

SALES TIPS | COMMUNICATION STRATEGIES | GROUP

CALIFORNIA BROKER

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

Spotlight on Group Benefits





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

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1. Applies to new to Covered California for Small Business (CCSB) groups with initial effective dates of 07/1/23, 08/1/23, 09/1/23, 10/1/23, 11/1/23, 12/1/23 and 1/1/24
2. Agency must submit minimum of three groups to qualify for bonus program
3. Bonuses will be calculated on number of subscribers (employees) in effect for the first effective month of the policy as determined by CCSB.
4. No pro-ration of target values will take place.
5. Business written through partnering General Agencies qualifies.
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For a complete list of the program rules go to:

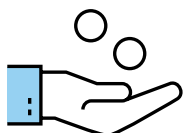
<http://www.coveredca.com/agents/PDFs/Agent-commission-schedule.pdf>



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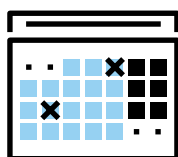
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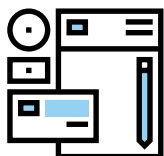
Event Opportunities

Keeping you in front of prospects is always our goal. Using our proven grassroots approach, we will help you connect with potential clients in your community like never before. Get qualified and start hosting!



Client Retention Programs

Yearly retention mailings, a monthly birthday card program, and digital retention resources are just a few ways we can help you retain clients or keep them informed of important changes.



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Flyers, websites, signage, mailers, digital ads, promo items and more! Our turnkey, personalized collateral is always CMS-compliant, so you never have to worry about the message you are promoting. Plus, you get 100 flyers FREE every month from AGA's ProShop!



TRANSITION TO OUR PAID PRINT SUBSCRIPTION



Beginning August 2023, our print piece, the **California Broker Magazine** professional journal, became a paid subscription. Priced at only \$18 a year, our loyal readers can continue to receive **California Broker Magazine** mailed to them in print each month. We also offer the option of receiving the magazine digitally for **FREE**.

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

Join our growing network of Covered California broker partners today!



Email brokerservices@iehp.org
or call **844-264-IEHP (4347)**





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

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

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

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

“Joining the Covered California exchange allows

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

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

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

About IEHP

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

CALIFORNIA BROKER

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Cal Broker's commitment is to be the leading source of news and information for California brokers and agents operating in the health, life, and annuity industry. We are committed to connecting Life and Health insurance professionals to valuable resources and solutions they can provide to their insurance clients.

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STRUCTURED FOR SUCCESS

The "5th Quarter" Is a Breeze With the Right Partner

BY KIM GOMEZ, SHAHRAM HOMAMI AND CARA MUDGETT

At Warner Pacific, we've spent decades structuring and refining our operational systems and teams for success *and* sanity.

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Tax friendly way to grow funds over time

Bringing annuities to your clients can help them solve their planning issues for retirement.

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SUBSCRIPTIONS

www.calbrokerstore.com

Subscriptions: U.S. one year: \$36. Send change of address notification at least 20 days prior to effective date; include old/new address to:

HEALTH BROKER PUBLISHING
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(714) 664-0311

California Broker (ISSN #0883-6159) is published monthly. Periodicals Postage Rates Paid at Burbank, CA and additional entry offices (USPS #744-450). POSTMASTER: Send address changes to California Broker, 14771 Plaza Drive Suite C • Tustin, CA 92780

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What is Breast Cancer Awareness Month?

Breast Cancer Awareness Month, held in October every year, aims to promote screening and prevention of the disease, which affects one in eight women in the United States every year and 2.3 million women worldwide. Known best for its pink theme color, the month features a number of campaigns and programs — conducted by groups ranging from breast cancer advocacy organizations to local community organizations to major retailers — aimed at:

- supporting people diagnosed with breast cancer, including metastatic breast cancer
- educating people about breast cancer risk factors
- stressing the importance of regular screening, starting at age 40 or an age that's appropriate for your personal breast cancer risk
- fundraising for breast cancer research

BREAST CANCER AWARENESS: STATISTICS

Breast cancer is the most commonly diagnosed cancer among American women. Black women are most likely to die from breast cancer than women of any other racial or ethnic group. Experts believe that it's partially because about 1 in 5 Black women is diagnosed with triple-negative breast cancer, more than any other racial or ethnic group. About 85% of breast cancers occur in women who have no family history of breast cancer. These occur due to genetic mutations that happen as a result of the aging process and life in general, rather than inherited mutations.

This information is provided by Breastcancer.org. Donate to support free resources and programming for people affected by breast cancer.

<https://give.breastcancer.org/give>

Announcing 2 ways to offer Long-Term Care to your clients

California Broker is pleased to have a collaborative relationship with Marc Glickman and his specialists at Buddy Insurance. This gives our subscribers looking for help with LTCi case design the option to use the LTCi portal we have set up with Buddy Insurance. This platform will help health and life insurance professionals learn more about LTCi and refer clients — or learn how to write LTCi policies using his process.

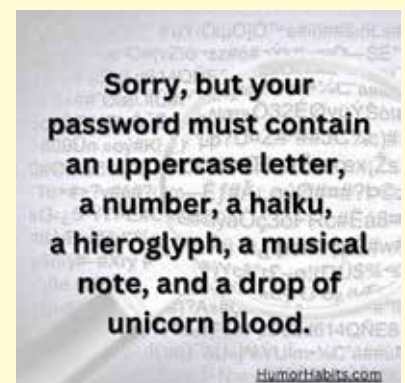
To collaborate on LTCi, go to the online portal listed below. See how you can get LTCi case design help, make referrals to LTCi specialists who will collaborate with you and help you help your client. You will share in the success of a LTCi sale from your referrals.

Once connected with a LTCi specialist, you can decide if you want to stay involved in each client's case leading to a successful LTCi policy sale or refer your client and get process updates.

Want to learn the LTCi business? Use the resources on the platform. In future communications we will share how the training process works.

CONNECT to the Buddy Insurance LTCi PORTAL HERE:

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Visit CalCPAHealth.com/CalBroker to learn how to sign up with us and about our eligibility guidelines.

Value-based benefit design using the 4 Ps

Excerpts from Benefits Pro article by Ari Hoffman

I've learned that the best approach to value integrates all aspects of an employee health benefits plan in one streamlined experience using a flexible technology and service platform designed to meet an organization's unique needs. In this article, I propose a conceptual framework for better value built on what I call the "Four Ps" of value-based benefits, with plan administration and navigation capabilities that are: predictive, precise, proven, and pleasing.

