

AWARDEES RECOGNIZED • CARRIERS/PROVIDERS • PUBLISHER'S NOTE

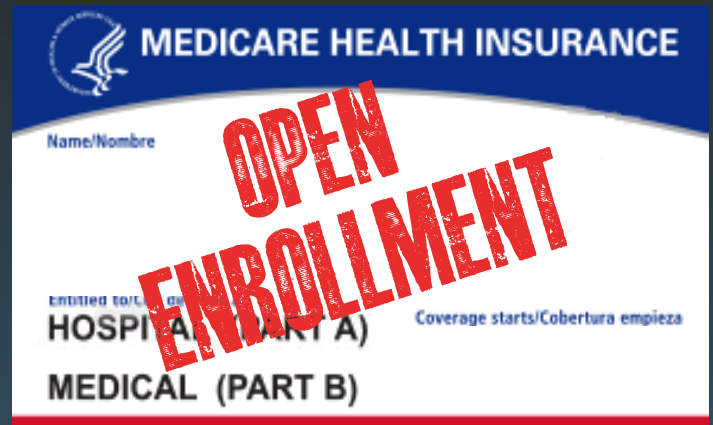
CALIFORNIA BROKER

SERVING CALIFORNIA'S ANNUITY, LIFE AND HEALTH INSURANCE PROFESSIONALS • MAY 2024



**Your
Client's
Health
Matters**

SPECIAL JULY MEDICARE ISSUE



REACH 120,000 HEALTH INSURANCE PROFESSIONALS

Special Issue Package to Include:

\$2,500

A. You get one two-page article in the Special July Medicare issue plus:

Your Two-page article is also sent out in our eNewsletter.

B. Two Half-page ads: One in the Special July Medicare magazine issue and the Second Ad repeated in the August magazine issue.

C. One-year eDirectory listing.

D. Year-Round inclusion of your events in Cal Broker's Monthly eCalendar of Events.

Our eCalendar of Events is posted- on our website, www.calbrokermag.com, in all of our magazines, and in our weekly eNewsletter.

E: ONE Hot Product email--- ALL Cal Broker subscribers receive a single, unique content email (between July and August.)

You also receive tracking reports of clicks on your content that is placed in our media

Special Issue Topics Planned:

- ✓ AEP Planning
- ✓ Medicare Summits in CA
- ✓ Prospecting tips for Medicare leads
- ✓ How to evaluate your FMO
- ✓ PDP impact for AEP
- ✓ MAPD new developments in CA
- ✓ Compliance issues with Medicare/CMS
- ✓ Changes in AHIP for 2025
- ✓ Silver Sneakers and other exercise programs for Medicare members
- ✓ Picking a PCP
- ✓ Provider issues for 2025
- ✓ Health care systems updates
- ✓ Medical Group updates
- ✓ Drug Formularies
- ✓ Tech and AI
- ✓ **Front Cover Option: AVAILABLE(Contact Us)**

Articles and advertorials due June 1st.

FOR MORE INFORMATION OR TO REQUEST
A MEDIA PLACEMENT AGREEMENT CONTACT

Phil Calhoun
publisher@calbrokermag.com
714-664-0311

REQUEST FOR ARTICLES & ADVERTISEMENTS FOR:

UPCOMING SPECIAL ISSUES



Reach 120,000 health insurance professionals

SEPTEMBER: GROUP BENEFITS



ARTICLES AND ADVERTORIALS DUE AUGUST 1ST.

Special Issue Topics Planned:

- Carrier Rates Changes
- Prospecting tips for Group leads and Inside
- Voluntary Ancillary Benefits
- Client Retention Tips
- How to evaluate your GA
- TPA Support
- Quoting Ideas
- Medical Network Changes for 2025
- Self-Funding from the Pros

- PEOs with BBSI
- Picking a PCP
- Joining a team
- Health care systems updates
- Drug Formularies
- Tech and AI
- Exit Planning Issues for Employers
- How to Sell your Group book of business –inside, outside, merge
- Protect Commissions remain active

Front Cover Option:
AVAILABLE (Contact Us)

NOVEMBER: LONG-TERM CARE INSURANCE

Special Issue Topics Planned:

- Group LTCi
- California LTCi Trends
- Hybrid LTCi Options in CA Grid
- In Home Care Services Grid
- LTCi insurance Subject Matter Experts- Glickman Family Story
- Small Facility Care Options
- Alzheimer's CA services/support
- New developments in LTCi
- Memory Care Services and Support
- Medical Care for Aging
- Hospice Care
- Skilled Care Coverage Options
- Care Giver Support
- Fiduciary Services
- Health care systems updates
- Drug Formularies
- Tech and AI

Front Cover Option:
AVAILABLE (Contact Us)



ARTICLES AND ADVERTORIALS DUE OCTOBER 1ST.

JANUARY 2025: LIFE AND ANNUITIES



ARTICLES AND ADVERTORIALS DUE NOVEMBER 1ST.

Special Issue Topics Planned:

- Prospecting tips for Group leads and Inside/ Outside the Box with CALCPA HEALTH, CCSB, MERPS
- Voluntary Ancillary Benefits
- Group Life options
- Collaboration with a Subject Matter Expert
- LTCi insurance Subject Matter Experts- Glickman Family Story
- Quoting and Sales support
- Concerns for 2025
- Underwriting
- Tech and AI

Front Cover Option: AVAILABLE (Contact Us)

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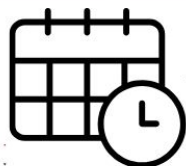
Insurance companies vary by region.

LIVE

STRATEGIES FOR SUCCESSFUL CLIENT RETENTION

WEBINAR

FIRST WEDNESDAY
OF EACH MONTH



JUNE 5TH

10AM- 11AM

Health insurance professionals can find ways to separate themselves from the competition when looking at the Best Practices of trusted advisors.

IN THIS WEBINAR, YOU'LL LEARN:

- 🎯 Common issues client face when using their health insurance benefits,
- 💡 Strategies to assist with accessing care to dealing with billing issues,
- 🚀 This and much more.

THE SPEAKER



CARMEN PONCE

VP of Client Services and Renewals

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Teams desktop app:

<https://bit.ly/3v0Y9XC>

1. When prompted to open desktop application
2. Select: "Cancel" option to open teams app.
3. "Click continue on this browser."

CALIFORNIA BROKER

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By Phil Calhoun

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2024

Commission Education Schedule— You're Invited Learn

How to Protect, Grow and Sell Health Insurance Commissions

MAY-JUNE-JULY WEBINARS

JOIN LIVE ZOOM MEETINGS

First Tuesday Webinars

Learn from retired brokers:

- How they made the decision to retire,
- How the process worked for them and why, and
- What made them select the Buyer they chose to trust.

MEETING ID: 843 0883 5586

LEARN FROM REAL CASE EXAMPLES

07 MAY @2PM

- DAVE AND LAURIE
- MARY
- RICHARD

04 JUNE @2PM

FATHER & SON

02 JULY @2PM

MAGGIE

Third Thursday Webinars

Learn how you can grow your commissions, the value of your commissions, and how to protect your commissions.

Take aways:

- How you can help a retiring broker sell their book to you.
- How to find the value of your commissions and then sell for more.
- What is the Best Practice to protect commissions.

MEETING ID: 878 1254 0453

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JULY

Commission Protection 101

View Recordings on our Vimeo Channel: <https://bit.ly/42Nj4Xb>

SCHEDULE YOUR FREE CALL



Schedule a 15 Minute Call

Get Time with a Subject Matter Expert in Commission Planning

- Discover How Personalized Planning Works
- Find New Ways To View How to Protect, Grow and Sell Health Commissions



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Industry News

Financial Literacy Month: Helping Gen Z and Millennial Consumers Navigate Today's Financial Landscape

Financial literacy is understanding financial concepts and products to make wise decisions with one's money. Being financially literate can lead to feeling more financially secure and able to withstand life's unexpected expenses.

Ideally, financial literacy should begin at home. According to LIMRA, about 8 in 10 Gen Z and Millennial adults said their parents discussed finances with them while they were growing up. Younger adults are more confident in their understanding of financial matters than older generations.

Yet, young adults feel less confident about their financial security. Data from the 2024 Insurance Barometer Study show that young adults report higher levels of financial concern than older generations about paying for medical expenses, supporting themselves if they are unable to work, and paying monthly bills. Time and life stages are significant here, as older adults benefit from having more life experience and time to build up their assets.

Additionally, more of today's young adults are reaching major life milestones — marriage, children, or home ownership — much later in life than their parents did. Life events often jumpstart the purchase of financial products like life insurance. The Pew Research Center finds that 25-year-olds today were less likely than 25-year-olds in 1980 to be: married (22% versus 63% respectively), have children (17% versus 39%), or live somewhere independently of their parents (68% versus 84%).¹

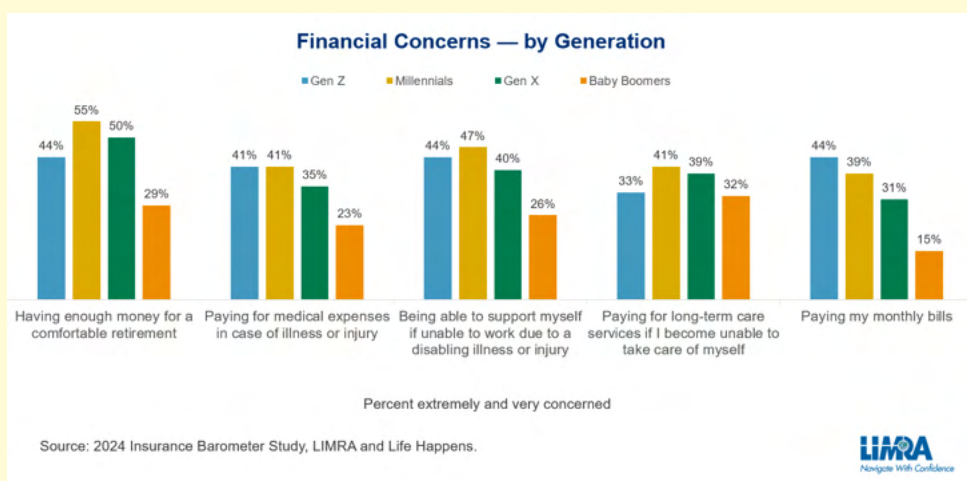
Arguably, young adults also face a tougher financial landscape today than their parents. The average cost of higher education, for example, more than doubled over two decades from \$152,716.89 in 2004 to \$320,431.43 (adjusting for inflation), according to the Bureau of Labor Statistics.²

Home prices nearly doubled over the past two decades as well — the Federal Reserve Bank of St. Louis reports the median home sales prices in the fourth quarter of 2023 reached \$417,700.³

Young adults would, therefore, benefit greatly from additional financial knowledge to help them successfully navigate the additional financial challenges they face. Two ways to help young people navigate today's financial landscape are through workplace benefits and financial professionals.

Workplace benefits programs can improve financial wellness:

More than 30% of Gen Z and Millennials say their personal financial worries have been a



distracted at work. More financial education can help workers address their financial challenges, reduce stress and improve employee focus and productivity.

LIMRA data shows that almost 7 in 10 young adults agree their employer should provide services that address financial stress. Additionally, 67% of Millennials and 64% of Gen Z workers agree their employers should offer employees financial education.

Financial professionals can boost financial literacy both individually and broadly:

Financial advisors can help young adults build healthy money management habits such as budgeting, saving for retirement, or funding an emergency savings account, while also demonstrating how products like life and disability insurance offer protection against the unexpected. A LIMRA consumer study shows that more than a quarter of young people say they value a professional who takes a holistic approach to their financial planning, addressing all areas of a customer's financial situation.

Financial professionals can also use social media to promote financial literacy to a broader audience of young adults. Visual, educational, and engaging content can make it easier for young people to connect with financial information. Among those who use social media for financial information, LIMRA data show the top 3 social media sites for young adults to use are:

Facebook: (67% Millennials and 54% Gen Z)
YouTube: (68% Millennials and 62% Gen Z)
and
Instagram: (54% Millennials and 57% Gen Z).

By helping young adults improve their financial literacy, they may take more action toward building a secure future regardless of the life milestones they achieve. A financial professional, for example, could highlight how a life insurance policy can be more affordable the younger and healthier a person is.

This month is a great opportunity for the industry to help improve consumers' financial knowledge and encourage them to take steps to build toward a secure financial future. The best time to learn financial literacy was yesterday, the next best time is today.

Show your support for Financial Literacy Month:

Educate and engage your consumers this month with our social media factoids. Download static posts below:

Download interactive content:
<https://bit.ly/447LP1y>

Sources:

1. "Most in the U.S. say young adults today face more challenges than their parents' generation in some key areas," Pew Research Center, 2022.

2. Price Inflation for College Tuition and Fees Since 1977, Consumer Price Index, U.S. Bureau of Labor Statistics.

3. Average Sales Price of Houses Sold for in the United States, Economic Research, Federal Reserve Bank of St. Louis.



Kaiser Permanente is now part of BBSI

We are excited to announce that Kaiser Permanente is now part of BBSI Benefits!

To Our Valued Partners:

We are excited to announce that Kaiser Permanente is now part of BBSI Benefits!

This addition brings you even more options and flexibility when it comes to offering your clients quality healthcare services. Kaiser Permanente is renowned for its comprehensive healthcare solutions, including primary care, specialist services, wellness programs, and more.

Here are a few key benefits of this new addition:

Expanded Network: Client access to Kaiser Permanente’s extensive network of healthcare professionals and facilities.

Comprehensive Care: Comprehensive healthcare service offerings, including preventive care, specialized treatments, and wellness programs.

Convenience: Promote the convenience of Kaiser Permanente locations for your clients’ healthcare needs, and experience ease of administration and support from your BBSI team.

Simultaneous Coverage: Aetna and Kaiser Permanente can be utilized concurrently within BBSI’s comprehensive network of healthcare providers.

At BBSI, we are committed to providing you with the healthcare options and experiences your clients expect, and partnering with Kaiser Permanente is a significant step in that direction.

If you are interested in learning more about medical benefits for your clients, our dedicated team is ready to assist you.

