Community Healthcare and ADOC Medical Group, we understand that quality healthcare encompasses more than just a visit to your doctor when you're sick. It also involves having readily accessible resources precisely when they are needed. This is why aligning with Southern California's largest physician-led network means more choices in providing the right solutions for your clients, including finding the right doctor and healthcare that best fits their needs. With over three decades of dedicated service, we have been caring for the diverse communities across Southern California, fostering healthier and happier lives.

We have thousands of doctors and specialists to choose from and everyday resources that extend beyond the doctor's office. With a focus on coordinated, comprehensive care and disease prevention, we offer well-rounded support for individuals and families through every stage of their unique health journey.

See why our members have chosen our network of doctors and hospitals:

- Largest doctor-led medical group in Southern California
- Comprehensive network of thousands of doctors and specialists
- Access to hundreds of local urgent care centers, labs, and hospitals
- Virtual and community health education, fitness classes, and more
- Appointment preparation
- In-person, online, and telehealth visits
- Preventive care and patient resources
- Contracted with most major health insurance plans
- 5-star rating in Standards of Excellence™ from America's Physician Groups
- They're never alone on their journey to better health

"Regardless of where a member is at on their journey, we meet them there," says Mindy Morgen, VP of Marketing and Health Education at Regal, Lakeside, and ADOC. "We work with members with a focus on making small, realistic changes that lead to

lasting and meaningful healthy life changes." On [HealthyWayEvents.com](https://www.healthywayevents.com), members can browse through daily offerings of free fitness classes like Yoga, Zumba and Strength and Balance, as well as Doc Talks, community events and health education presentations.

For members who have serious health issues or chronic conditions, Regal, Lakeside and ADOC offer chronic condition management programs and extra support custom-tailored to their needs. This can include resources like one-on-one health coaching, dedicated social services support, pharmacy consultation for patients and families, specialized care teams catering to short and long-term recovery and more.

"The goal is to provide a very customized and member-centered experience," says Nirav Shah, M.D., Senior Medical Director of Regal, Lakeside and ADOC. "We believe in the importance of well-rounded and complete healthcare — access to providers that speak their language and understand their culture, extra support beyond their doctor's office and a highly encouraging and comforting environment that is tailored to their goals and health needs."

Maximizing Medicare benefits for your clients

By working closely with our broker community during the annual open enrollment period, we strive to ensure that clients maintain precisely-tailored coverage to meet their evolving needs in the upcoming year. Our unwavering commitment is deeply rooted in the health and well-being of our valued members and the communities we are privileged to serve. And, with Medicare benefits changing each year, we do all that we can to help mitigate their out-of-pocket expenses, while simultaneously equipping them with the essential resources to maintain optimum health.

"We truly appreciate and cherish the invaluable partnerships we have formed with our esteemed broker community," states Maarten Lobker, SVP of Marketing at Regal, Lakeside and ADOC. "Their instrumental role in pairing the precise care and coverage for each member significantly contributes to our

ability to deliver seamlessly coordinated, top-tier healthcare that is focused on quality."

Seamless access to resources with our Broker Portal

By partnering with us, you unlock exclusive access to our online Broker Portal. Our dedicated Broker Portal is your gateway to indispensable tools and resources, all accessible from one convenient location. This platform streamlines the process of supporting and engaging with both your current and prospective clients. It is the ultimate resource at your fingertips, providing everything a broker requires for a successful enrollment year.

Sign up for our Broker Portal today if you haven't already. For detailed enrollment instructions and more information, please call:

- Orange County, Long Beach, Downey and surrounding areas (844)588-5287
- Riverside/San Bernardino Counties, Pomona, Chino and surrounding areas (844) 588-5288
- Los Angeles, San Gabriel and Ventura County (818) 516-4239

Introducing our NEW My Wellness Passport Program!

We're excited to announce the launch our brand-new My Wellness Passport program, beginning October 1, 2023. My Wellness Passport will guide and reward your clients' journey to better health.

It's an exclusive benefit for newly-joined Medicare Advantage and duals senior members who enroll after October 1, 2023.

- Offers members a chance to earn up to \$280 in e-gift cards for select health activities
- Provides one convenient place to keep track of important information

And, every newly-joined senior will be invited to an exclusive orientation session to educate them about our organization and to take full advantage of our value-added programs.

Members are eligible to earn rewards by participating in various health activities, such

as completing their annual wellness exams, receiving the flu shot, staying up-to-date with COVID-19 vaccinations and boosters, and attending Health Education fitness classes. It's that simple. Members receive rewards for engaging in health activities they would typically complete throughout the year. As an example, by subscribing to our monthly member e-newsletter, they can anticipate receiving a \$15 CVS gift card as a token of our appreciation.

At our recent 2023 Broker Mixer event in Long Beach, we distributed samples of My Wellness Passport, and the response was overwhelmingly positive. As we embark on this year's annual open enrollment, our broker partners are well-equipped to promote the advantages of My Wellness Passport, offering a compelling incentive for clients to prioritize and reward themselves for maintaining their health.

We help members find their HealthyWay

At Regal, Lakeside, and ADOC, we are committed to nurturing an environment that actively encourages overall health and

wellness. We believe that good health helps to inspire longer, more enriching lives. When your clients become part of the Regal, Lakeside, and ADOC family, they gain access to our free HealthyWay programs, designed to empower and support their journey toward a healthier lifestyle.

The health and wellness activities we offer through HealthyWay are designed for all ages and all fitness levels so that anyone can participate. There is something for everyone no matter where they are in their healthcare journey. We collaborate with a diverse range of professionals, including fitness coaches, health educators, physicians, community centers and more to bring fun and engaging classes and events all year along – always free of charge. Among the classes we offer are:

- Strength and Balance
- Fall Prevention
- Zumba
- Shao Chi
- Yoga

Our members also enjoy exclusive access to our extensive video library, where they can discover a wealth of pre-recorded content

covering diverse subjects including health and wellness, chronic disease management, and exercise routines. We firmly believe in the philosophy that mastering the art of incorporating minor adjustments into your daily routine can yield profound results in your overall health and well-being. Our purpose is to better every life we touch through the way we care.

Contact:
Senior Member Concierge Line
818-357-5000 option 1, then option 6.
brokers.regalmed.com

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When it comes to healthcare, network size matters

Regal Medical Group, Lakeside Community Healthcare, and ADOC Medical Group bring your clients comprehensive care close to home. We have been serving the community for 30 years, providing a vast network of quality doctors, specialists, hospitals, and urgent care centers throughout Southern California. With resources that go beyond the doctor's office, we help your clients live a well-balanced life through every stage of their healthcare journey.



One of SoCal's largest physician-led medical groups



Exclusive Broker Portal to access contacts and resources



Thousands of primary care physicians and specialists



Free online nutrition, health education and fitness classes



Hundreds of urgent care centers, hospitals and labs

For more information, please visit our dedicated broker portal at **RegalMed.com/Brokers.**



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