I have found these four components to be the ingredients to success when architecting a benefits design that works for and with people. Let's take a closer look ...

Predictive

An ounce of prevention is worth a pound of cure. The earlier we can identify a person's needs and appropriately match those needs with available and cost-effective resources, the better the outcomes.

Precise

To truly harness the power of predictive and personalized analytics, our care suggestions must be precise. We need to get it right at every touchpoint, because getting it wrong erodes the trust we need to truly serve member needs.

Proven

So much of health care and benefits boils down to behavior change. To be effective, employers need to give the right information to the right person, through the right communication channel, at the right time. In many instances, a lack of information delivered properly will lead to care avoidance altogether.

Pleasing

Finally, care needs to be easy to navigate for the individual end user. If the process of selecting care proves strenuous on the individual, they won't be motivated to take the steps they need to get care. An effective member experience strategy combines digital innovation, grounded in easily navigated interfaces, with human support to help employees better understand and manage their care.

<https://www.benefitspro.com>

I Found a Mind-Boggling Labyrinth When I Set Out to Create a Simple Map for How to Appeal Your Insurance Denial

by Cheryl Clark for ProPublica

I spoke with more than 50 insurance experts, patients, lawyers, physicians and consumer advocates about building a tool anyone could use to navigate insurance appeals. Nearly everyone said the same thing: Great idea. But almost impossible to do.

The insurance industry and its regulators have made it so complicated to file an appeal that only a tiny percentage of patients ever do. For example, less than two-tenths of 1% of patients in Obamacare plans bothered to appeal claims denied in 2021.

The central problem: There are many kinds of insurance in the U.S., and they have different processes for appealing a denial. And no lawmakers or regulators in state and federal governments have forced all insurers to follow one simple standard.

www.propublica.org/article/how-to-appeal-insurance-denials-too-complicated

Calendar

Oct. 6, 9:30 am - 1 pm PST **CAHIP-LA** All Aboard for 4th Quarter @ Los Angeles Live Steamers Railroad Museum. Register: cahip-la.org

Oct. 5-6 **NAIFA-California's 2023 Career Advancement Conference**, "e3 to EMPOWER, ENGAGE, and EXPLORE" @ Humphreys Half Moon Inn, San Diego. Register: ca.naifa.org/e3conference

Oct. 8-10 **2023 SIIA National Conference** @ JW Marriott Desert Ridge, Phoenix. Register: siiaconferences.org/nationalconference/2023

Oct. 31-Nov. 2 **ITC InsurTech Connect** @ Las Vegas. Register: vegas.insuretechconnect.com

Nov. 09, 9:00 - 11:00 AM PST, **GGAHU Mental Health CE, Is Parity Working?** Mental Health and Substance Use Disorder Claim Advocacy for Brokers @ Lafayette, CA. Register: ggahu.org

Nov. 09, 11:30 AM - 12:30 PM PST **What Advisors Should Know About Broker Compensation: The Past, Present and Future** @ Online Dickerson-Group.com
NOTE: Dickerson offers variety of ongoing CE credit courses, found at DICKERSON-GROUP.COM

2024

Jan. 22 @10 am - 5pm PST **CAHIP Innovation Expo**, Sheraton Universal, LA. Register: CAHIP.com

March 25-27 **Ellevate Women's Leadership Summit 2024** @ JW Marriott Las Vegas. Register: <https://ellevatefoundation.org>

May 6-8 **CAHIP Capital Summit** @ Kimpton Sawyer Hotel, Sacramento; Register: CAHIP.com

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

Self-insured vs. fully insured: What it takes to customize healthcare plans

As employers watch healthcare premiums rise each year, many are questioning whether their health plans are sustainable or a liability to their employees and business.

That brings employers to an age-old benefits question: to be self-insured or fully insured?

A majority of employers are fully-insured, meaning they pay a monthly premium to a health insurance company in exchange for their employees' healthcare coverage. A self-insured employer takes on the financial risk of directly providing healthcare benefits that are unique to their workforce, paying for a share of their employees' appointments, treatment and medication. Self-insured employers often work with a third-party administrator (TPA), which specializes in handling the administrative side of healthcare benefits.

While the financial responsibility and logistical hurdles that come with a self-insured plan are intimidating, it can save employers money in the long run and lead to more quality care.

Read more:

<https://bit.ly/3Pyg5Mj>

AGA OFFERS BROKER RESOURCES

Broker's Guide on Digital Advertising to Seniors

Digital ads are a very effective way to reach seniors at a lower cost per lead. However, it requires creating good content and knowing where to run your ads.

86% of today's seniors are active online — giving healthcare insurance agents a unique opportunity for lead generation through digital advertising to seniors.

To do this successfully, one needs to know their target audience – how long they spend online? What websites do they frequent? How do they speak? What do they want to learn? Understanding the nuances of effective headlines, visuals, and messaging is essential. It's not just outreach; it's resonance.

Go to our blog at appliedga.com/blog for these resources.

An Independent Agent's Guide to Effective Social Media Marketing to Seniors

Over the last 10 years, social media marketing has quickly become one of the most important facets of a digital marketing strategy. Today, it remains a critical part of an independent insurance agent's sales arsenal.

According to a Pew Research Study, 45% of adults in the United States over 65 use at least one social media site. That means 45% of your target market is online, and you should be too.

Use our guides to become a savvy online marketer!



Employers expect health benefit costs to climb 5.4% in 2024

High inflation, labor shortages and industry consolidation contributed to the projected increase, according to a new survey of employers from consultancy firm Mercer. In addition to inflation and labor shortages, healthcare consolidation and the introduction of “ultra-expensive” gene and cellular therapies contributed to the increased cost projections.

- Employers face the challenge of balancing improvements to benefit plans with cost reduction strategies. Surveyed employers indicated that, if they had not made efforts to cut costs, health benefits for their largest medical plans would rise by an average of 6.6%.
- The Mercer survey is the latest to point to rising healthcare costs. In June, consultancy firm PwC predicted in its annual report that healthcare costs would rise by 7% in 2024 as drug costs climb and inflation drives providers to ask for rate increases from insurers.
- “One factor may be that as employers have moved away from cost-shifting to employees, they’ve been implementing cost-management strategies directed at the biggest drivers of cost – complex care and chronic medical conditions,” Tracy Watts, national leader of U.S. health policy at Mercer.

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Traveling abroad?