Thank you for partnering with BBSI. We look forward to continuing to serve you.

Rachael Stutzman
 Senior Vice President of Strategic Partnerships
 Rachael.Stutzman1@bbsi.com
 www.bbsi.com

Market Share CoveredCA

Francisco-based Blue Cross of California has the largest market share of insurers participating in California's ACA health insurance marketplace, Covered California, according to a California Healthline report.

Here are the top five insurers in Covered California, based on market share and enrollment.

- Blue Shield of California: 31 percent market share, 389,480 enrollees**
- Indianapolis-based Anthem Blue Cross: 25 percent, 310,690**
- Oakland, Calif.-based Kaiser Permanente: 24 percent, 297,030**
- Woodland Hills, Calif.-based Health Net: 11 percent, 142,790**
- Long Beach, Calif.-based Molina Healthcare: 5 percent, 68,590**

Calendar

2024 CONFERENCES

May 13-15,
CAHIP Capital Summit
 @Kimpton Sawyer Hotel, Sacramento,
 Register: <http://cahip.com/>

June 23-26,
Society for Human Resources
Management SHRM24 Annual
Conference and Expo @Chicago,
 Register: <https://annual.shrm.org/>

August 28
SAHU Business Medicare Expo,
@ 8:00 am-4:00pm,
Save the Date

October 6-8
NAIFA e3 Conference @ Sonesta
Redondo Beach & Marina,
 Register: <https://ca.naifa.org/e3>

May

May 15 @9:30AM-12:00AM Mental
Health Awareness Month-Membership
Meeting, @ The Odyssey 15600 Odyssey
Drive Granada Hills,
 Register: <https://bit.ly/4aRVuLT>

May 16: SAHU Golf Tournament @ The
Ridge Golf Club,
 Register: <https://bit.ly/4aDTo2E>

Virtual Trainings

May 8
@1:00pm: Unlocking the Power of
Personalization: Elevating Benefits
Offerings with Lifestyle Spending
Accounts on a Limited Budget,
 Register: <https://bit.ly/3TUPV8r>

May 14
@ 1:00pm-4:00pm, NABIP Live Virtual
Self-Funded Certification Course,
 Register: <https://bit.ly/4cRXaQz>

May 22
@ 11:00 pm -1:00 pm, CAHIP San
Diego Medicare Roundtable,
 Register: <https://bit.ly/4aDTo2E>

May 23
@11:30 am-1:00 pm NAIFA LA
Disability Plans with Petersen Int’l.,
 Register: <https://bit.ly/4d5dqEE>

May 23 @3:30 pm-6:00pm
CAHIP San Diego Legislative
Update Meeting @Riverwalk Golf
Club 1150 Fashion Valley Road,
 Register: <https://bit.ly/3Qa9HvR>



CALIFORNIA OT RULES : Help your clients with California overtime rules and exceptions.

Basic California Overtime Pay Requirements

For almost all nonexempt private sector California employees who are not covered by collective bargaining agreements, California overtime pay is based primarily on the number of hours worked in a day. However, you must also account for weekly totals when calculating California overtime.

Calculating California Overtime

The trickiest part of payroll administration is calculating overtime. You should use a step-by-step approach:

Identify those hours that must be paid on an overtime basis;

Decide whether you need to pay time-and-one-half or double-time for those hours; then

Determine the "regular rate" you must use to calculate the overtime pay.

Regular Rate of Pay

When calculating overtime pay in California, you must use the employee's "regular rate" of pay — which isn't always simply an employee's normal hourly amount. The regular rate is a term used to mean the employee's actual rate of pay after all hourly earnings and other types of compensation are considered, such as commissions, production/ nondiscretionary bonuses and piece rates. The regular rate must include nearly all forms of pay received by that employee (but certain payments, such as expense reimbursements and discretionary bonuses, are excluded).

Weekly Overtime

Only hours worked at straight-time apply to the weekly 40-hour limit. This prevents "pyramiding" of overtime, where an employee earns overtime on top of overtime already paid.

Salaried Nonexempt Employees

Paying a nonexempt employee a salary doesn't relieve you of your obligation to pay overtime. Nonexempt employees must be paid for all hours worked, including any daily or weekly overtime.

California Overtime Example

Calculating daily and weekly overtime in California can be quite confusing. Below is an example that shows the proper overtime calculations for one common situation.

Sample: Sarah S. Swingshift Sarah works the swing shift, usually starting work at 8 p.m. each evening and working into the morning of the next calendar day. Thus, each shift is partially in one workday and partially in another, as her employer uses 12:01 a.m. to 12 midnight as its "workday." Sarah's shift begins on Sunday night, the first day of the seven-day workweek used by her employer. Even though Sarah works a nine-hour shift (with a 30-minute meal break), the first four hours are on Sunday, and the remaining five hours (12 a.m. to 5:30 a.m.) are on the second workday — Monday. When Sarah returns to work Monday night, the first four hours are included in her time for Monday, and the next five hours on Tuesday. For any day in which Sarah works more than eight hours, she will be entitled to overtime for hours worked in excess of eight. To avoid the confusion caused by working on two workdays each shift, her employer might change the definition of the workday and workweek for employees on the swing shift, perhaps making their workday run from 8 p.m. to 7:59 p.m. each day, with a workweek starting at 8 p.m. on Sunday.

Overtime Exceptions for Specific Industries in California

The Wage Orders, along with various California statutes, contain certain exceptions to the general rules for calculating overtime and premium pay for specific industries, including agriculture, domestic work/ personal attendants, hospitals, transportation, residential care and many others. If you are in one of those industries, familiarizing yourself with the exceptions can help you avoid penalties and may even save you money.

5 things to know about health insurance contract negotiations

Blue Shield and Providence are in negotiations to continue their relationship which is set to end June 1st, 2024. With the past provider-carrier situations as a guide, this could be a bumpy road for the many Employer Groups and Individual policy holders who want to keep their Providence providers, doctors and hospitals.

We encourage Health Insurance Professionals as the key advocate for their client's insurance issues, to get ahead of this issue which may result in thousands of people losing access to their doctors and hospitals. Most of these people are clients of an insurance professional.

Blue Shield and Providence are vital players in the health care industry. We encourage you as your client's health insurance advocate to develop a plan for your clients should this change happen. Group clients do have options in most markets in California and they look to you to show them options. Work with your General Agency and get quotes as several employer groups will want to make a change to keep their Providence providers. Also, be prepared to help your clients who need continuity of care as they try and navigate this issue you can be a great resource.

Excerpt from Providence letter:

5 things to know about health insurance contract negotiations

Providence's first focus is our patients. We know you rely on Providence to keep you and your family healthy. Every day we are hard at work to make care more accessible and affordable for everyone we serve.

Yet, we face serious challenges. Health systems across the country and in our community, including Providence, are experiencing rapidly rising costs of care caused by inflation, labor shortages, wage increases and supply disruption. Additional financial stressors include SB 1953, California's seismic requirements, and SB 525, which increases minimum wage for health care workers to \$25 per hour by June 2026.

This is why we're negotiating with insurance providers – asking for fair and equitable increases.

The contract negotiations between Providence and Blue Shield may end up with a separation on June 1, 2024.

1. What is happening between Providence and Blue Shield?

For months, Providence has been negotiating with Blue Shield for fair and equitable reimbursement rates. Providence also is asking Blue Shield to stop denying or delaying coverage for necessary patient care.

Many patients are being denied treatment for essential care, including medications, therapies and procedures. This adds unnecessary stress to our patients.

Here are the facts:

- Denials increased by almost \$250 million from 2019 to 2023. In 2024, Blue Shield denials are already up 11.7%.
- Additionally, Providence accounts receivable balance due from Blue Shield has increased from 24.9% in 2019 to almost 37% in 2023, resulting in delayed payment to the health system for care provided to their members.
- Providence relies on adequate and timely reimbursement to pay its employees market-competitive wages and to fund new technology and cover the rising costs of pharmaceuticals and supplies, which increased 19% from 2020-22.

2. What Blue Shield plans are included in the negotiations?

Providence's contract with Blue Shield covers commercial HMO members including Trio HMO members, Blue Shield PPO members and Blue Shield POS members in California.

It also covers Blue Shield Medicare Advantage members enrolled with Saint John's Physician Partners.

Our Blue Shield Medicare Advantage members enrolled with PHN through Facey Medical Group and Providence Medical Associates and the Providence Affiliates are currently not impacted by this pending termination. In addition, Providence caregivers enrolled with Blue Shield through Providence will not be impacted.

3. What if I have an appointment or procedure scheduled at Providence?

- There is no change in care delivery at Providence hospitals, clinics and medical groups until the contract terminates on May 31/June 1.
- If you have a scheduled procedure or appointment on or after June 1, call Blue Shield to understand your options and so you can determine whether you want to keep the appointment/scheduled procedure with us or reschedule with another provider covered by Blue Shield. If you choose to keep your appointment, you may be required to pay out-of-network copays/co-insurance, based on the health insurance plan you have with Blue Shield. Call Blue Shield to understand your out-of-pocket costs.
- If you are pregnant or getting active treatment for a chronic condition you may qualify for extended in-network access, also known as "Continuity of Care" through Blue Shield. If you think you may qualify, call the

number on the back of your insurance card.

- As always, Providence will continue to provide care to anyone who walks through our doors. Our hospitals and clinics serve everyone, and patients can always access our services.
- Providence offers financial assistance for those who need help with out-of-pocket costs. Patients can call 855-229-6466 for help or visit [providence.org/financialhelp](https://www.providence.org/financialhelp).

4. Can I still use Providence for emergencies?

Yes. By law, patients always have access to our emergency departments, regardless of our contract status with Blue Shield. If you experience an emergency, you should visit the nearest emergency department.

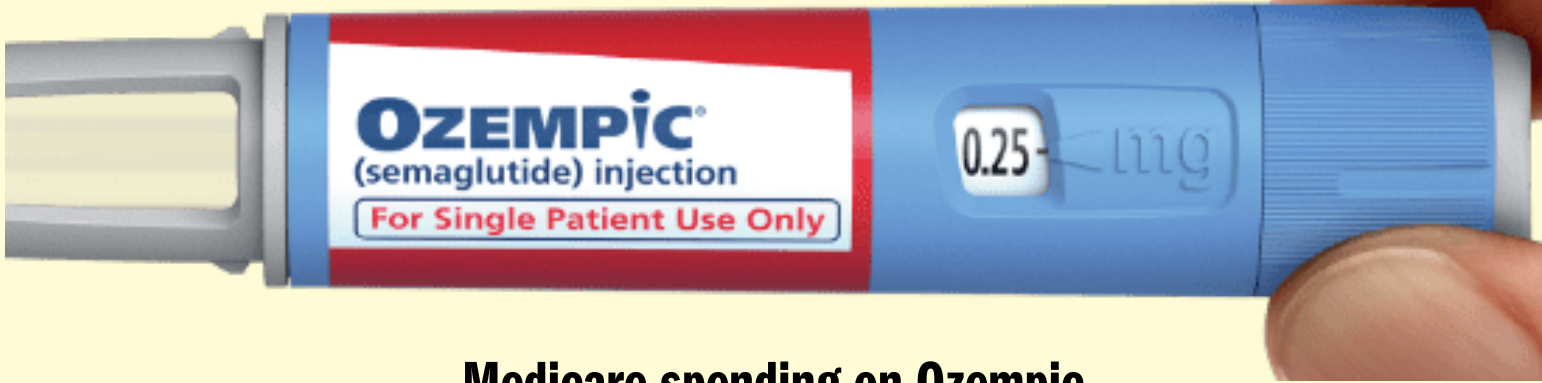
5. What are my options for continuing to see my Providence doctors?

- Starting June 1, 2024, Providence hospitals, clinics and medical groups may be out of network.
- If you have commercial HMO benefits, including Blue Shield Trio, and your employer group offers an alternate plan that's contracted with Providence, you can switch plans during open enrollment.
- If you purchased insurance directly, either on-exchange via Covered California, or off-exchange directly from Blue Shield, you can switch to a new plan during the annual open enrollment period.
- If you have PPO benefits, you can continue to receive services by accessing your out-of-network benefits.
- If you have a Medicare Advantage plan through Saint John's Physician Partners, you may be able to switch to a new plan via a special enrollment period.
- Call Blue Shield at 800-541-6652 with questions about how your insurance coverage may be affected if our contract expires.
- If you think you may qualify, call Blue Shield at 800-541-6652.

We understand that disruptions in your access to health care are frustrating and we will do our best to keep you updated. As always, Providence has a team of financial counselors available to help those who are uninsured, underinsured or otherwise unable to pay for their health care, providing assistance with medical bills, including free or discounted care. Patients can call 855-229-6466 for help or visit [providence.org/financialhelp](https://www.providence.org/financialhelp).

Thank you for trusting Providence with your health care needs.

Blue Shield of California FAQs
Blue Shield of California press release



Medicare spending on Ozempic sees huge spikes Total gross Medicare spending on GLP-1 drugs has skyrocketed, rising from \$57 million in 2018 to \$5.7 billion in 2022.

By Jeff Lagasse, Editor

Spending on GLP-1 drugs under the Medicare Part D program has increased dramatically in recent years, and the annual cost of these drugs in the United States – upwards of \$11,000 at recent list prices – has raised concerns about the fiscal impact of broad coverage of GLP-1 drugs on Medicare, other health insurers and patients, a KFF analysis finds.

GLP-1 drugs such as Ozempic, Wegovy and Mounjaro were initially developed to treat type 2 diabetes, but have demonstrated effectiveness in treating obesity and their popularity has grown as a result. These drugs are also being tested to treat other conditions, and the FDA has just approved a new use for Wegovy to reduce the risk of adverse cardiovascular events.

Medicare is prohibited under current law from covering drugs used for weight loss, but Medicare Part D plans can cover GLP-1s for their other medically-accepted indications, including to treat diabetes, and now to cut cardiovascular risk, based on a recent memo from the Centers for Medicare and Medicaid Services.