Make sure your health insurance includes these 5 benefits

BY DON VAN SCYOC

Your customers' travel plans are in full swing this time of the year. Many people take advantage of time off from work and school during the holidays to visit friends and family or to treat themselves to an international trip. It's also a popular time to book spring break vacations. While your customers are making sure their passports, flights and itineraries are set, have they considered what happens if they need medical care? They should.

Critical gaps in coverage

Most people assume they can use their U.S. health insurance abroad. Especially if their insurance card says "PPO," they believe they're covered wherever they go. Your customers probably don't know there are often major gaps in coverage when using their domestic insurance

overseas and that critical benefits are not provided.

Don't just take my word for it. Although few people likely read their U.S. passports, if they turn to page 6, they'll find the following information listed under "Important Information": "HEALTH INSURANCE – Medicare/Medicaid does not cover healthcare costs outside the U.S. Does your insurance apply overseas, including medical evacuation, payment to a hospital or doctor overseas, or reimbursement to you later?"

The passport language also directs travelers to consult the travel.state.gov website, which encourages travelers to learn before they go abroad what medical services their health insurance will cover overseas. The website emphasizes once again that Medicare and Medicaid do not

cover medical costs overseas and points out that travel insurance is different than travel medical insurance. **Travel insurance protects your financial investment in a trip — things like lost luggage and canceled flights. Travel medical insurance covers the medical care you may need while outside your home country.**

How you can help

If you know of customers planning international travel, ask if they've secured travel medical insurance. Also proactively reach out to your entire customer list, see if overseas trips are in their future and plant the seed about the need for more comprehensive coverage.

Now, many of your customers will say they don't know what travel medical insurance is — or they may immediately

say it's not necessary. Don't be afraid to (gently) push the need for it. You're only looking out for their best interests (and hey, even the U.S. government says it's necessary!).

The best way to do this is to start with the coverage they already have. Ask if they know what their domestic plan covers. They may know top-line details, but you can use the following topics to dig deeper and guide your conversation. This will help your customers realize what their current domestic plan doesn't cover overseas — and what to ensure their international healthcare plan does.

Top 5 must-have health insurance benefits for traveling internationally

1. Medical evacuation and repatriation capabilities and coverage.

Medical evacuations can have devastating consequences if the person doesn't have coverage. They often require upfront payment with reimbursement later, and they can cost in the tens of thousands (sometimes well over \$250,000). Customers may wipe out their accounts, spend critical time finding people who can loan them money or may not receive the care they need because they can't pay for it.

2. Global telemedicine services included as a standard benefit.

Even if a domestic plan offers telemedicine, customers may not be able to use it outside the U.S. This may sound surprising, as we've become accustomed to online meetings and calls with people all over the world. However, telemedicine providers' licenses may prohibit them from practicing outside the U.S. or even outside the state where they're licensed.

3. 24/7/365 multilingual support for medical assistance, benefits verification and case management.

If customers require care or have questions, is there someone who is available all the time, given time zone differences? Providers in other countries may not speak English— is there someone who can help customers communicate? If customers need help on the weekends, is the carrier available? It's easy to see how the ideal choice in these situations is a large insurance carrier

with a worldwide network and 24/7/365 support.

4. Guarantee of payment (GOP).

Many hospitals won't provide care without a GOP — or will require the patient to pay in full (often out of pocket!) before they receive care. Part of the job of international medical insurance carriers is to negotiate on their customers' behalf and send a GOP to the medical facility. When customers are sick, the last thing they need to worry about is how they're going to pay for the care they receive. And in serious cases, customers may be unconscious or physically unable to make the calls necessary to secure a GOP. An international carrier can be your customers' literal lifeline.

5. Coverage of pre-existing conditions.

If your customers have medical conditions, it's vitally important they seek out a travel medical insurance plan that covers pre-existing conditions; otherwise, any care related to that condition may not be covered. Here's an example. A customer takes blood thinners but has a heart attack while traveling. Although they purchased international medical insurance, their plan doesn't include pre-existing conditions. The blood thinners are evidence of a pre-existing condition — and the customer must pay out-of-pocket for treatment related to the heart attack. Pre-existing condition coverage is an absolute must for many people.

This is only a partial list of benefits your customers should insist on when traveling internationally. Are global wellness and mental health services available? What if your customers left an important daily prescription at home — how will they get it filled overseas? Does the plan offer digital tools and resources your customers can easily access from their phone?

These scenarios could happen to anyone — anywhere. Your customers will likely realize that traveling without the security of these benefits simply isn't worth the risk.

Guide your customers in taking the next step

You've helped your customers understand the type of coverage they

need. Now they can take a step back and do some research on their current domestic plan. Encourage them to go to their employee benefits website and confirm what their domestic plan covers internationally. They can also call their benefits or human resources representative directly, explain that they're taking an international trip and ask what their plan covers in that destination.

If (more likely, when) your customers learn their domestic plan does not include most of the important items discussed above, they'll know they need to purchase international coverage— and you've already helped them know what to look for.

One last thing. Be sure to preemptively address the often-mistaken assumption that international plans aren't affordable. Make sure customers know they can secure coverage for just dollars a day. And remind them that, yes, it's worth it. This may help put things into perspective: Your customers will probably spend hours researching their cellular plan and may have to pay a fee to ensure their phone works when they go overseas — isn't their health and financial well-being worth that same investment?



Don Van Scyoc,

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

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

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COLLABORATION

Secure Your Clients Financial Well-Being with a Team Approach

**Diverse needs demand diverse
professional partnerships**

BY JERRY SLUSIEWICZ



In the ever-evolving landscape of financial planning, the role of insurance sales professionals has transcended beyond simply selling policies. Today, the most successful insurance executives are embracing an integrated approach, transforming themselves into well-rounded advisors who orchestrate a symphony of financial expertise for their clients. By fostering collaborative relationships with certified public accountants (CPAs), estate planning attorneys, and investment advisors, insurance sales professionals are uniquely positioned to provide comprehensive solutions that secure their clients' financial well-being.

Traditionally, insurance salespeople focused primarily on providing coverage for life, health, annuities, Medicare and disability needs. However, the contemporary financial landscape demands a broader understanding of their clients' circumstances. By collaborating with a diverse team of financial professionals, insurance advisors can offer a comprehensive suite of services that address clients' unique situations while remaining in complete control of the relationship.

One crucial aspect of this holistic advisory approach is the partnership with **CPAs**. The tax implications of financial decisions can significantly impact a client's overall financial health. By working alongside a skilled CPA, health insurance advisors can navigate complex tax codes, optimize tax strategies, and minimize tax burdens for their clients. This collaborative effort not only highlights the advisor's commitment to the client's financial success but also builds trust and reinforces the advisor's role as a central figure in the client's financial journey.