While the potential cost of authorizing Medicare coverage of anti-obesity drugs has presented a barrier to enacting legislation to lift the prohibition, covering these drugs under Medicare for authorized uses has already caused the medications to rank among the top-selling drugs covered by Part D, Medicare's outpatient drug benefit program, the analysis found.

The analysis of new Medicare Part D spending data from CMS shows that total gross Medicare spending on Ozempic, Rybelsus and Mounjaro has skyrocketed in recent years, rising from \$57 million in 2018 to \$5.7 billion in 2022.

WHAT'S THE IMPACT?

Spending on Ozempic alone increased substantially between 2021 and 2022, rising from a tenth-place ranking among the 10 top-selling Part D drugs in 2021, with gross spending of \$2.6 billion, to sixth place in 2022, with spending of \$4.6 billion.

In total, gross spending under Medicare Part D was \$240 billion in 2022; Ozempic accounted for 2% of this amount. This is before taking into account rebates, which Medicare's actuaries estimated to be 31.5% overall in 2022 but could be as high as 69% for Ozempic.

CONTINUE READING:

<https://www.healthcarefinancenews.com/news/medicare-spending-ozempic-sees-huge-spikes>



Colonoscopy

OPTIONS

By CalBroker

Colonoscopies are a critical screening tool, both on a diagnostic and preventative level. Insurance coverage can vary depending on the reason for the colonoscopy, as well as the methods and equipment used to perform the procedure. By understanding the different procedures, methods, and costs, you can guide your clients to make more informed decisions about colorectal screening options.

Preventative vs. Diagnostic Colonoscopies

From an insurance standpoint, coding and invoicing for a preventative colonoscopy differ from those for a diagnostic colonoscopy.

Preventative Colonoscopy

Preventative screening colonoscopies are typically covered by insurance as part of annual preventative services. The U.S. Preventive Services Task Force recommends that individuals between the ages of 45 and 75 receive screenings for colorectal cancer every 10 years. The Affordable Care Act (ACA) requires all Marketplace health plans to cover colorectal screening procedures free of charge.

Diagnostic Colonoscopy

Doctors suggest a diagnostic colonoscopy when a patient has symptoms, history, prior conditions, or test results that indicate an issue. An insurance company is more likely to require co-pays or payments toward a deductible for a diagnostic than a preventative colonoscopy.

Types of Colonoscopies

There are several types of colon screening and diagnostic methods to prevent or identify colorectal issues. The most common methods include standard colonoscopies, sigmoidoscopies, ColoGuard at-home tests, and virtual colonoscopies. Each has unique benefits, preparation requirements, and procedures.

Colonoscopy

A traditional colonoscopy is a physical procedure that involves inserting a camera into the patient's colon. This type of colonoscopy is still the best method for identifying polyps and potential signs of disease.

Preparation

Before the procedure, patients have to consume a clear liquid diet for 24 hours. The doctor will also prescribe special medication designed to clear the patient's bowel of anything that could compromise the doctor's ability to detect imperfections in the colon wall.

Procedure

The patient may be placed under moderate sedation, monitored anesthesia care, or general anesthesia during the procedure. The doctor will determine which type of sedation is appropriate, depending on the expected length and complexity of the procedure.

During a colonoscopy, the doctor inserts a small camera and light on the end of a narrow, flexible tube. They use the camera to survey the inner surface of your colon and identify any potentially cancerous polyps. Usually, they will remove polyps during the colonoscopy and send them to a pathologist for analysis.

Cost

Depending on insurance coverage, the patient may pay nothing for a preventative colonoscopy. The ACA requires private insurance providers and Medicare to cover colorectal cancer screenings. However, if the colonoscopy is diagnostic or if it returns a positive result for precancerous or cancerous polyps, the insurance carrier may charge a co-pay, coinsurance, or deductible.

Out-of-pocket costs for colonoscopies in California can be upward of \$5,000, so patients and providers benefit from working with insurance companies, if possible. Fortunately, if insurance covers the colonoscopy, the federal government has ruled that it must also cover the anesthesia and polyp removal.

Sigmoidoscopy

A sigmoidoscopy is like a colonoscopy but only for the lower part of your colon, which is called the sigmoid colon. The procedure is similar to a colonoscopy and is used to diagnose the causes of symptoms like diarrhea and abdominal pain.

Preparation

Sigmoidoscopies also require a clear liquid diet 24 hours prior and medical preparation to cleanse the bowel.

Procedure

Since the area being scoped is smaller and closer to the rectal opening, the doctor may use a shorter scope, which is typically flexible. To ensure the patient's comfort during the procedure, the doctor may use sedation.

Cost

Like colonoscopies, sigmoidoscopies are covered under insurance and Medicare if they are for preventative screening. For diagnostic sigmoidoscopies, the patient may owe a co-pay, coinsurance, or deductible.

Virtual Colonoscopy

During a virtual colonoscopy, the doctor uses computed tomography (CT) scans to create a 3D image of the colon. The doctor can review these images to identify abnormalities in the colon wall.

Preparation

Getting a clear picture with CT imaging still requires a clean bowel. The doctor will ask the patient to consume only clear liquids for 24 hours before the procedure and laxative drugs to clear the colon before scoping.

Procedure

Since a virtual colonoscopy is not invasive, the doctor will not typically use any form of sedation. During the procedure, a technician will take several X-ray images of the colon. A computer will combine the images to create a full 3D view of the colon. The test typically takes about 15 minutes.

Cost

Virtual colonoscopies are not as effective as physical colonoscopies for cancer screening. If a polyp is found, the doctor will still have to do a regular colonoscopy to confirm and remove the polyp. For this reason, Medicare and some insurance companies do not cover virtual colonoscopies.

The out-of-pocket cost for a virtual colonoscopy can exceed \$5,000. However, some providers, like Stanford Health, offer discounts for self-paying patients.

Cologuard At-Home Test

Cologuard is an at-home colon cancer screening kit prescribed by a doctor. It differs from a colonoscopy in that it does not use a camera or scope to look for precancerous polyps or signs of colon cancer. Instead of imaging, Cologuard detects DNA or blood markers in the stool that can indicate the presence of polyps or cancer.

Preparation

The patient's doctor must prescribe Cologuard because it's not available over the counter. The kit arrives in the mail, and the patient does not need to do any preparation before taking the sample.

Procedure

Cologuard is a testing kit for stool samples. The procedure is relatively simple. When the patient receives the kit, they unpack it, check the expiration date, and ensure the kit is complete with the following pieces:

- Sample container
- Tube with scraper
- Bottle of preservative liquid
- Toilet bracket
- Sample labels

The patient uses the kit to collect a stool sample and sends it to a lab for testing. Cologuard provides step-by-step instructions with the kit and on their website.

Cost

Per Cologuard's website, most major insurance companies and Medicare cover Cologuard testing. Patients and their providers should still check with the insurance carrier before ordering the kit.

Some insurance policies may cover Cologuard as a preventative measure. However, if a test comes back positive, the carrier may charge a co-pay or deductible. Without insurance coverage, the test can cost up to \$600, according to GoodRx.

Insurance coverage for colonoscopies depends heavily on whether the procedure is classified as preventative screening or diagnostic procedure. As trusted client advocates, you can help your clients understand how insurance handles various screening and diagnostic procedures when planning for colonoscopies and other colorectal cancer tests.

SOURCES:

1. CDC: "Colorectal Cancer Screening Tests."
2. HealthCare.gov: "Preventive care benefits for adults."
3. The University of Texas MD Anderson Cancer Center: "Colonoscopy anesthesia: 7 things to know."
4. The American Gastroenterological Association GI Patient Center: "Paying for your colonoscopy."
5. Centers for Medicare & Medicaid Services: "FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION (PART XXVI)."
6. Stanford Medicine: "CT Virtual Colonoscopy: Stanford Imaging Services."
7. Cologuard: "COLOGUARD® INSURANCE COVERAGE."

Harnessing the Future: The Best Health Tech Tools of Today



In an era where technology has become an integral part of our daily lives, it's no surprise that it's revolutionizing the healthcare industry too. From wearable devices to telemedicine platforms, health tech tools are empowering your clients to take charge of their well-being like before. Here's a glimpse into some of the best health tech tools shaping the landscape of modern healthcare:

By Emma Peters

Fitness Trackers: Devices like Fitbit, Apple Watch, and Garmin have become ubiquitous in tracking daily physical activity, heart rate, sleep patterns, and more. They provide real-time feedback, motivating users to stay active and make healthier choices.

Telemedicine Platforms: Telemedicine has surged in popularity, especially in recent times, offering remote consultations with healthcare professionals through video calls or chats. Platforms like Amwell, Teladoc, and Doctor On Demand provide convenient access to medical advice and prescriptions without the need for in-person visits.

Mental Health Apps: Mental health awareness has seen a significant rise, and so have the apps catering to it. Tools like Headspace, Calm, and Talkspace offer guided meditation, therapy sessions, and mood tracking, helping users manage stress, anxiety, and depression from the comfort of their homes.

Nutrition Apps: Maintaining a balanced diet is crucial for overall health, and nutrition apps like MyFitnessPal, Lose It!, and Cronometer make it easier than ever. They track food intake, provide personalized meal plans, and offer insights into nutritional content, empowering users to make informed dietary choices.

Smart Scales and Body Analyzers: Beyond just measuring weight, smart scales like Withings Body+ and FitTrack analyze body composition, including muscle mass, body fat percentage, and water retention. This comprehensive data offers a deeper understanding of one's health and fitness progress.

Remote Monitoring Devices: For individuals with chronic conditions, remote monitoring devices like blood pressure monitors, glucose meters, and pulse oximeters provide invaluable insights into



their health status. These devices enable users to track vital signs regularly and share data with healthcare providers for proactive management of their conditions.

Health Apps for Chronic Disease Management:

Conditions such as diabetes, hypertension, and asthma require diligent management, and health apps like Livongo, Omada Health, and Propeller Health offer tailored solutions. They provide personalized coaching, medication reminders, and behavior tracking to help individuals better manage their chronic diseases.

Sleep Trackers: Quality sleep is essential for overall health and well-being, and sleep trackers like Sleep Cycle, Oura Ring, and Beddit monitor sleep patterns and offer insights to improve sleep quality. By tracking factors like sleep duration, cycles, and disturbances, users can identify areas for improvement and adopt healthier sleep habits.

Online Medical Records Trackers: Platforms such as MyChart offer patients personalized and secure online access to portions of their medical records. It enables patients to securely use the Internet to help manage and receive information about your health and connect with their medical care team.

For more information on some rankings for these health tech devices, here are lists which have been compiled for fitness trackers and telemedicine platforms.

Which of these tools are covered by health insurance?

Since many of these digital health tools are newer and in various development phases, health insurance companies have been slower in providing coverage for their clients. However, as some of these devices have become more commonplace in healthcare spaces, they have been insured by certain companies. Telemedicine and Telehealth are tools that are the most widely covered by health insurance. According to HealthNews “Since COVID-19 made virtual consultants the norm, telehealth apps such as Doctor on Demand, Amwell, and Talkspace for mental health therapy have become widely accepted in the medical community. Most insurers these days

cover some of the cost of telehealth appointments. You usually must fulfill specific privacy requirements to get your appointment covered, but it isn’t difficult”. If your clients are covered by government programs such as Medicare or Medicaid, they will most likely have access to these services. The AMA found that Medicare and Medicare Advantage plans cover all 21 digital medicine services. Although it’s taking longer for commercial payers to cover digital medicine, they are slowly expanding coverage as these tools are more integrated in healthcare. On some SCAN Medicare Advantage Health plans, there are fitness tracker benefits (you can order a free FitBit every two years). SCAN also provides free membership for apps and online programs such as Rally and BrainHQ. Click here to discover which health tech platforms are available to SCAN members.

These are just a few examples of the myriad health tech tools available today, each offering unique benefits and functionalities. As technology continues to evolve, we can expect even more innovative solutions to emerge, further empowering individuals to prioritize and optimize their health journey. It’s important that health insurance professionals are kept up to date with these health tech tools that would best support their clients and are aware of what is covered by their specific health insurance plan.

Let us know which devices you like and if you are offering any to your clients. We want to share good ideas and your success stories with the Cal Broker community, so we can all stay informed and up-to-date.

Email Emma@calbrokermag.com

Nutrition Facts

Apple, raw

Serving Size 100g/3.5oz

Amount	% Daily Value
Calories 55	
Calories from Fat 1	
Total Fat 0.3 g	1%
Saturated Fat 0 g	0%
Trans Fat 0 g	
Cholesterol 0 mg	0%
Sodium 0 mg	0%
Carbohydrate 15 g	6%
Fiber 3 g	11%
Sugars 10 g	
Protein 0.2 g	
Vitamin A	1%
Vitamin C	8%
Calcium	1%
Iron	1%

Reading a Nutrition Label

BY MEGAN WROE

How many grams of fat is healthy? Is there a maximum milligrams of sodium? What on earth is inulin? These are just a few of the questions circling in most of our heads as we peruse the grocery aisles. It can be so hard to understand what all those numbers and words read on a label and then apply that knowledge to our own unique health needs. While every individual will need to look at labels differently due to their personalized nutrition goals, here are some more general label reading guidelines from a dietitian that will help steer you toward more health-supporting products and away from those that provide very little (if any) nourishment:

Skip over the calories. These are based on whatever arbitrary serving size has been selected for that product and does not tell us anything about the actual nutrition of that food. Case in point, diet sodas have zero calories, but I don't think any of us would argue that they are healthy food items.

Skip over cholesterol too. Our bodies make their own cholesterol whether we eat it or not. The current Dietary Guidelines have actually removed cholesterol restrictions since research shows dietary cholesterol does not translate to blood cholesterol levels.

Focus on the fiber. Your baseline number for anything with carbohydrate in it is 3g per serving. When it comes to fiber, the more the merrier so if you are comparing bread labels and everything else is similar but one has 3g of fiber per slice and the other has 6g, go for the 6g bread. 31 High-Fiber Foods You Should Eat (clevelandclinic.org)

Limit added sugar. Less than 4g added sugar per serving is your target. If "added sugar" is not listed then aim for less than 7g total sugar per serving. Also keep serving size in mind – if you are choosing a cereal that has only 3g added sugar per ¼ cup but you eat a full cup at breakfast, that's 12g added sugar per bowl my friends.