Estate planning attorneys play a pivotal role in ensuring a client's assets are protected and distributed according to their wishes. Collaborating with an estate planning attorney allows health insurance advisors to guide clients through the intricacies of wills, trusts, and other legal instruments, creating a comprehensive plan that aligns with their financial goals. This shared approach underscores the advisor's dedication to securing the client's legacy and instills confidence in their ability to navigate complex financial landscapes.

Moreover, the involvement of **investment advisors** can further elevate the universal advisory experience. While health insurance products provide stability and protection, investments such as stocks, bonds, mutual funds and ETF's offer growth potential, while maintaining a level of liquidity not found in many insurance-based offerings. By partnering with a competent investment advisor, health insurance professionals can help clients maximize their fluid asset potential while ensuring diversification and risk management. This collaborative approach enables clients to achieve a balanced portfolio that aligns with both their short and long-term financial objectives.

It is essential to note that, despite the collaborative nature of these partnerships, the health insurance professional remains the lead client representative. This dynamic ensures that the client's overall financial strategy is cohesive and tailored to their needs. When you bring your client into a collaborative process, you fill the trusted insurance advisor's role as the orchestrator of this joint effort. The effort underscores the commitment to your client's financial journey, and places you as the trusted guide in a complex financial landscape.

The benefits of a holistic advisory approach extend beyond the

immediate financial gains. Clients receive a more comprehensive and personalized experience, resulting in greater satisfaction and more loyalty to you. The collaborative efforts of insurance professionals, CPAs, estate planning attorneys and investment advisors create a seamless flow of information. This enables you to take the initiative to respond to your client's changing circumstances and opportunities.

The take away ...

The modern insurance sales professional is no longer limited to selling policies; they have evolved into holistic advisors who curate a team of experts to cater to their clients' financial well-being. By partnering with CPAs, estate planning attorneys, and investment advisors, insurance experts can provide comprehensive solutions that address all facets of their clients' financial lives. This collective approach not only enhances the quality of service but also cements the insurance advisor's role as the central figure in the client's financial journey. As the financial landscape continues to evolve, embracing a universal advisory approach remains a powerful way for insurance professionals to create enduring value for their clients while putting themselves into a position of being a one stop authority for any client needs.



Jerry Slusiewicz, principal of Pacific Financial Planners, has more than 30 years of experience as a financial advisor offering investment and insurance products and services. He is focused on helping clients work toward their retirement dreams through a well thought out financial strategy. Jerry began his career as an advisor in 1987 and has worked for several Wall Street firms, including Shearson, Lehman Brothers, UBS and others. Wanting to create a more client-first approach to portfolio management, he began his own Registered Investment Advisor firm in 2004, specializing in managing risk and creating income streams for retirees and those soon to be retired.

Community service has been a constant over the course of his career. He served as mayor of Laguna Niguel, was a volunteer coach for several youth sports programs, helped coordinate fundraising walks for juvenile diabetes, and guest lectures at local high schools, colleges and universities. Outside the office, Jerry enjoys spending time with his wife of 30 years, Vicki. They have two grown children, Sierra and Jaden.

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Successful health insurance professionals understand the benefit of the collaborative process and value of working with subject matter experts (SMEs) to extend more services and solutions to help their clients.

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Tips to Sustain the Flow of Referrals & Introductions

Find out what clients love about working with you and get referrals

October is a prime month for building our culture of doing business through referrals and personal introductions. For most agents, brokers, and advisors, October is filled with client-service meetings and other reasons for being in touch with prospects and clients. **By Bill Cates**

Here's a checklist of 10 important things you want to do consistently to bring continued value, enhance personal connections and, therefore, multiply your best clients through personal introductions.

1. Your Client-Focused Why.

Telling a prospect *why you believe* in the work you do usually has a story connected to it. Telling this very short story or anecdote will help you build trust with your new prospects. This, in turn, helps you win more clients and become more referable at the same time. Make sure you end this short story with a benefit to your prospect or clients.

I'm telling you this because I'm on a mission to make sure most everyone I meet is equipped to make educated financial decisions that are always in their best interest.

2. Be Curious.

Pay attention to who your prospects and clients know — family, friends and colleagues. Who is impacted by their financial decisions? Whose financial decisions impact them? What do your clients do socially? How about philanthropic or community activity? The more context you gain about your client, the better you are able to serve them. And, at the same time, you are building an *inventory* of folks to whom you can seek introductions later.

3. Discuss Expectations.

One destroyer of relationships (business and personal) is when one party has an unexpressed expectation. When they don't communicate that expectation, the expectation goes unmet. You

know exactly what I'm saying. Everyone has experienced this on multiple occasions.

Check in regularly with your clients and centers of influence (COIs) to see if any expectations aren't being met, to clear up issues, and to verify value is being recognized by them. Learn their pet peeves. Find out what they love about working with you and your team. This conversation will strengthen satisfaction and loyalty and it can turn into referrals without even asking.

4. Promote Introductions.

Sometimes I call this "planting referral seeds." This is something you can do early and often with prospects and clients. Insert the concept of introductions into the relationship early by celebrating meeting others through introductions. I've been teaching financial professionals to say, "Don't keep me/us a secret" for years. This usually creates a smile and sometimes introductions right on the spot. Let your clients know that if any of their friends, family members or colleagues are feeling concerned or unsettled about their financial planning — you are never too busy to *see* if you can be a *resource* for them.

5. Teach Your Prospects, Clients and COIs How You Handle Introductions.

Two big reasons some clients don't like to give referrals are:

- Concern about privacy
- Concern about how you will handle their introductions to others.

Let them know that everything remains confidential (even with very close friends and family members) and that you work

Manage your appointments with an agenda so you don't run out of time and you don't forget key points. -

through introductions. You're not going to call anyone from out of the blue. You will work with them to create a process that feels comfortable for everyone.

6. Use an Agenda in Your Meetings. Manage your appointments with an agenda so you don't run out of time and you don't forget key points. Put *Value Discussion* or *Expectations Check* near the end. Show the agenda to your prospect or client so you each check off the items as you complete them. This expectations check and possible conversation about introductions should be part of the meeting, *not* an afterthought.

7. Use a Pre-Appointment Routine. Just as athletes have their pre-game routine and musicians have their pre-performance routine, you can have a pre-appointment routine related to introductions. Create your meeting agenda as described above. Then think through who you know that they know or what categories you might run by them for possible introductions. When you create some focus on this conversation beforehand, you'll be more confident and, therefore, produce better results.