Recognize the ingredients. If the ingredient list looks like a recipe and you could find each of those items at the store if you wanted, it is generally a less processed food. If the ingredient list looks like a science experiment with more chemicals, dyes and unknown words than real food, just put that back on the shelf. Processed ingredients are not good so try and avoid them.

Processed foods are foods that have been altered from their natural state for convenience, safety, or shelf life. Some processed foods, such as ready meals, baked goods, and processed meats, can have negative health effects. They can lead to weight gain, increase the risk of type 2 diabetes, and more. They can also contain high amounts of salt, sugar, fat, and calories. Not all processed foods are bad, but it is advisable to limit the intake of highly or heavily processed foods.

Want to learn more about reading labels? St. Jude Wellness Center is teaching a free webinar that goes into even deeper information on May 21st at noon. Register on the Programs & Events page at www.stjudewellnesscenter.org or call 714-578-8770.



Megan Wroe, MS, RD, CNE, CLEC, manages St. Jude Wellness Center; an integrative wellness department of St. Jude Medical Center. St. Jude Wellness Center is located in Brea, CA and offers a

variety of nutrition, fitness and restorative programs and services for prevention and condition management such as PD.

Visit their website for more information:
www.stjudewellnesscenter.org

DIABETES

An Overview

By Jessica Yanez

MS, RDN, CHES; Sr. Health Education Manager

According to the CDC, 38 million Americans currently have diabetes, with approximately 5-10% diagnosed with diabetes Type 1 and 90-95% diagnosed with diabetes Type 2. Since this disease is the eighth leading cause of death in the United States, and the numbers of those affected are rising, the risk factors and daily management of both types of diabetes is critical knowledge for Americans who may find themselves at risk. In this article, we will assess the preventive measures, symptoms to watch out for, and best methods of daily management of both types of diabetes backed by the advice of a Registered Dietitian Nutritionist and Sr. Health Education Manager, Jessica Yanez at Regal Medical Group and Lakeside Community Healthcare. Health insurance professionals can use the information provided below to advise their clients on how to prevent and manage diabetes.

It's important to know that preventing diabetes involves adopting a healthy lifestyle that promotes overall well-being. Here are some top lifestyle changes you can make to reduce your risk of developing diabetes:

- **Maintain a Healthy Weight:** Excess weight, especially around the waistline, increases the risk of type 2 diabetes. Aim for a healthy weight range through a balanced diet and regular physical activity.
- **Eat a Balanced Diet:** Focus on whole foods such as fruits, vegetables, whole grains, lean proteins, and healthy fats. Limit your intake of sugary foods, refined carbohydrates, and saturated fats.
- **Exercise Regularly:** Physical activity helps control weight, uses up glucose as energy, and makes cells more sensitive to insulin. Aim for at least 150 minutes of moderate-intensity aerobic exercise per week, along with strength training exercises.
- **Stay Hydrated:** Drink plenty of water throughout the day. Limit sugary drinks and alcohol, as they can contribute to weight gain and increase the risk of diabetes.
- **Quit Smoking:** Smoking increases the risk of type 2 diabetes and complicates its management. Quitting smoking can significantly reduce this risk.
- **Manage Stress:** Chronic stress can contribute to unhealthy habits like overeating or poor food choices, which can increase the risk of diabetes. Practice stress-reducing activities such as yoga, meditation, deep breathing exercises, or hobbies you enjoy.

• **Get Quality Sleep:** Lack of sleep or poor sleep quality can disrupt hormones involved in regulating appetite and glucose metabolism, increasing the risk of diabetes. Aim for 7-9 hours of quality sleep each night.

• **Monitor Blood Sugar Levels:** If you have prediabetes or other risk factors for diabetes, monitor your blood sugar levels regularly and follow your healthcare provider's recommendations for managing them.

• **Limit Sedentary Time:** Prolonged sitting or a sedentary lifestyle is associated with an increased risk of diabetes. Take breaks to stand, stretch, or walk throughout the day, and aim to reduce the time spent sitting.

• **Regular Health Check-ups:** Visit your healthcare provider regularly for check-ups and screenings. Early detection and intervention can help prevent or delay the onset of diabetes and its complications.

By incorporating these lifestyle changes into your daily routine, you can significantly reduce your risk of developing diabetes and improve your overall health and well-being. [Word count: 482]

ASK THE REGISTERED DIETITIAN NUTRITIONIST INTERVIEW BY EMMA PETERS

Q1: What are some common misconceptions about diabetes Type 1 and Type 2 that patients have which prevents them from managing the disease to the best of their ability?

A: As a Registered Dietitian Nutritionist, I often address misconceptions about Type 1 and Type 2 diabetes. One common myth is that only overweight individuals get diabetes, but both types can affect people of any weight. Type 1 diabetes is an autoimmune condition unrelated to weight. Additionally, diabetes is often underestimated as not serious, but it requires diligent management to prevent complications such as heart disease, kidney damage, and vision problems. Some patients believe that once they start medication, they no longer need to manage their diet or take medication, but this isn't true. Diabetes medication is often necessary even with controlled blood sugar levels, and stopping it without consulting a healthcare provider can lead to complications. Regular monitoring of blood sugar levels is crucial for effective management.

Q2. What lifestyle changes and daily management techniques do you recommend to patients who have diabetes Type 1 vs. Type 2?

A: Managing Type 1 diabetes involves taking insulin as prescribed, counting carbohydrates to control blood sugar levels, regularly checking blood sugar, maintaining a balanced diet, and incorporating regular exercise while monitoring blood sugar levels before, during, and after physical activity. For Type 2 diabetes, it's all about lifestyle changes like healthy eating and exercise, portion control, getting at least 150 minutes of exercise per week, taking medications as prescribed, and regularly monitoring blood sugar levels. Each approach is tailored to the individual's needs, emphasizing the importance of consistent care and monitoring for effective management of both types of diabetes.

Q3. What do you suggest is the best way to get diagnosed for diabetes Type 1 vs. Type 2?

A: To diagnose both Type 1 and Type 2 diabetes, consult a healthcare professional, typically a primary care physician or an endocrinologist. They'll conduct a physical exam, review your medical history, and inquire about symptoms like thirst, frequent urination, weight loss, fatigue, and blurred vision. Common tests include checking blood sugar levels with fasting blood glucose, an oral glucose tolerance test (OGTT), and an A1C test. Your provider may also test for autoantibodies common in Type 1 diabetes to help distinguish between Type 1 and Type 2 diabetes when the diagnosis is uncertain.

Q4. Is there anything else that you would like to suggest for those who are learning to cope with and manage diabetes?

A: From my experience counseling patients with diabetes, I've found that seeking support through groups or connecting with others who have the condition is truly helpful. Continuously educate yourself about diabetes management, including healthy eating, physical activity, medication, and blood sugar monitoring. Establish a consistent daily routine for medication, meals, and exercise to maintain stability. Set realistic goals, practice stress management techniques, and maintain open communication with healthcare providers. Be kind to yourself, stay positive, and celebrate small victories while learning from setbacks. With hard work and support, you can effectively manage your diabetes and lead a fulfilling life.

To learn more about Regal Medical Group and Lakeside Community Healthcare, visit RegalMed.com, or LakesideMed.com. Use our Doctor Finder to find a provider in Southern California.



Sign up for our Broker Portal at www.regalmed.com/brokers to access all of the information you need for your clients in one convenient location.



Jessica Yanez manages the Health Education Team, overseeing clinical health education services and the development of health and wellness content for Regal and Lakeside Medical Groups.

EMMA PETERS (INTERVIEWER)



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.

"Shine the Light"

Awardees

What makes someone outstanding at their job? Some might respond and say an unwavering commitment to clients. Some might propose that they are adaptable and innovative thinkers. Some may even say it's as simple as approaching their work and their clients with empathy and kindness. At California Broker Magazine, we understand that it takes all these qualities and more to be an outstanding professional in the industry. In December, we asked our subscribers to join us as we launched our first annual recognition program called "Shine the Light". We were looking to honor professionals who were 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.

Thankfully, many of our subscribers delivered, and nominated colleagues who fit these criteria and more! The nominees of this award received a free print subscription for one year of our magazine and a free basic e-Directory listing. www.ca-brokerdirectory.com

Here are the last five awardees of the "Shine the Light" recognition. They were nominated by peers or colleagues who provided a short summation explaining why these professionals deserve to be considered. We included this summary and asked the three professional goals for 2024 that each awardee provided. You will also find their contact information and a link to their website.

It's important that we recognize those who are making strides in our industry and pave the way for others to do the same! We are so grateful to have committed California insurance professionals in our midst who work with such a commitment to excellence!



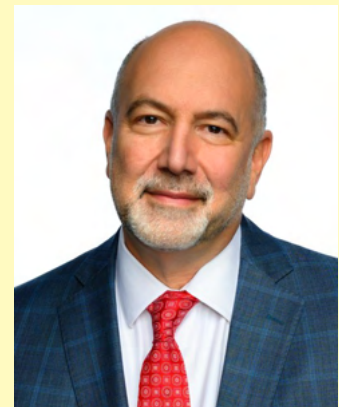
Dierdre Kennedy

dedek@benassisthealth.com
626-683-1390
BenAssist Health

Dede Kennedy is an outstanding broker. She truly cares for her clients and goes above and beyond. I feel that she treats her clients like family. She is leading the way in helping to ensure her clients and others have options to become aware, prevent and treat mental health issues. She donates her time on a local and state level with CAHIP.

Three goals:

1. To grow my agency by 20% in 2024
2. To embody my words for 2024 – Strength, Purpose, Miracles and Breakthrough – and I'll add kindness and compassion to that list!
3. To present the NABIP Mental Health Working Group's California mental health advocacy training for agents CE course to 1,000 agents in 2024.



Steve Crane

steve@dickerson-group.com
323-805-2923
Dickerson Insurance

Steve has consistently demonstrated a remarkable ability to provide solutions that exceed clients' expectations. His deep understanding of employee benefits and his insight into clients' needs allows him to tailor solutions for his brokers. Steve's commitment to his work is truly commendable. He consistently goes above and beyond to ensure that every client interaction is handled with professionalism. His work ethic and passion for delivering exceptional results have set a high standard for the entire team.

Three goals:

1. Be awarded Alera Group President's Club (earning a prestigious 3 years in a row!)
2. Mentor and train newer Sales Reps at Dickerson.
3. Read 10 pages a day of motivational sales literature.



Sarena Warner

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818-377-7260
CorpStrat

I would like to nominate my boss, Sarena Warner, for the first annual Shine the Light insurance professionals of the year. Sarena is one of the smartest people I know and a great inspiration to her Employee Benefits Team as well as to women working in the insurance industry! Her expert knowledge of the employee benefits products, keeping abreast of changes in the industry, and having built great relationships with the carrier reps and general agency reps over the years as well as actively participating in industry networking groups are what gets clients the most competitive benefits packages. She produces innovative solutions to client's needs when their business structure changes, or grows rapidly, or expands to include employees in several states, or moves out of state completely so the employer and employees feel as little disruption with their employee benefits as possible. Not only is Sarena good to her clients but she is also an advocate for employees within our own agency. Sarena promotes teamwork and is generous in sharing her knowledge and helpful tips with us to help us grow as Account Managers. Sarena is also a strong supporter of self-care for employees, taking time to get our wellness checks (medical/dental/vision) and has an open-door policy if we get overwhelmed and need some help...especially during the fourth quarter! For this and all the reasons listed above, I think Sarena Warner deserves recognition as Health Broker/Agent of the Year.

Three goals:

1. Continue to mentor and guide my staff, particularly female members of my team.
2. Create deeper, professional relationships with colleagues in our industry.
3. Develop additional strategic partnerships that will be mutually rewarding



Dawn McFarland

dawn@mnmbenefitsolutions.com
888-650-1788
M&M Benefit Solutions

Dawn McFarland is a shining example of dedication and leadership within the healthcare and health insurance field. Her passion for advocating for members extends beyond California, reaching the national level. She actively engages with Medicare seniors, ensuring they understand their plan options, enroll seamlessly, and utilize their benefits effectively. Dawn's leadership extends to the broader industry, where she champions legislation and fosters professional development for California insurance brokers. Her service in various executive roles at the California Agents and Health Insurance Professionals (CAHIP) and her participation in national committees with the National Association of Benefits and Insurance Professionals (NABIP) further demonstrate her commitment to the industry. She is also a contributor to Cal Broker and has written many articles for its readers. Dawn inspires her colleagues with her dedication to lifelong learning, kindness, and service to both clients and the industry. Her contributions are invaluable, making her a highly deserving candidate for the inaugural Cal Broker Health Insurance Professionals.

Three goals:

1. Scaling my business as it pushes past the current boundaries.
2. Committed to staying informed of solutions that will help increase consumer access to care and drive the cost of healthcare down.
3. Strengthen personal and professional relationships that feed my growth and my soul and allow me to give back in the same way.



Fernando Almeida

Fernando.Almeida@Norcal.AAA.com
559-440-7335
AAA Northern California

I would like to nominate Fernando Almeida of AAA. He has been my agent for the past year and is always there to help with anything I need at any time whether he is on or off the clock. When I purchased my new vehicle, he was only a phone call away and had me driving off the lot fully covered in no time at all.

Three goals:

1. Continue to grow my professional network.
2. Obtain first professional insurance designation in the Life & Health Insurance Field.
3. Learn new markets as a method to educate my clients on new products that may benefit them through all stages of life.

How to Combat Egregious Medical Overbilling Practices in the Group Medical Space

Picture this: a podiatrist's assistant surgeon in New York City charged \$169,410 for two common procedures, which a clinical bill review reduced to just \$632. Another claim for \$99,380 involving three mastectomies to lower a 47-year-old cancer patient's risk of recurrence was reviewed and repriced at \$3,072. Neither case is an outlier. In fact, they're commonplace.

Most of your group health insurance clients are overbilled millions of dollars every year, and they don't even know it – nor do their brokers. Egregious medical billing practices serve as a major obstacle to providing accessible and affordable health coverage, running afoul of intensifying government oversight to strengthen a plan's fiduciary standards. They also stand in the way of client satisfaction at renewal time, as well as building a prosperous brokerage. However, a new generation of payment-integrity solutions is emerging to combat these outrageous practices, avoid pain points and elevate the power of employee benefits.

Egregious medical billing practices are now in the crosshairs of the Consolidated Appropriations Act, which lays the groundwork for greater transparency and stewardship of health and welfare benefits. The CAA calls for stronger due diligence that introduces opportunities for improved clinical outcomes at a lower cost. Other significant legislative and regulatory efforts designed to curtail any malfeasance and uncover hidden information on negotiated prices for health care services include the No Surprises Act and Transparency-in-Coverage rule. These landmark initiatives will serve to help producers, who have an opportunity to take on a meaningful leadership role in guiding their frazzled employer clients to greater clarity. It will be a combination of education about what to expect in this changing climate and aligning with the partners who have the expertise needed to solve this problem. Their effort will benefit health plan participants who are struggling to afford rising premiums, co-pays and deductibles, which ultimately is what being a broker is all about.

By William R. Mattecheck

CLU,RHU,National Director of
Broker Relations, WellRhythms

As shocking as it may sound, medical bills that exceed justifiable charges by a factor of ten or even as much as 100 times are commonplace.

Mounting Financial Hardships

Consider that nearly half of American adults (46%) faced a problem with a medical bill in the past year. Also, almost half with low or average incomes (46%) delayed or declined needed care because of price – the highest rate in any of nine countries analyzed.

A lack of price transparency strikes at the heart of this issue. JAMA Network Open estimates that medical pricing irregularities, fraud and abuse cost between \$289 billion and \$324 billion. To put that in perspective, it's more than the entire state budget of California or New York. It's no wonder that unpaid medical bills are now the leading cause of personal bankruptcy in the U.S.

The nation spends about twice as much on health care per capita as other industrialized nations with a terrible return on investment as seen across an increasingly sick population saddled with multiple chronic conditions and comorbidity factors. Inflated medical bills play a significant role in gaslighting this growing cost crisis.

When surgeons and hospitals engage in deliberate overbilling, they are essentially imposing a phantom tax on the healthcare ecosystem that chokes business investment and growth, erodes competitiveness, inflates out-of-pocket costs and decimates family budgets.

Ripped from the Headlines

Since millions of working Americans are affected, brokers don't have to look far for countless examples of widespread medical errors involving eye-popping prices. They can be easily found in recent headlines, underscoring the urgency for innovative solutions to prevent these practices:

MultiCare Health System allegedly falsified diagnoses, approved medically unnecessary spinal surgeries and fraudulently billed federal healthcare programs. As part of that case, a high volume of surgeries were traced to one doctor in particular who generated significant revenue that was tied to incentive compensation.

A New York man was convicted of healthcare fraud, wire fraud and identity theft in a scheme that generated more than \$600 million for a medical billing company he operated. Under the elaborate ruse, doctors were instructed to schedule elective surgeries through the emergency room for substantially higher reimbursement rates.

Johnson & Johnson was charged with mismanaging employee prescription drug benefits and overpaying by millions of dollars for some generic drugs designated as specialty medications. Observers view this first-of-its-kind lawsuit as a shot across the bow to hold employers accountable for high prescription costs that opens a new front in the battle over price transparency and cost of employee benefits.

Solutions at Hand

As shocking as it may sound, medical bills that exceed justifiable charges by a factor of ten or even as much as 100 times are commonplace. Bills running into the hundreds of thousands of dollars, if not millions, when legitimate charges are only a fraction of that, need to be stopped. More importantly, they can be halted. Specialists in uncovering these discrepancies can save clients millions yearly. Their expertise in claim review and repricing shields patients from

predatory practices.

What has been sorely needed is a way to transform healthcare pricing transparency to level the 'paying' field for healthcare payors, providers and patients. Ironclad payment integrity technology, along with technical, medical and legal acumen, are required to ensure that every facility bill is reviewed and priced with precision to ensure the most fair and accurate payment.

This technology must be paired with experienced physicians and surgeons who understand the medicine behind the charges that are being incurred for various medical procedures. They are the ones who should be poring over these bills, not non-medical coders or administrative personnel who lack their knowledge and are prone to burnout and high turnover.

Coupling the most technically advanced bill review process with such a deep level of human expertise guarantees precision in claims payment accuracy, prevents overbilling and eliminates egregious errors. When medical professionals are the ones who scrub bills line by line, they are easily able to spot redundancies and items that should not ever require separate billing. Without that level of expertise, there is no true payment integrity or hope of ever paying providers fairly.

It's a recipe for success given the current climate, aligning the objectives of key stakeholders. What is good for health and welfare plan sponsors is also good for participants and their beneficiaries – and, of course, a company's financial well-being. The right blend of technology and human touches is designed to support trusted professionals in meeting their fiduciary responsibilities and helping them seize opportunities for improving benefits, reducing costs and decreasing waste.

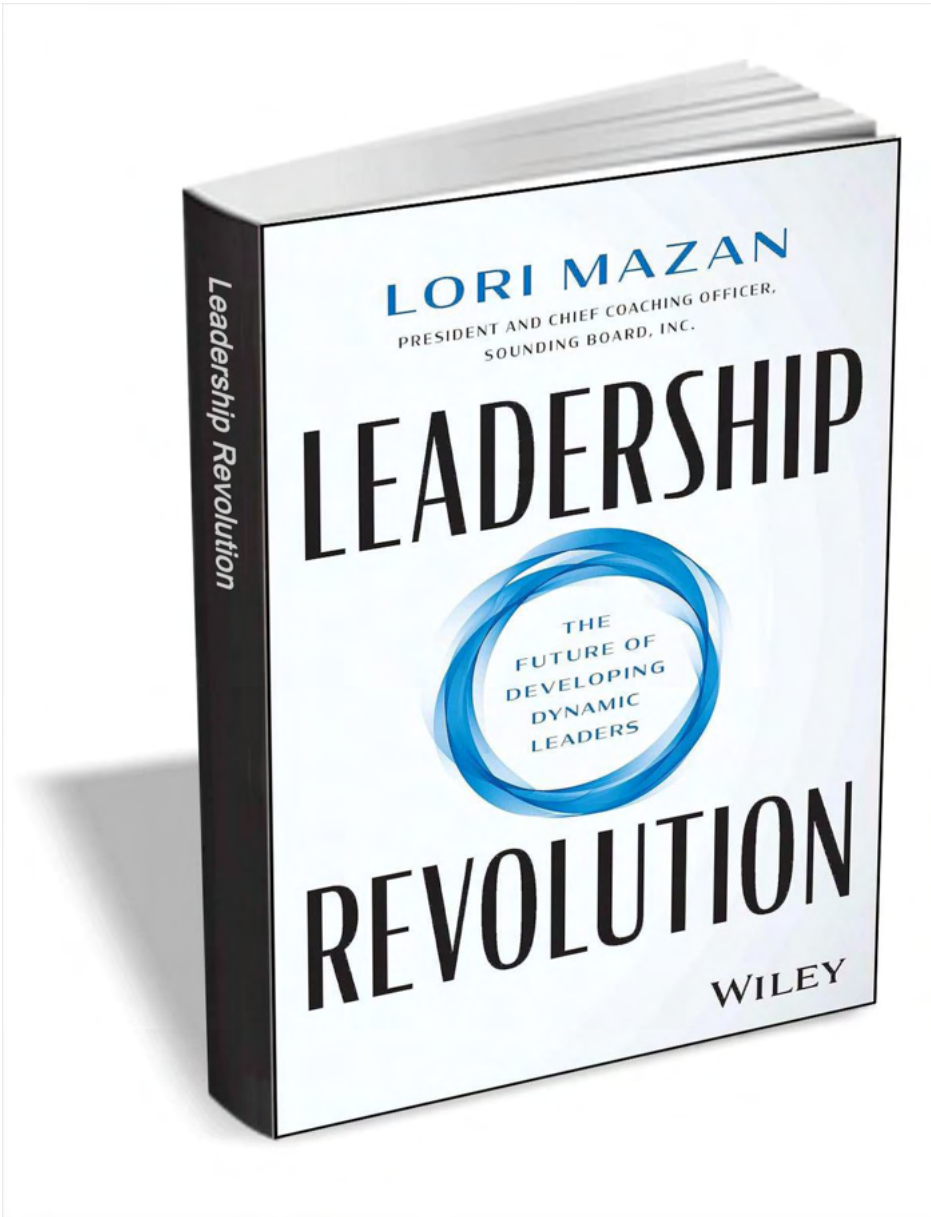
Health insurance brokers who have a keen understanding about higher expectations of fiduciary duties in this changing climate and take more proactive steps will reap the spoils as they work to solve a deepening national crisis.



William R. Mattechek, CLU, RHU,
*National Director of Broker Relations,
WellRithms.*

Bill Mattechek brings 45 years of experience in the insurance industry to WellRithms. Prior to joining the company in 2023, he owned his own benefits firm, Mattechek & Associates, for 20 years. He began his insurance career in 1977 with Northwestern Mutual Life, started working in the benefits area in 1980 and, in 1985, took over as manager of SEBS

(Strategic Employee Benefit Services), a part of Northwestern Mutual, running that division until 2004.



Leadership Revolution: The Future of Developing Dynamic Leaders

By Emma Peters

In distinguished executive coach Lori Mazan’s new book, *Leadership Revolution: The Future of Developing Dynamic Leaders*, she outlines an approach to leadership development that embraces the individual and the changes in the work environment of the 21st century.

Mazan places herself opposite of the formulaic “five traits of strong leadership” advice that has been given for decades and instead emphasizes, “...there is no single leadership paradigm”. Instead, Mazan offers guidelines for creating a leadership paradigm that works for you and those that you are leading.

One of the foundational guidelines that Mazan offers for leadership development is to help individuals identify “The Big Leap”. She argues that it’s essential to first ask questions that articulate goals for the future clearly, instead of analyzing the past: “What are we trying to do here? What change do we wish, or need, to achieve?” This stress on the future and asking questions that create practical solutions based on the specific individual carries on throughout the rest of her book, which provides a path to leadership that is agreeable to the diverse talents of the 21st century workforce.

Mazan offers guidelines for creating a leadership paradigm that works for you and those that you are leading.

One of the pieces of advice that stands out in Mazan’s writing, is one that takes a spin on The Golden Rule, where she instead states to, “treat others how they want to be treated”. It’s the responsibility of the leader to embody a level of empathy that meets workers where they’re at, instead of pushing them into a cookie-cutter outline of what it means to be successful. If workers feel valued and free to break from the typical mold that’s been given to them, good delegation and growth will ensue.

Throughout the book, Mazan references the teachings of Tai Chi, a practice which she has engaged with for years, and something which isn’t necessarily expected to be used as a metaphor in writing on leadership development. However, she’s able to compare concepts within Tai Chi such as letting go and persistence over time to the kinds of practices that should be used by dynamic leaders. These practices illustrate how an individual can transform their way of thinking to become self-reliant & able to deal with any issues that may come their way in the modern work environment.

As a young person entering the workforce, it was inspiring to learn from the wisdom of Mazan who couples her vast experience and knowledge over the years while stressing the importance of embracing the ever-changing work environment of today. Post-pandemic, in the age of technology, with more diverse workers and skill sets than ever, Mazan proposes that letting go of the familiar and convenient established rules of leadership must be let go of to meet the future goals that were established in The Big Leap. She describes moving away from horizontal development, and moving towards vertical development, which is about, “transforming the ways a leader thinks, which will impact what they do and how they behave”. With Mazan’s advice, the gap between older and newer generations in the workforce may be closed as leaders learn to think differently and more openly.

Lori Mazan’s new approach towards leadership and coaching can be helpful for any health insurance professional with new employees, looking to hire, or with a desire to improve their existing work environment. This book will give you a perspective on leadership that is sustainable over time, provides goal-centered thinking, practical ways to use failure towards success, and a specific interest in the individual.



Meet the Author!

Lori Mazan is the co-founder, president, and chief coaching officer for Sounding Board, the first Dynamic Leader Development Suite designed to bridge the leadership gap.

One of the first 250 ICF-certified coaches globally, she has spent more than 25 years coaching C-suite executives in developing critical leadership capabilities that have

immediate, positive business impact.

Lori has coached leaders in top companies such as Chevron, Sprint, and Citibank, as well as venture-backed high-growth companies like Intellikine, Tapjoy, and 10XGenomics.

In 2016, Lori partnered with her previous executive coaching client Christine Tao to launch the Sounding Board Dynamic Leader Development Suite, with the vision of empowering organizations to develop leaders at all levels by eliminating key barriers such as limited access, lack of measurement, unsuccessful coach selection as well as reducing costs. Suite combines solution design, adaptive software, people-to-people development, and measurable data and insights.



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.

What Rights Does an Insured Patient Have: Understanding Complaints, Appeals, and Grievances

By CalBroker

Insured patients in California are lawfully entitled to certain protections when it comes to insurance coverage. Patient rights in California extend to all medical care, including testing, treatment, and medication, consistent with good professional practice.

In the event of an unfair or unlawful denial or delay of care, an insured patient can file a complaint, grievance, or appeal with their insurance provider or the appropriate regulatory authority. Health insurance professionals should be aware of these rights and act as advocates for their clients in case of mistreatment or unlawful healthcare practices.

Requesting an Independent Medical Review

Patients or healthcare providers unhappy with an insurance carrier's decision to deny, modify, or delay healthcare services have a right to request an independent medical review (IMR) through the California Department of Insurance (CDI) or the Department of Managed Health Care (DMHC).

Per CIC §§ 10169-10169.5, a patient with private medical insurance can request an IMR if the issues are not related to coverage, such as:

- Decisions about experimental treatments
- Decisions about medical necessity
- Denials for urgent or emergency medical care

CDI Independent Medical Review Request

When a patient or healthcare provider submits a request for independent medical review, the process typically follows these six steps:

1. Receive notification of insurance denial
2. Apply for an IMR and sign the consent form
3. Receive CDI eligibility determination
4. Independent medical review
5. Receive IMR decision
6. Implement IMR determination

If the case is not eligible for IMR per the CDI, the case is automatically referred to the CDI's complaint program.