8. Don't Settle for Word of Mouth. Get Introduced! These days, since it has become increasingly difficult to get through to prospects, referrals are pretty much worthless if you don't get *connected* (introduced) to the prospect. So, turn your clients' willingness to refer into an effective introduction. In-person intros are great, if logistics are easy. Three-way virtual introductions are also very effective. My favorite method — because of its efficiency and effectiveness — is an email introduction. Here, your introducer is introducing you to a prospect via email, similar to if all of you ran into each other at a restaurant. "*George meet Laura.... Laura meet George.*"

9. Keep the Introducer in the Loop. Keep your referral source updated with your progress. Keep them cc'd on your initial email with the prospect but remove them after that. If you set an appointment, let them know. If you are having trouble reaching the new prospect, let the source know. Your source will often reach out to their friend to help the connection get established.

10. Say "Thank you."

You want to *reward* your referral source by saying *thank you*. Don't wait for the prospect to become a client. Reward the giving. A handwritten note is the minimum. Gift cards are great. It's not about the money; it's the gesture of saying thank you. My favorite thank you is something affordable and personal — such as a tumbler or coasters with their university logo. Whatever you do, keep these compliant.

While each of these items stands alone and can further your effort to generate more referrals and introductions, I think you can see how they can all work together to help you establish a culture of referrals and introductions that will help you multiply your best clients over and over again.



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

**CalBroker readers can get free valuable tools here:
www.ReferralCoach.com/resources.**

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GROUP

A Client Guide to Open Enrollment and Employee Communications

Make sure employees are using benefits all year long

BY MELISSA SCHACHTER

Open enrollment is finally upon us! You and your clients have spent months reviewing employee benefits usage and making adjustments to 2024 offerings. Together, you've run through your checklists to ensure a robust package of benefits that meet your client's goals and maximize their available budget. You've dotted every I and crossed every T... or have you?

Your clients may feel confident in their understanding of their 2024 offerings and the pros and cons of various ancillary offerings, but can the same be said for their colleagues across the company? Have you and your clients discussed how they will educate employees on their benefits — not just new

options? Established offerings may have been forgotten or misunderstood. To ensure that employees are making the most of their carefully curated benefits packages, brokers should remind clients to discuss these four things in their open enrollment communications.

Outline significant changes in coverage or offerings

If a client has changed insurance carriers, they'll want to take more time than usual to explain the changes and help employees understand when to update their providers and which plans are most analogous to their previous coverage.

Similarly, if your client is introducing new voluntary

products like identity theft protection, pet insurance or legal services, they'll want to spotlight how the benefit works and why employees should opt-in. While many employees are familiar with non-medical benefits like vision and dental, the growing range of voluntary benefits may be unfamiliar or confusing without guidance.

Remind employees to look at all options, not just renew past choices

Employees who have experienced qualifying life events since their hiring — or who are anticipating one in 2024 — should take care to thoroughly review all of their benefits offerings. Often, we overlook things that do not apply to us in the moment. While new employees may have been told about dependent care or life insurance during orientation, a single employee with no dependents likely just nodded and promptly forgot the conversation since it wasn't applicable to them.

Employers put a great deal of time and effort into developing comprehensive benefits packages that support employees in multiple aspects of their lives. Particularly with long-time employees, it's worth reminding them of the full scope of benefits offerings available to them.

Explain Medicaid unwinding, which may impact some employees

During the COVID-19 pandemic and Public Health Emergency (PHE), Congress provided increased Medicaid funding to the states, as long as certain conditions were met. One of these conditions was a prohibition against terminating Medicaid enrollees' coverage while the PHE was in effect.

With the end of the PHE in May 2023, states are now free to begin the process of "unwinding" to determine if there are individuals currently enrolled in Medicaid who no longer qualify, such as those who are now eligible for employer-sponsored coverage. Each state sets its own timeline for unwinding, which means there may be employees who are currently enrolled in Medicaid, but who will not be notified of their coverage termination until sometime in 2024.

Losing Medicaid coverage is considered a qualifying life event and triggers a special enrollment period. As a result, if someone enrolled in Medicaid received notice of loss of coverage of Medicaid prior to July 10, 2023, they have 60 days from July 10 to enroll in another plan – Sept. 8, 2023. If someone loses Medicaid coverage on July 10 or after, they have 60 days to enroll in another plan. If employees do not enroll within the time period allotted for the special enrollment period, they will need to wait for the next annual open enrollment period.

Highlight Employee Assistance Programs (EAPs)

With growing awareness of the importance of mental health, 98% of mid to large U.S. companies are offering EAPs — voluntary benefits programs that provide support to employees dealing with personal or life challenges that impact their job performance, health and mental well-being. Despite the ubiquity of EAPs, there are many misconceptions that prevent employees from taking advantage of these programs — employees may fear that information shared with an EAP will be used against them

or that these programs are only for people in distress.

EAP services are generally provided by third parties who are prevented by federal law from disclosing information shared by employees with their employers. In order to encourage use of EAPs, employers should take time to educate employees on how such programs work and share examples of ways they support employees.

Reminder: Don't forget to share materials

Clients are not on their own when it comes to creating their open enrollment communication plans. Brokers have access to a wide variety of white-labeled materials, collateral and tools from vendors. These resources should be shared with clients to simplify the process of explaining benefits options to employees and guide employees in selecting benefit plans that meet their individual needs.

You and your clients have worked hard to provide a curated package of competitive, high-quality options that allow employees to tailor their benefits to their specific needs. To ensure that employees are making the most of their options, make sure your clients have thought through how they will introduce and explain various benefits ahead of open enrollment.



Melissa Schachter is VP of Administration, People & Culture at BenefitMall.

Melissa joined BenefitMall in March 2022 and took responsibility for BenefitMall's culture and engagement, talent management, performance management, recruiting, employee communications, employee onboarding and training, compensation, benefits, and employee relations.

She earned a bachelor of arts degree from the University of Texas at Austin. Melissa holds a Senior Professional in Human Resources (SHPR) certification from the HR Certification Institute and is a Society for Human Resource Management Senior Certified Professional (SHRM-SCP).