DMHC Independent Medical Review Request

If an enrollee wishes to file a complaint with a health plan regulated by the DMHC, the process is slightly different. The patient must first file a complaint with the health plan directly. The health plan has 30 days

to resolve the complaint unless there is an immediate threat to the patient's health or the request involves experimental treatment.

Once a patient has participated in the process for 30 days without resolution or they receive a decision they are not satisfied with, they can file a complaint with the DMHC as follows:

Download and fill out an IMR/ Complaint Form

Download and complete a DMHC Authorized Assistant Form, if needed

Send the form and supporting documents by mail or fax to the DMHC

Receive IMR decision within 7 days for urgent cases and 45 days for non-urgent cases

Implement IMR determination

If the DMHC determines the case is not eligible for an IMR, they will automatically refer it to Consumer Complaints. The patient should receive a response to their consumer complaint in writing within 30 days.

Filing a Complaint With a Regulatory Organization

If a patient or provider in California experiences issues related to private insurance coverage policies, they have a right to file a complaint with the CDI

or DMHC. Each organization regulates different healthcare plans.

California Department of Insurance Complaints Process

Healthcare providers and patients can follow these steps to submit a complaint to the CDI:

Review the CDI's list of insurers to ensure the provider falls under their jurisdiction.

Determine whether you have grounds to submit a claim, such as improper denial or delay, issues with dispute resolution, or health insurance misconduct.

Complete a Health Care Provider Request for Assistance Form for each claim or complaint.

Submit the form along with patient medical records, assignment of benefits, claim forms, correspondence with the insurance provider, dispute resolution process determination, patient insurance information, and the provider's contract with the insurance company.

Patients and providers can also file complaints electronically via the CDI online portal.

Department of Managed Health Care Complaints Process

The DMHC uses the same forms and processes for IMR and consumer complaints, as indicated above. For complaints that are not eligible for IMR, the DMHC will automatically review the complaint and provide a determination within 30 days.

Providers who wish to register a complaint against an insurance carrier regulated by the DMHC must:

Attempt to negotiate with the carrier for at least 45 days using the appropriate Provider Dispute Resolution (PDR) mechanism.

Verify that the services were rendered within the past four years.

Confirm that the claim dispute is with a health plan licensed under the Knox-Keene Act.

Submit the complaint and supporting documentation, with protected health information (PHI) redacted, through the DMHC Provider Complaint System.

Submitting a Grievance to Medicare

Patients with Medicare coverage have the right to file a grievance within 60 days of an event that resulted in substandard care. Incidents that could result in a grievance include:

- Unprofessional behavior by medical professionals
- Difficulty securing an appointment within a reasonable time frame
- Failure to diagnose or treat a condition consistent with professional standards
- Declined claims by the patient's Medicare plan during an organization determination

Reconsideration Request

A Medicare enrollee whose medical service is denied during organization determination can submit a reconsideration request to Medicare verbally or in writing. The patient's doctor or representative can also file a reconsideration request on the patient's behalf.

Independent Review Entity

If a patient with a Medicare Advantage Part C health plan receives a negative result to their reconsideration request, the claim goes to a Part C Independent Review Entity (IRE).

Beneficiary Family Centered Care-Quality Improvement Organization Review
Patients whose pre-authorized coverage for inpatient care, home care, skilled nursing facilities, or outpatient rehabilitation was rejected can request an independent review through the Beneficiary Family Centered Care-Quality Improvement Organization (BFCC-QIO).

Appeal Before an Administrative Law Judge

Any party involved in the reconsideration can request an appeal of the IRE's decision before an administrative law judge (ALJ). Appeals submitted for hearing with an ALJ must meet threshold requirements, which are updated annually by the Department of Health and Human Services.

Medicare Appeals Council Review

The Medicare Appeals Council reviews contested decisions made by an administrative law judge should any involved party be dissatisfied. Their decision includes information that can be used to file a final appeal with a Federal District Court.

Federal District Court Review

Any party involved in the appeal action who is dissatisfied with the Medicare Appeals Council's decision can request a judicial review before a Federal District Court. The amount in controversy required

for a Federal District Court review is much higher than for an ALJ appeal, and it changes annually.

If your client encounters changes, delays, or denials of medical services for diagnosis and treatment, you can let them know that they have options. Providers and patients have the right to request independent medical reviews, file complaints, or submit grievances to resolve insurance issues.

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TIPS

on Selling a Book of Business

BY PHIL CALHOUN AND DAVID ETHINGTON

Selling a business is a significant decision that requires careful planning and consideration. When retirement is also part of the decision to sell, many new and often deep concerns start to cloud the planning process. Most significantly, financial thoughts combine with the emotional concerns and make the retirement/sell a business decision even more difficult for many business owners. We prefer to use the term business exit planning as it encompasses how to protect, enhance, and someday reap the reward when the plan is completed as expected.

When health insurance professionals are faced with selling and retiring from the business, we often see a range of issues that must be acknowledged and addressed in the planning process. In many cases when working with brokers to help them through this process, it is rewarding work. Yes, we get paid for our consulting and guidance on commission solutions. What is even more lasting is how rewarding it is to help a broker build and then navigate the exit plan process that leads to achievement of their end goals.

In all cases we work with our broker clients to get to the planned for result which is a financial and emotional reward for their efforts to grow their book of business, manage the many years of renewals, and be the trusted advisor for clients.

Here are some key considerations health insurance professionals will need to address when they work through the process to sell their business:

Financial Preparedness: Ensure that your financial records are in order and accurately reflect the financial health and performance of your business. Potential buyers will scrutinize your financial statements, so it's crucial to have clean and transparent records. Work with a bookkeeper or CPA to find the best online tools to keep your records organized.

Valuation: Determine the fair market value of your business. Most brokers are dialed into a few lines of insurance and the value of a book is based 90% on a multiple of commission revenue. For larger agencies consider consulting with business valuation experts or financial advisors to get an accurate assessment of your company's worth.

Timing: Assess the market conditions and timing for selling your business. It's essential to sell when your business is performing well and when market conditions are favorable. Waiting too long may reduce the value of your book of business especially as new sales do not keep up with replacement of lost business. Including tools that provide value to clients will improve retention and referrals both will boost your revenues.

Reasons for Selling: Be clear about your reasons for selling the business. Whether it's retirement, pursuing other opportunities, or financial reasons, understanding your motivations will help guide the selling process. Brokers can choose to sell some lines of business in order to focus more on profitable lines or when adding a new insurance line.

Potential Buyers: Identify potential buyers for your business. This could include competitors, strategic buyers, private equity firms, or individual investors. Consider which type of buyer aligns best with your objectives and the future of your business. Most solo brokers will sell to employees, colleagues, or merge with someone.

Confidentiality: Maintain confidentiality throughout the selling process to avoid disrupting operations and relationships with employees, customers, and carriers. Consider using non-disclosure agreements (NDAs) when sharing sensitive information with potential buyers. The health insurance industry is huge but word travels fast. Be aware of your role in this process and share your plans with strategic intent.

Legal and Regulatory Compliance: Ensure that your business is compliant with all legal and regulatory requirements. CMS and DOI are two regulatory bodies that are considered. Address any outstanding enrollment violations, legal issues or liabilities before initiating the sale process. Debt is also a factor to address, buyers do not assume your personal or company debt with carriers or banks.

Preparation of Documentation: Prepare necessary documentation for the sale, including financial statements, tax returns, carrier contracts, marketing agreements of value, equipment leases, and other relevant documents. Having this information readily available will streamline the due diligence process for potential buyers. Confirming there are no financial issues to report is helpful.

Employee Considerations: Consider the impact of the sale on your employees. Communicate transparently with your staff about the impending sale and how it may affect them. Consider retention plans to incentivize key employees to stay on after the sale.

Exit Strategy: Develop a clear exit strategy outlining the terms and conditions of the sale, including the purchase price, payment structure, and any contingencies. Work with legal and financial advisors to ensure that the terms are fair and favorable to you. Use a proven legal agreement to cover all the deal points of a sale.

Post-Sale Involvement: Decide whether you'll remain involved in the business post-sale, such as through a transition period or consultancy role. Clarify your level of involvement with the buyer to avoid misunderstandings.

Emotional Preparedness: Selling a book of business can be an emotional process. Most brokers have invested significant time and effort into building their book of business one client at a time. Prepare yourself mentally for the transition and focus on the opportunities that lie ahead.

By carefully considering the factors above and when working with planning professionals' guidance when necessary, health insurance professionals can navigate the selling process effectively and maximize the value of their business.

Phil and David have worked with brokers from the initial steps to understand the value of their book of business to designing their exit plan. We have increased our consulting practice working to help brokers. In our experience we find every broker has their individual ideas and beliefs about their book of business value and what they desire for the future. From this work we believe all brokers need a plan to protect their commissions while active so they can sell when they are ready to exit.

Over the past 12 years the commission solutions process we built has helped hundreds of brokers move from a set of general ideas and beliefs about selling and retiring to working on reaching their goals to protect and sell on their terms.

Our planning process enables family-owned agencies and solo brokers to reach their goals.

Get our book---

A Health Broker's Guide: How to Protect, Grow, and Sell Commissions

We have videos on our website to help visitors understand the planning processes.

If you have questions and would like a phone appointment, please contact us.



Phil Calhoun MBA is a board member of the Exit Planning Institute Orange County Chapter, he owns Integrity Advisors.

Integrity Advisors is a health insurance agency which specializes in educating health brokers on the importance of commission protection. Commission Solutions is a program offered by Integrity Advisors.

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David Ethington is VP of the Medicare Division and director of Broker Relations with Commission Solutions, part of Integrity Advisors. David is an expert in the process to acquire and transfer health commissions. He has trained numerous brokers in commission education and he built the commission transfer planning module for Medicare commissions which is provided to our broker colleagues His work has excelled due to

his commitment to providing the best service to both health clients and health brokers. David respects the hard work it takes to build a book of business and enjoys working with retiring brokers and their families. He serves as the CAHIP-Orange County VP of Membership. David has participated in the commission protection process for seven years. He's also involved in acquisitions, especially in the broker relationship transfer of commissions. David lives in Orange County with his wife and their cats. He is an avid runner and completes several long-distance events annually.

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Navigating Long Term Care Insurance Rate Increases:

A Guide for LTCi Professionals

BY JASON DUTRA

As a long term care insurance professional, you are often called upon to have uncomfortable conversations with your clients. You have to be able to guide your clients through financial ups and downs. Though these conversations are a part of our duty, it doesn't necessarily make them any easier to navigate.

One of the most sensitive conversations you'll have with policyholders and clients is about in-force rate increases. It's crucial to handle these discussions with transparency, empathy, and expertise. It can be hard to avoid feeling a bit on the defensive, but there are positives to be taken away from the conversation. Here's a guide to help you navigate these discussions effectively.

Meet the Policyholder Where They're At

It's important to acknowledge the emotional aspect of rate increases. Listen to the policyholder's concerns and address them with compassion and empathy. Nobody likes getting this letter. It's disheartening to find out that your plan is going to get more expensive if it's to stay fully intact. Let your client know that you understand how they must be feeling. It's the first step to getting them on board with understanding why this is happening, and working toward a solution.

Review Their Benefits

Before diving into the decision-making behind a rate increase, review the policy's benefits. Remind the policyholder of what they purchased, and how it's grown, and what the game plan is should it need to be activated. Remind them that there are professionals on their side. This can be a pivotal moment for policyholders to remember and recognize what they have.

Remind them of the policy's purpose. This product is designed to help both them, and their family in the event of an extended care need. It may have been a while since the policyholder has reviewed their coverage. Though hindsight is always 20/20, yearly reviews are always recommended, if possible. At any rate, a refresher is always useful, and when facing a rate increase, it's good to bring it back to what you have and why you purchased it.

Understand and Communicate the History of Long-Term Care Insurance

When compared to most other lines of insurance, long-term care is still in its infancy. If you've been working with long-term care since the '80s and '90s, you've been around since the very beginning. You've had a front-row seat for all of the growth, change, and innovation that the industry has experienced.

You've also seen some of the mistakes made in early years, their identification, and the adjustments made to make sure that they're not repeated. You're the perfect professional to be having this conversation with.

If you're still relatively new to the industry, take some time to learn about its short history. It can help you to become well equipped to help a client through a rate increase. Understanding what led everyone to this conversation is crucial to getting policyholders to keep their faith in their plan. Here's a short history lesson to get you up to speed:

- **Lapse Rates:** To put it in simple terms, assumptions were built into early long-term care plans that more people would lapse their policy than what actually occurred. A shockingly high percentage of people held on to their plans, leading to more people claiming on their policies than was expected. This is not the only contributing factor to rate increases, but it's a big one.
- **Underpriced policies:** Due to many factors, including those overestimated lapse rates, long-term care plans were significantly underpriced in the industry's early years.
- **Extremely Robust Benefits:** Paired with these underpriced premiums were substantial policy benefits. Perhaps the most egregiously underpriced were policies that contained 5% compound inflation protection, lifetime unlimited benefits, or both. Underpriced policies with robust benefits meant that far more claims dollars were being paid out than premium dollars taken in.
- **Longevity:** People are living longer, but not necessarily healthier, increasing the duration of claims, increasing the impact of compounding inflation protection, and increasing the overall financial risk for insurers.

So when we add it all up: Policies were sold at underpriced rates,

with benefits that were too rich, and more people wisely held on to their coverage and utilized it for as long as they could. This is exactly why the carrier is petitioning for a rate increase with state insurance departments. They need to recoup some of the financial losses suffered from these legacy blocks of business. If you can explain this in simple enough terms, the policyholder will appreciate the context.

Turn the History into a Positive

What does this history mean for our conversation? The policyholder you're speaking to is likely affected by the history we just went over. As I mentioned, you should absolutely meet them where they're at and understand their frustration, but you should also congratulate them. They made an extremely wise decision to purchase their policy when they did. As a result, they've gotten a once-in-a-lifetime deal by getting their long-term care insurance at what is essentially a massive discount.