Melissa resides in Dallas with her husband and their two kids. Outside of work, she can be found reading, cheering on her kids' softball and football teams, and volunteering in the community with her son through the Young Men's Service League.

www.benefitmall.com

Five Ways to Help Your Clients Comparison Shop for Health Care Services

*Remind employers and employees
how to best use their benefits all year long*

By Shawn Wagoner

While technology has changed how we all shop for everything from car rides to vacation rentals, health care quality and cost information has often remained elusive for many Americans. In fact, research from McKinsey shows that access to health care quality and price transparency information may help reduce out-of-pocket costs for consumers and lower the total cost of care for employers. That's because the cost for health care services at hospitals and doctors' offices can vary nationwide and within the same city, despite research showing higher-priced care does not necessarily deliver higher-quality care. In Los Angeles, for instance, UnitedHealthcare shows a knee MRI can cost from \$210 to \$5,950, and childbirth can range from \$3,820 to \$22,150.

That's why it is important to make it clear to your employer groups that even when employees have an insurance plan, they should still seek to make wise choices when accessing medical services. To help make comparison shopping for care more available, some hospitals and health plans are now publicly sharing price information, while new safeguards are helping reduce the likelihood of people receiving an unexpectedly large balance medical bill in certain emergency or hospital scenarios. While these are

important efforts, people still need to understand where and how to access this information — and what to do with it once they have it. As a broker, you can help guide your clients on how to best use the coverage they have purchased.

Consider these five strategies to help your clients more effectively comparison shop for health care services.

Offering to help your clients communicate to employees how to maximize the value of their benefits throughout the year can go a long way to establishing yourself as a trusted advisor.

1. Suggest checking with local hospitals or health plans.

Some hospitals and health plans are publicly disclosing cost information, including online. However, it may be difficult to decipher what you'll pay for a visit or procedure if you're only looking at online data, especially hospital pricing information that may not account for your health plans negotiated rates.

Checking with your health plan is generally the better option, as some are making estimates available based on the member's specific plan and actual contracted rates with care providers.

Other approaches to consider include

reviewing publicly available transparency resources (www.guroo.com), asking your doctor or their support staff how much the service will cost or calling around to other local health care providers to ask about pricing. Always make sure what a specific plan covers, and who and where you can get services that are 'in network.'

2. Consider enrolling in a plan with upfront pricing.

Some newer health plans like Surest are moving away from estimates and instead offering upfront cost and coverage information, which enables members to review out-of-pocket expenses before medical care is delivered. Some of these plans use value-based copays, rather than deductibles or coinsurance, which means the copay for the same service may vary depending on the care provider and facility you select. This approach can encourage people to select higher-quality, higher-value care providers and settings, in the process reducing out-of-pocket costs for consumers and lowering the total cost of care for employers.

3. Select the right setting.

When seeking nonemergency care, it's important to always start with in-network health care professionals and facilities, as receiving care out of network may lead to an exorbitant charge. The type of facility

The importance of information when deciding on where to receive care.

Respondents ranked 8–10 on a 10-point scale,¹ %



¹ Question Q2: How important is the following information when you're deciding where to get care? (Population: All respondents; n = 4,957; top 12 of 24 shown). Source: 2019 McKinsey Consumer Health Insights Survey

McKinsey
& Company

you select can also have a significant impact on the cost.

Receiving care at a hospital tends to be the costliest setting, while services at freestanding, ambulatory or same-day clinics typically cost less. For instance, UnitedHealthcare data shows that MRIs and CT scans at hospitals average over \$1,250, compared to \$480 at freestanding facilities. To help people make more informed decisions, consider reviewing communications from your health plan at the start of each plan year and throughout the following months, including for near real-time alerts (emails/text messages) that can assist with selecting the optimal setting.

For minor, nonemergency and certain specialty services, a virtual care appointment may offer improved convenience and affordability. In some cases there is \$0 out of pocket cost.

4. Save on prescription medications.

About half of Americans take at least one prescription medication, resulting in out-of-pocket expenses of more than \$1,200 per year. For help to lower that, new resources are enabling people to compare available direct-to-consumer pricing for traditional generic drugs with insurance pricing to help individuals get the best available prescription drug price. Separately, care providers are

gaining access to systems that enable them to identify which medications are covered by a patient's health plan and the cost for each, offering suggestions for other clinically appropriate, lower-cost alternatives that could be prescribed.

5. Avoid and negotiate surprise bills.

Even with upfront research, there are still a few potential risks to be aware of. To ensure preventive services are covered by your health plan, and not deemed an advanced screening that could result in an out-of-pocket charge, confirm with your health plan that any services or tests are covered under your benefits.

In the event of an unexpected balance bill, there are several steps to pursue. First, examine the explanation of benefits (EOB) to help determine if the amount you owe is higher than your cost share. While it may be possible to talk with the support staff at the hospital or doctor's office to request that the charge be waived or reduced, it is often more effective to check with your health plan to determine what type of resolution support may be offered to help negotiate on behalf of members with hospitals and care providers.

If you receive a balance bill from an out-of-network care provider, call the number on your insurance ID card to alert your health plan and check on assistance.

These strategies can help brokers show their value beyond open enrollment activities. Making sure your client groups know how to use their benefit plans can improve their health and save money in the long run.



Shawn Wagoner

is the SVP of the Surest health plan for UnitedHealthcare, the nation's largest health care company. In this role, Shawn leads the sales, underwriting,

account management,

technology, and product teams for Surest, which offers a new approach to health benefits that removes deductibles and provides members with clear, upfront cost and coverage information before treatment.

Shawn is driven by the belief that the health insurance industry can do more to help employers offer better, more affordable and accessible benefits to their employees. Through Surest, Shawn has helped create a new approach to health insurance that combines an intuitive member experience, a novel plan design and advanced algorithms to improve satisfaction and reduce health care costs for consumers and employers.

Before his health care career, Shawn served as an officer in the U.S. Army and is a veteran of the Iraq War.

Shawn is a graduate of the United States Military Academy at West Point and earned his MBA from the Harvard Business School. He is based in Minneapolis.

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www.uhc.com and www.surest.com

Video available:

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Ways the Benefits Landscape is Changing

New report offers insights for how brokers can pitch benefits to group clients now and in the future

By VSP Vision's Global Innovation Center



Since 2020, the modern workforce and workplace have experienced seismic shifts in the U.S., with a new-found level of flexibility that is both freeing and unfettering.

Remote work has led to new opportunities (and even more questions), as employers adapt at light speed to these changing employee expectations. This flexibility has triggered unprecedented job movement, with women in particular leaving roles at record rates, and companies struggling to retain younger workers.

However, the always-on nature of remote and hybrid work, coupled with economic volatility, is also contributing to increased employee burnout, with nearly two-thirds of the workforce saying their work is impacting their mental health. In response to these workforce trends that are both empowering and exacting, innovations in benefits — new technologies, models, and segments — have emerged to help organizations offer holistic, individualized solutions that address an employee's unique situation and needs.