The discount is so good that their insurance carrier had to petition their state insurance department to ask for a rate increase. That insurance department, which is a watchdog for consumers, found that the carrier demonstrated significant enough losses to then approve that rate increase. That is very convincing circumstantial evidence to prove that what your policyholder has is extremely valuable.

That's all well and good, but we haven't even talked dollars and cents yet! There's very convincing evidence to be had in that part of the conversation, too.

Demonstrate the Value of Current Coverage

One effective strategy is to demonstrate the current value of the policyholder's coverage compared to what it would cost if they were to purchase the same coverage now. Try to quote a similar product with similar benefits for new business. Try to quote this a few ways:

- What it would cost to purchase a similar policy at their current age (if possible)
- What it would cost to purchase a similar policy at the age they originally purchased their policy.

This perspective helps policyholders appreciate the worth of their existing policy, even when faced with rate increases. They may be quite surprised at what it costs to purchase what they have today, if it's even possible. They may find it surprising if their compound inflation protection has pushed their benefit above new business maximums. They may find it surprising that many carriers aren't insuring people of their current age. They may find it surprising that many carriers don't offer lifetime unlimited benefits anymore, because it's not profitable or too risky to offer it.

Let them play around with the numbers and give them concrete answers. The wheels will start turning when they add the history and the numbers together. In many cases, the policyholder will find that their policy is extremely valuable in its current form. Hopefully, that helps them make the connection to why they're seeing a rate increase, and logic will begin to replace some of the raw emotion.

Guide The Policyholder to the Solution

We can tell stories and crunch numbers all we want. At the end of the day, the policyholder has to come to a decision. They have to choose to keep their coverage in place, adjust the benefits to reduce the premium, or (hopefully not) drop the policy altogether.

In almost every experience I've had with rate increase consultations,

the client chooses to keep their coverage as is and pay the rate increase if their budget allows. Once they're able to have someone understand where they're coming from, explain why this is happening to them, and show them what the market looks like today, they're able to bypass some of the initial emotion and feel good about that planning they did all those years ago.

That doesn't mean that this is the right answer for everyone, though. You must still do your due diligence on every single case to make sure that you're choosing the best outcome for the client in a customized way. Make sure the recommendation fits the client's budget and coverage needs. Review every premium reduction option offered by the carrier in the rate increase letter. Call the carrier with the client to see if there are more options available. Turn over every stone if you have to. Analyze every option in an objective manner. Their plan should be important to you, too.

Bottom Line: Build Trust with a Value Narrative

Rate increases in long-term care insurance are challenging and can be a source of stress and confusion for policyholders, but with the right approach, policyholders can be left feeling empowered by their situation.

Take the time to be there for them and hear them out. Call on a long-term care specialist if you need help with technical questions or with the conversation as a whole. Take the time to educate them on their plan, and why they're here with you today. Take the time to compare what's out there, and drive them to an informed decision. If you can do that, the policyholder will likely feel thankful that they purchased this years ago. I hope that with this guide, you'll be able to turn a few frowns upside-down.



Jason Dutra has been in the long-term care industry for 9 years- First as a producer, then as a long-term care specialist for a brokerage firm, and now as Director of Partner Success at BuddyIns. His passion is helping long-term care professionals get the information, mentorship, and technology that they need to successfully help families plan for extended care needs. Jason lives in San Diego, CA and enjoys exploring with his girlfriend Tash and dog Audi."

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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Should Brokers Partner with PEOs to Sell Health Insurance?

By Chris Leyba
BBSI Benefits Consultant

After a few years in the Navy and over a decade in the fitness industry, including owning a retail business, Chris Leyba began his insurance career in 2011. He has worked as a carrier sales rep, a broker benefits consultant, a broker account manager, and a PEO benefits account manager. Chris' professional strengths lie in using his vast experience to help employers devise long-term benefit strategies, while bringing the insurance conversation to worksite employees in a relatable manner. His aim is to help all involved get the most from their benefits investment.

Life and health benefits brokers have historically been wary of professional employer organizations (PEOs), but when a broker partners with a PEO that genuinely values the relationship, they can access substantial advantages and benefits for themselves and their clients.

The right broker-PEO partnership deepens broker-client relationships, frees up brokers' bandwidth, and allows brokers to retain their pivotal role while leveraging the resources and expertise of a trusted partner.

What Does a Traditional Health Benefits Plan Look Like?

Often brokers are working to find the best traditional employer-provided health benefit plans they can for their clients. These plans typically operate on a one-employer-per-group basis. As with most insurance plans, the coverage and rates depend on the size of the group to distribute the risk. If the group is small, risk distribution becomes less effective, potentially leading to higher premiums and more limited coverage options.

Under the Affordable Care Act, small businesses and their brokers are subject to geographic rate setting on traditional benefit plans. This makes the business location a crucial factor in determining insurance premiums over the actual risk of a particular group. Under this model, insurance providers may pool small employers together to achieve better plan options or the rate advantages of larger pools.

How are PEO Benefit Plans Different?

One of the main differences between PEO benefit plans and traditional benefit plans is the size of the employer pool. Most PEO plans have a much larger pool of plan participants, so they can provide opportunities that small to mid-size employers won't find in traditional carrier-direct health plans. Employers also benefit from the advantage of direct underwriting, which can give them access to plans and rates they wouldn't otherwise have access to.

When hundreds of small businesses join together, they can secure far more competitive plans through their PEO's carrier partnership. These partnerships can also create the opportunity for additional ancillary services often supported by the PEO. This helps brokers free up administrative time while balancing existing client administration and new client acquisition. Small businesses and their brokers often face a tremendous administrative workload without a PEO partner.

Other administrative benefits of PEO partnerships include support from the PEO for:

- Distribution of plan information materials and forms
- Employee education about plan options
- Communication with the carrier
- Access to direct carrier feeds for seamless enrollment and administration
- Employee single-sign-on with an integrated benefits and payroll platform
- COBRA administration
- Distribution of W2 forms and collecting, depositing, and reporting employment taxes
- ACA services for applicable large employers

How Do PEO Benefit Plans Differ from Open Market Plans?

Employers looking for small group benefits on the open market still face issues with location-based pricing and limited plan options for smaller groups. They also must navigate the complicated process of choosing the best employee plan, which can be challenging for employers without experience in this area.

PEOs negotiate directly with carriers due to their large pool of clients, generally allowing them to get better coverage and better rates with more plan options that are often not otherwise available.

The Right PEO Will Streamline Employee Health Insurance Coverage for SMBs

SMB owners joining a PEO benefit plan should expect both convenience and advantages when it comes to adding employee health insurance coverage to their list of benefits.

- **Competitive Rates:** PEOs offer access to national coverage at competitive rates, even for small employers with less than 20 employees.
- **Larger Risk Pools:** PEOs can pool all their client businesses into one large group, which presents a lower risk profile to insurers, potentially lowering premiums.
- **Strategic Partnerships:** PEOs have more leverage to negotiate long-term partnerships with leading health insurance companies, enabling them to provide access to industry-leading provider networks at competitive rates.
- **Comprehensive Service Offering:** The best PEOs offer comprehensive combinations of services, including payroll, workers' comp, health insurance, risk management, and HR consulting. This can lead to better pricing for health insurance as part of a broader package of services.

What Hesitations Do Brokers Have in Partnering with PEOs?

Some brokers are hesitant to work with PEOs, even though they can offer many benefits to their benefit plan participants. Some PEOs have developed a reputation for leaving the broker out of communication with their mutual clients.

Even with a trusted and reputable PEO, brokers sometimes experience hesitation over the loss of control. But when a broker decides to partner with a PEO like BBSI, the relationship can offer tremendous benefits. BBSI is a broker-friendly PEO that views brokers as mutual partners and invests in their success. We strive to keep the broker as involved as they want by including them in client communication and by building good relationships with the broker and their mutual clients.

Rather than cut the broker out, BBSI positions the broker as the lead in the partnership, maintaining their client relationship and offering value-add services and additional coverage options.

How BBSI Helps Brokers Offer Their Clients More Value

If you want to work with a true PEO partner and offer unique plan designs customized to SMBs, consider partnering with BBSI. As an experienced PEO, we offer payroll, HR, risk and safety, benefits, and business consulting services to SMBs across California.

With BBSI's local Benefits Specialists and Business Unit teams, brokers can take advantage of an entire team to tackle responsibilities together. We'll provide professional guidance on choosing the best plans, managing enrollment, and supporting administration.

Brokers who partner with BBSI can offer a variety of plan designs and rates otherwise unavailable to their clients and reclaim significant bandwidth by outsourcing administration. With a strong reputation for fostering mutually beneficial partnerships with brokers and a 95% client retention rate, BBSI consistently demonstrates it's one of the PEOs you can trust.

Reach out today to learn if BBSI is the right PEO partner for you.



Chris Leyba, BBSI Benefits Consultant After a few years in the Navy and over a decade in the fitness industry, including owning a retail business, Chris Leyba began his insurance career in 2011. He has worked as a carrier sales rep, a broker benefits consultant, a broker account manager, and a PEO benefits account manager. Chris' professional strengths lie in using his vast experience to help employers devise long-term benefit strategies, while bringing the insurance conversation to worksite employees in a relatable manner. His aim is to help all involved get the most from their benefits investment.



No Deliveries: When Maternity Wards Close, Close, Where Do Patients Go?

By Emma Peters

On Wednesday, March 27th, CalMatters hosted a panel of experts & prenatal care advocates to discuss the reasoning, impact, and potential solutions for the rising numbers of closed maternity wards in California. In the past three years, 29 California hospitals have closed their maternity wards, and there are currently 12 counties in California without maternity wards. On the panel to discuss these issues was Peggy Wheeler (Vice President of Policy, California Hospital Association), Robert Moore, MD, MPH, MBA (Chief Medical Officer, Partnership Healthcare California), Kimberly Robinson (Health Equity Advocate) and Paris Maloof-Bury, (President, California Nurse-Midwives Association). Health insurance professionals can benefit from this discussion which can affect many of their clients who need these kinds of services.

Regarding the reasons for these closures, Peggy Wheeler explained the financial troubles that hospitals currently face, which pushes them to shut down their maternal care facilities. Labor and delivery units are usually the second-most expensive departments for hospitals to run behind emergency departments.

Obstetric units must be ready to take care of a patient 24 hours a day with highly trained clinical staff, specialized equipment, and dedicated space for labor and delivery. At the same time, Medi-Cal plans' reimbursement rates are typically five times less than commercial plans, which is not sustainable for hospitals. This is especially difficult for smaller and remote facilities (who are the hospitals at most risk in closing their maternity wards) to recruit and retain specialized OB services that are available 24 hours a day.

Robert Moore confirmed these financial issues while emphasizing that Covid caused many hospitals to have their reserves decimated (especially the smaller hospitals in rural areas). Moore referred to the term "structural urbanism", which is the phenomenon where policies are designed by people in cities that don't translate or work for the infrastructure in rural areas. Essentially, the current system which allows for maternal care facilities to be staffed with enough certified nurses and doctors is unsustainable and costly for those in rural areas with at-risk patients.

What happens when these maternity wards are closed? Health equity advocate Kimberly Robinson stressed the negative impact this has had on communities not only in rural areas, but also in cities like Los Angeles. Areas of Los Angeles have been coined as "Maternity Deserts" and have caused patients in Los Angeles to travel up to two hours to the nearest hospital to receive care for maternal issues which warrant urgent care. Robinson also discussed the disproportionate communities which are affected by these Maternity Deserts, as black women are 4-6 times more likely to die from a birthing cause than any other population. The effects of this have been extremely tragic as mothers experience mortality rates and health issues during births that could have been prevented if sufficient care was provided and available.

What are possible solutions for this situation? Wheeler reiterated that for these maternity wards to remain open, hospitals must have the financial means to retain their staff and resources. She offered the solution for Medi-Cal reimbursement rates to be increased so that there is less disparity between commercial insurance for a birth vs. Medi-Cal. She also proposed annual sustainability grants that prop up the OB units so they could bring in those interventions for nurse training so that nurses are kept up to date with the training and standards

that are currently mandatory. To address the structural urbanism policies that have infiltrated the health care system and do not work in rural areas, Moore offered the option of a rural nursing education track. Since nursing schools have become so specialized that nurses need additional training on top of school to go into any area of nursing, a rural education track would produce nurses with general skills and decrease the staffing burden in these areas. He also proposed a stand-by prenatal service that would help with the cost structure and have doctors/nurses who can come in when they are needed, to lessen the financial pressures of retaining staff that are available 24 hours a day.

Robinson and Maloof-Bury both emphasized the need to value midwives and doulas within our maternal healthcare systems, as they have been statistically proven to decrease mortality rates in births for at-risk patients. Maloof-Bury described the structure in the MLK Hospital in LA where 96% of patients are on Medi-Cal as an example for hospitals to adopt. In this hospital, midwives are entry to care when patients come in and doctors are used when needed. They have the lowest caesarean rates in the county and extremely high rates of black birth compared to other hospitals. She emphasized that the midwifery workforce should be utilized to help distribute care. Unfortunately, there are only two midwifery programs in California due to a lack of funding, and a lot of midwives aren't even working as midwives but as nurse practitioners or RN's. Maloof-Bury suggests that the high-risk patients who are most affected by the ward closures could be greatly supported if there was increased funding and structural changes so that midwives could be more accessible to patients. She also discussed funding towards community clinics that can work in collaboration with physicians to provide care to patients.

It's clear that this is an issue which must be addressed not only on a financial level, but a structural level as well. The current systems and policies which exist for hospitals do not allow them to retain their staff or give sufficient care to their patients. The diverse perspectives provided by these four panelists who are immersed in this issue at different capacities can all agree on one notion: there must be structural changes within this sector of healthcare to provide for patient need and retain maternity wards. As health insurance professionals, it's important to be aware of the current state of California hospitals so that clients are knowledgeable of the services that may or may not be available to their clients.

Watch the full panel discussion here.



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.



Patient Medical History

Applying For A (Check any that apply)
 Learner Permit ID Card Renewal Replacement

Your Personal
Full Last Name: _____
Full First Name: _____
Date of birth: Day: 01, Month: January, Year: 2016, Gender: Male
Nationality: _____

Identification Information
Driver license? Yes No
Learner permit? Yes No
Non-driver ID Card? Yes No

There are lots of places to explore. Places could be urban or suburban. Some people loves to be with nature to free their minds and refresh their souls, but some like to be in the city. You will get lots of benefits such as exploring new culture, meet new people while learning to be adaptive, gain new experiences through things, improve

PHOTO HERE

Driver license, Lerner Permit, or Non-Driver ID card number: _____
Date of Expiration: _____
Type of License: _____
Out-of-State License ID No: _____

Your Personal Details
Height: _____ cm / inches
Eye color: _____

Contact Details
Home Phone No. _____

Digital

Health Records 101

By CalBroker

As technology advances at a rapid pace, people worldwide increasingly turn to digital devices for personal health tracking. Whether they're using a smartwatch or mobile app to track fitness levels or monitor blood sugar and heart rate, more people are becoming vigilant about their health.¹ Digital devices provide them with convenient access to their health records.

Monitoring vital statistics enables people to detect health issues earlier, improving health outcomes and saving insurance companies money on claims.

As a life and health insurance professional, you can empower your clients to take control of their health by providing guidance in personal health tracking. Explore different tools your clients can use to access their health records, along with their pros and cons.

The Importance of Tracking Digital Health Records

When your clients have access to their health records, they can actively participate in their healthcare. Individuals with access to their health records — including laboratory test results, medical records, and prescriptions — report a better understanding of their care plans and a more trusting relationship with their providers.²

Access to digital health records also enables your clients to identify errors in their files, which helps improve patient safety and care.

Ways To Access Digital Health Records

You can recommend various tools to clients seeking online

access to their health records. For instance, your insurance company may offer a branded mobile app or software solution where your clients can log in and view their electronic health records. Many medical providers also offer platforms for patients to access their medical records.

If these services are not available, you can suggest one of these platforms instead.

MyChart

MyChart is a patient portal your clients can use to access their medical records. The platform displays health summaries, medical appointments, lists of medications and prescriptions, and notes recorded from each visit.

With this tool, your clients can share their medical records with friends and family. They can also grant temporary access to a caregiver to help speed up their treatment.

Benefits of MyChart

MyChart has a simple interface, making it easy for your clients to read their test results. It also offers suggestions for preventative care, which helps your clients stay on top of their health. They can also use the platform to communicate with their caregivers.

The app can also send appointment reminders, medication refill reminders, and more. It can be a great selling point for corporate clients interested in client-focused insurance providers.



questions instead of interrupting patient appointments to take phone calls.

These portals also offer comprehensive medical records, letting your clients monitor their health over time. Some physicians store records indefinitely, which helps when your client wants to assess disease progression and other comparative metrics.

Drawbacks of Patient Portals

Since healthcare providers manage patient portals, your clients are required to create individual accounts for each of their doctors. They have to remember multiple logins and set their own

appointment reminders.

Apps such as FollowMyHealth and MyChart consolidate health records from multiple providers in one location. Your clients can set up reminders directly in the app to be notified of appointments, reducing the risk of double-booking appointments or forgetting about them.

As caregivers use patient portals differently, your clients may not always know what to expect when setting up an account. Some clinics let patients schedule appointments in the portal, while others require them to call their office. Even if multiple caregivers use the same portal, they may not necessarily use the same features. This lack of consistency can be frustrating.

Empower Your Clients With Digital Health Records

The Affordable Care Act included provisions aimed at making preventative care accessible and affordable for Americans.⁵ Many California medical plan members may be unaware of how much they can save in healthcare costs by investing in preventative health.

As a trusted client advocate, you can share available resources to help your clients actively manage their health, stay updated with their appointments, and maintain a healthy lifestyle. Encourage your clients to monitor their health using digital health records to improve their quality of life and reduce healthcare costs.

SOURCES:

1. OliverWyman: "The Rising Demand for Tech in Personal Health Monitoring."
2. The BMJ: "Patient Empowerment Through Online Access to Health Records."
3. G2: "FollowMyHealth Reviews & Product Details."
4. Centers for Disease Control and Prevention: "Health Insurance Portability and Accountability Act of 1996 (HIPAA)."
5. Centers for Medicare & Medicaid Services: "Background: The Affordable Care Act's New Rules on Preventive Care."

Drawbacks of MyChart

Other similar apps offer live chat features that streamline the communication process between patients and their caregivers. Additionally, users can't access the app outside of the United States. If your clients have employees who frequently travel, other options may better meet their requirements.

FollowMyHealth

FollowMyHealth is accessible to a wider range of patients, regardless of the software used by their healthcare providers. It can seamlessly integrate with the caregiver's software, giving them access to patient data.

Benefits of FollowMyHealth

Since this tool integrates with various EHR software, many of your in-network providers can offer it to their patients. Your clients can access their health information from multiple providers and track all their preventative and wellness visits — from dentists to general practitioners.

The app also features communication tools your clients can use to request appointments, follow up on prescriptions, and ask questions.

Drawbacks of FollowMyHealth

Lab results are delivered to this app immediately, so an individual may receive concerning news before their doctor or nurse has had a chance to talk to them. Some users have also reported issues with customer service when the app stops working.³

Patient Portals

Due to HIPAA regulations, healthcare providers within your network are unable to transmit health records via unsecured email.⁴ Many practitioners use secure patient portals to communicate with their patients and fulfill requests for personal health information.

Benefits of Patient Portals

Most patient portals are user-friendly and easy to navigate. They offer messaging features patients can use to ask questions or express concerns. Physicians can log in in their free time and answer

Inside CMS' Latest Final rule For MA and Part D plans



CMS on Thursday released a final rule for Medicare Advantage (MA) and Part D plans for 2025, which will enhance standards for marketing, prior authorization, and network adequacy.

Policy primer:
A guide to MA plan types and how they impact care

New standards increase consumer protections

As of March 1, MA plans covered 33.8 million people, a 6.4% increase from a year before. According to CMS, the new policies in the final rule will improve the MA program and offer greater protections to consumers.

In the final rule, CMS set a cap on the compensation amount MA or Part D plans can pay agents or brokers to prevent them from guiding patients to plans that don't best suit their needs. The compensation cap is set to increase to \$100 from the initially proposed \$31.

"We are thrilled CMS embraced our proposal to cap total broker payment," said Ceci Connolly, president and CEO of the Alliance of Community Health Plans. "This commonsense policy change eliminates those perverse financial incentives and levels the playing field for health competition."

The final rule also generally prohibits contract terms between MA organizations or Part D sponsors and third-party marketing organizations that could directly or indirectly prevent agents or brokers from objectively assessing and recommending the most suitable plan for potential enrollees. CMS

provides several examples of impermissible contract terms, including provisions that offer volume-based bonuses for enrollment in certain plans.

CMS is also requiring MA plans to have health equity experts on their utilization management committees. These committees are required to conduct an annual health equity analysis of their plans' prior authorization policies and procedures. According to CMS, this analysis will help identify any disproportionate delay or denials for enrollees who have limited income and resources or a disability.

"CMS is continuing its commitment to ensuring that Medicare Advantage and Part D prescription drug plans remain strong, stable, and affordable for people with Medicare," said CMS Administrator Chiquita Brooks-LaSure. "This final rule builds on Biden-Harris Administration efforts to strengthen consumer protections so that people with Medicare can more easily choose the Medicare coverage options that are right for them."

Additional changes to improve access

The final rule also aims to increase access to behavioral health providers

and services by expanding network adequacy evaluation requirements to include a new outpatient behavioral health specialty. This specialty includes marriage and family therapists, mental health counselors, and addiction medicine clinicians.

To ensure that enrollees are aware of supplemental benefits in their MA plans, plans are required to send out a "Mid-Year Enrollee Notification of Unused Supplemental Benefits" between June 30 and July 31 of every plan year. The notifications must be tailored to each enrollee and include the scope of the benefit, cost-sharing, instructions on how to access the benefit, and more.

Finally, the rule allows Part D plans greater flexibility to substitute lower-cost biosimilar biological products so that enrollees will have access to equally effective, but potentially more affordable, treatments more quickly.

"In my travels around the country, I always hear from Medicare enrollees that Medicare can be confusing and access to accurate, unbiased, actionable information is vital — whether it's about enrollment or how to access services," said Meena Seshamani, CMS deputy administrator and director of the Center for Medicare. "This final rule builds on the bold actions we took last year to improve access to care and address predatory marketing, strengthening the Medicare program and improving the lives of the people we serve."

(BERRYMAN/TEPPER, MODERN HEALTHCARE, 4/4; AHA NEWS, 4/1; CMS)

PUBLISHER'S NOTE

By Phil Calhoun, MBA

A Look Ahead

CalBroker Media is now a true digital media company.

The future of print magazines is a topic that has been debated for years, especially with the rise of digital media and online publishing. We asked CHAT GBT about the future of magazines and added the CalBroker take on the findings.

FACTS: With over 115,500 subscribers our reach exceeds any other industry journal focused on life and health insurance professionals in California.

We compare CalBroker's current and future plans with potential scenarios and trends for the future of print magazines per CHATGBT:

Decline in traditional print magazines: With the increasing popularity of digital media consumption, traditional print magazines may continue to see a decline in readership and revenue. This trend has been evident over the past decade as many print publications have shifted focus or even ceased production altogether. CalBroker moved from 25,000 mailed magazines in 2024 to a digital magazine in 2024. Insurance professionals in California have few options to get the amount of valuable news and educational content delivered to their email box free that CalBroker offers.

Niche and specialized markets: While general interest print magazines may struggle, there may still be a place for niche and specialized publications catering to specific interests or demographics. These magazines may attract dedicated readerships who prefer the tactile experience of print or value the in-depth content they offer. CalBroker heard from very few brokers who enjoy the paper magazine mailed since 1981. Less than 500 brokers purchased a print subscription. This has opened the door to move to print on demand option later this year. Once we find a partner who can help us get a quality product delivered within a reasonable price point print on demand will be available.

Quality over quantity: Print magazines that focus on high-quality content, premium design, and unique storytelling may find success by offering readers an experience they can't easily replicate online. This could involve investing in luxurious paper stock, unique printing techniques, and compelling visual design to create a more immersive reading experience. CalBroker has continued to deliver high quality content. This will be enhanced as plans for 2024 include future "Special" issues to include

a Medicare issue in July; a Employee Benefits issue in September; a Long Term Care insurance issue in November; and in the January/February 2025 issue a focus on Planning to cover financial planning, and succession planning for brokers, and exit planning for business owners.

Integration with digital platforms: Many print magazines have already embraced digital platforms to complement their print editions. This might involve offering digital subscriptions, creating multimedia content, or building online communities around the magazine's brand. Integration with digital platforms can help magazines reach a broader audience and adapt to changing consumer preferences. CalBroker moved to a digital platform in August last year. At the same time over 130,000 e-subscribers were added. This increase enabled us to offer a paid subscription. The move to a print on demand option for those who desire a print magazine will round out the ways to receive the monthly magazine.

Sustainability and eco-consciousness: As environmental concerns become increasingly important, print magazines may need to prioritize sustainability in their production processes. This could involve using recycled paper, minimizing waste, and exploring alternative printing methods to reduce their environmental impact.

Hybrid models: Some magazines may adopt hybrid models that combine elements of print and digital publishing. For example, a magazine might offer a print edition alongside a digital subscription that includes access to additional online content,

interactive features, or exclusive events. CalBroker offers numerous links to content. From recorded webinars to web meeting registration to special offers and appointment, digital offers authors and advertisers new and valuable ways for subscribers to access resources.

Localized and community-focused publications: Print magazines that focus on local communities or niche markets may continue to thrive by providing hyper-local content and fostering connections among readers. These publications can become valuable resources for readers seeking information, events, and businesses within their communities. CalBroker has more health industry content covering providers, carriers and brokers, in the state of California than any other journal

NOTE: In addition to the monthly digital magazine, subscribers also receive:



CalBroker has more health industry content covering providers, carriers and brokers, in the state of California than any other journal.

A weekly eNewsletter packed with a variety of information with a quick read format.

A monthly eCalendar packed with industry events and links to attend and learn more.

A monthly eDirectory with many resources and links to colleagues and education on industry products and services needed to provide solutions to clients.

CHATGBT: Overall, while the future of print magazines may be challenging, there are still opportunities for innovation and adaptation. Magazines that are able to differentiate themselves, provide unique value to their readers, and effectively leverage digital platforms may continue to find success in the evolving media landscape.

CalBroker plans to meet the challenge posed by ChatGbt by providing fresh digital based content, more resources for subscribers with immediate access, seldom found offers for subscribers from advertisers, and interesting content to help provide client solutions via collaboration with subject matter experts.

Phil Calhoun purchased *California Broker magazine* two years ago from McGee Publishers owned by Richard Madden. Rick started the magazine in 1981. After a period of learning the business Phil started the move to digital media and the first step was to build the subscriber base. In March 2023 the Department of Insurance list was added to the original database of about 25,000 subscribers. Over the next few months more of the 130,000 licensed life and health insurance professionals were added to the eMagazine subscriber list, about 10,000 a month.

Cal Broker reaches ALL resident licensed life and health insurance professionals in CA.

The list was so clean that in August of 2023 the list management company was consulted and they gave the green light to add all names on the DOI list into our subscriber list. We are pleased the delivery rate is a consistent 98.5% which is due to the source of the list coming from individuals who provide their contact information to the DOI. With a few insurance professionals leaving the industry over the past year, today the total list is over 115,500. It has been one year since the original list purchase and the plan is to add in all of the newly licensed since last year. It is expected that there could be another 20,000 new life and health licensed individual which will bring the total back to 130,000.

With the email subscriber list strong, the focus shifted to the rising printing cost and postage for sending out 25,000 magazines each month which became a financial concern. Costs increased three times in two years and in August of 2023 the decision was to email free but charge a fee for individuals to get the print magazine mailed. After almost a year the paid print subscriptions have not risen above 200 and later this year the move to a print on demand service is planned. Cost per printed magazine is likely to be about \$10. The eMagazine remains FREE.

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