In addition, organizations are balancing this premium on talent retention and attraction, increasing benefits offerings by 22% since the pandemic, with real inflation-induced cost concerns. The result is new technologies and startups geared toward benefits access, utilization and engagement.

And it's not just about the new. Long-standing benefits, such as healthcare and vision care, are evolving with these shifts, investing in and rolling out services and models to meet employee demand. For example, VSP Vision Care, the leader in health-focused vision care for nearly 70 years, launched its VSP LightCare™ benefit during the pandemic to expand access to blue light filtering products aimed at reducing digital eye strain.

A new report from VSP Vision's Global Innovation Center shines a spotlight on these shifts, introducing five leading employment and technological trends that are driving the future of benefits: the changing nature of work, considerations for specific stages of life, expanded access, at home everything, and gamification.



This is more than an 18% increase from 2022.

Roughly a third of U.S. employees experience burnout and distress at work. In response, 67% of employers plan to prioritize mental health solutions in the next three years.



Five Transformative Trends of Benefits

1 Hybrid work has increased demands for lifestyle benefits.

During the pandemic, organizations had to grapple with the switch to remote and hybrid work arrangements. Additionally, other forces such as digitization, the increased need for upskilling and reskilling, employee demand for purposeful work, and unrelenting burnout are all bringing the future of work into the present.

Benefits must now catch up to these rapid developments. Job postings that include relocation benefits are up 75% compared to 2022, as many employers seek to encourage employees to go back to the office. To combat the always-on nature of remote work, vision care providers like VSP Vision Care offer blue light filtering solutions to support employees' eye health throughout increased screen usage. And various travel startups have also emerged to enable digital nomads' frequent changes of location and help combine business trips with leisurely ones.

Personalizing future-of-work benefits will be key to accommodating the various needs of employees. This includes providing the right upskilling resources at the right time, offering corporate volunteering opportunities that align with the social causes employees are passionate about, and delivering benefits targeting both physical and mental health.

“The workforce benefits marketplace continues to change at a transformational scale and accelerated pace, thanks in part to the widespread disruption of the working world since 2020, the rise of nontraditional workers and the growing demand for new types of benefits.”

~ Chris Morbelli, Life & Group Insurance Transformation leader

Where is the momentum now?

The pandemic has changed the way we work for good. Now, organizations are focusing on funding programs to create a workplace that supports the future of work.

Over a third (35%) of U.S. workers whose jobs can be performed remotely already work from home full time, while 41% are hybrid workers. On average, remote workers are 20% happier than those who work from the office.

In 2023, future-of-work investments will reach nearly \$1B.

2 Workers need benefits to meet their unique stage-of-life.

The U.S. workforce has never been more diverse age-wise. According to the Bureau of Labor Statistics, one in four workers is over the age of 55, compared to just one in seven in 1979. In addition to Baby Boomers, four other generations are part of the workforce — the Silent Generation, Gen X, Millennials, and Gen Z. Organizations that aim to offer tailored benefits must focus on employees' stages of life.

Instead of taking a universal, all-purpose approach, stage-of-life benefits include programs that address the various challenges employees of different generations face. VSP, for instance, personalizes vision care with a portfolio of benefits for different age groups to support them as their eyesight changes, while also offering enhancements, like VSP EasyOptions, that enables members to personalize their very own benefits. In addition, VSP also offers individual plans for those without employer-sponsored benefits and employees planning to retire.

The same approach can be applied to all benefits. Whether it's tackling student debt or supporting maternal health, family planning and eldercare, these stage-of-life benefits allow employees to tap into a menu of options designed to support their unique needs.

“Employee retention and recruitment are top priorities for our clients. In today's economy, employers also want benefits that offer the best value for the price. To achieve that, they're seeking personalized benefits to meet each employee's unique life stage and needs. By adding value for employees of all generations, they're building a strong foundation for long-term employee loyalty and engagement — which ultimately boosts the bottom line.”

~ Kate Renwick-Espinosa, president, VSP Vision Care

Where is the momentum now?

Employee needs are always evolving, giving rise to unique stage-of-life solutions spanning fertility treatments, caregiving and debt assistance.

Seventeen percent of the U.S. population is 65 or older, an increase of 38% compared to 2010. Although the exact number of informal caregivers in the U.S. is unknown, some estimate as many as 43.5M Americans are unpaid caregivers to an adult family member.

About 50% of American families live in a childcare desert, where there are more than three kids for every daycare slot. As a response, funding has flocked to childcare startups; \$516M was invested in childcare tech in 2021, up from \$171M in 2020.

In 2018, 32% of employers offered or planned to offer assistance with student loan debt. The figure grew to 48% by late 2021.



3 Employees want more access to navigate benefits menus.

Providing individualized and relevant employee benefits is a crucial first step to improving an organization’s offerings, but it is equally important to ensure employees know how to access, use and maximize these benefits.

Benefits access goes beyond geographical considerations, such as whether a specific benefit is available in an employee’s location. Does the employee have the right digital tools and resources to access their benefits? Are these tools user-friendly, and do they account for different types of accessibility? Is it easy for employees to evaluate all of their benefits options to make the best decision?

At large organizations with hundreds of job types, the demand for access will even fluctuate by role. For example, frontline workers may need to access benefits differently or need more flexibly than corporate employees, perhaps opting to trade PTO for additional income.

Innovative startups are answering these questions with technologies that improve benefits access. A number of these solutions make it easy to navigate different benefits options and increase engagement with physical, mental and financial wellness programs. Virtual access to benefits has also become table stakes as employees want a level of convenience they’re already accustomed to with other services used daily. In addition, by streamlining navigation, these technologies also have the ability to not just impact how benefits are utilized, but how they’re bought, sold and managed.

“Our focus is on integrating employee benefits with life to make work easier and better for everyone.”

~ Sam Hammock, CHRO, Verizon

Where is the momentum now?

Poor benefits access lowers utilization, which ultimately impacts employee engagement and retention. Technologies and startups are helping companies successfully navigate this challenge.

A Bank of America survey found that 71% of workers are unaware that their employer offered a caretaking benefit.

Forty-three percent of employees who quit their job say they did so because the benefits weren’t good.



4 Employees are looking for at-home benefits.

The pandemic expedited the malleability of the home, with the home serving as living space, office, restaurant, gym, therapist couch and more. And while employees are now either in the office, hybrid or fully remote, the home is still the center of gravity for many workers and serves as their preferred first-touch for work, care and leisure.

On the health and wellness side, technological advancements in the fields of diagnostics and remote patient monitoring (RPM) are bringing individualized care to the home. In 2022 alone, on-demand healthcare startups raised over \$2.4B in venture capital.

At-home diagnostics allow patients to perform screening tests for different medical conditions using home testing kits, while ambient RPM devices, which payers are supporting, now track vitals non-invasively, powering always-on care from the comfort of one’s home.

Beyond care, other at-home benefits, from ergonomic furniture to connected fitness equipment, are continuing to grow post-pandemic. The home office furniture market is expected to grow annually by 4.61%, while the home fitness category continues to surge at an annual rate of 8.2%.

Benefits have always evolved to meet employees where they are; ten years ago, with office occupancy high, workplaces were all about tangible perks. Now, those benefits are adapting to expand beyond the office walls and into the living room.

“To truly transform health care, we need to focus less on what happens in care settings and more on what happens where people live their lives”

~ Patrick Charmel, CEO, Griffin Health Services Corporation

Where is the momentum now?

While offices re-open, the home remains a place for work, play and care for many. In fact, home-based care is becoming the norm as health systems invest in meeting patients where it’s most convenient.

In response to the rise of remote work, ten states have implemented laws requiring employers to reimburse employees for certain remote work expenses, including California, New York, Washington D.C., Illinois and Massachusetts.

Nine out of 10 health systems plan to offer home-based models for primary and specialty care in 2023. And McKinsey estimates \$265B worth of care for Medicare patients could be delivered at the home by 2025, a 3X spike over current levels.



5 Gamification helps increase engagement and utilization.

Employers are turning to gamification to increase the stickiness of their benefits, scaling adoption and enrollment and driving engagement. For example, a Canadian company that incorporated a gamified wellness program helped employees significantly reduce blood pressure, stress and fatigue, aiding in retention.

Interactive games can also allow employees to get individualized health recommendations and understand how they can make the most out of their benefits. VSP Vision Care’s “VSP & You,” for example, is a digital experience that gamifies the pre-enrollment process, offering personalized recommendations and insights for prospective members. The optimization of benefits is one way employers can unlock employee retention.

In addition to health and wellness, gamification is being applied to financial and insurance programs, keeping employees engaged with the performance of their benefits.

Finally, gamification is being leveraged to accelerate overall employee growth and engagement, a key tactic for improving

retention and keeping workforces ‘sticky.’

“While gamification has been around for years, what’s changed is that it’s starting to infiltrate nearly every industry and has become the driver of long-term utilization, how interactions are done, and how behaviors are conveyed.”

~ Alexander Lennox-Miller, lead analyst in Healthcare IT, CB Insights

Where is the momentum now?

With an increased focus on retention, gamification is being used across multiple industries, including in benefits, to drive engagement and stickiness.

According to a Gartner report, 85% of employees are shown to be more engaged when gamification solutions are applied to their workplace. As a result, gamification has now been adopted by more than 70% of businesses belonging to the Global 2000.

As many businesses invest in benefits to improve retention and productivity, gamification can help augment both pursuits: 69% of workers are reportedly more likely to stay at a company for 3+ years when gamification is in place and 72% say that gamification inspires them to work harder.

What does this mean for brokers?

When it comes to benefits packages, clients are looking to meet the demands of their employees. So, it’s about knowing in advance where employee and customer mindsets are shifting now and into the future in terms of benefits. The research shows that employees are looking for more individualized solutions that evolve with their specific needs and behaviors, while employers are aiming to balance these expectations with benefit offerings that are both accessible and engaging to their employees.

Brokers may want to look out for plans and offerings, and leverage talking points, that are consistent with these five trends taking shape in the benefits landscape.

<https://vspvision.com/innovation.html>

How to Reduce Costs and Improve Benefits using Medical Expense Reimbursement Plans

What you need to know

By Eric Calciano

Looking for a robust tool for employers seeking to manage healthcare costs effectively? Take a look at Medical Expense Reimbursement Plans (MERPs). Not just a funny word, MERPs are recognized under Section 105 of the Internal Revenue Code (IRC). These plans allow employers to contribute towards employees' health plan deductibles, coinsurance, copayments and other qualified medical expenses tax-free. Unlike Health Reimbursement Arrangements (HRAs), MERPs are not associated with a physical account. Instead, employers reimburse incurred expenses, crafting an adaptable and responsive process for each employee's healthcare needs.

Adopting a MERP is a strategic step towards taking consistent control over healthcare costs. Employers typically see considerable savings in the first year of implementing a MERP, with a longer-term goal of stabilizing these costs over time.

What Is a Medical Expense Reimbursement Plan?

A MERP is a health benefits plan sanctioned by the IRS, enabling organizations to reimburse employees for out-of-pocket medical expenses. These expenses can either be incurred by the employees themselves or their dependents. Properly administered, all employee reimbursements are entirely tax-free.

Working synergistically with a group health insurance plan, a MERP provides an extra layer of financial security for employees' healthcare costs. Unlike section 125 plans, cafeteria plans, or flexible spending accounts, a MERP falls under the section 105 plan category, aligning it closely with a Health Reimbursement Arrangement (HRA). Its innovative approach to managing healthcare costs ensures employees can access required healthcare without incurring significant financial stress.

How MERPs Operate within Group Health Insurance

A MERP allows employers to offer tax-free financial assistance to employees, specifically covering approved medical expenses under the group health insurance plan. In this context, employers set an annual reimbursement limit for each employee. This limit represents the highest amount that an employer will reimburse employees for their qualified healthcare expenses in a given year. The expenses must be approved by the group health plan to be eligible for reimbursement. The details of this annual limit are dictated by the specifics of the individual plan design and the employer's policies.

A key function of a MERP within a group health insurance context is to provide coverage for approved out-of-pocket healthcare expenses.

Facilitating Coverage of Healthcare Expenses

A key function of a MERP within a group health insurance context is to provide coverage for approved out-of-pocket healthcare expenses. It isn't a discretionary fund for employees to use at will, but it operates within the parameters set by the associated group health insurance plan. The expenses that can be covered include, but aren't limited to: coinsurance, copayments, deductibles and specific medical services or products. These services and products must be considered eligible and approved by the group health insurance plan. The MERP thus acts as a supplemental mechanism, bridging any financial gaps in coverage and helping to alleviate the healthcare cost burden on employees.

Overseeing MERP using a TPA

It's a good idea to engage a dedicated MERP Third Party Administrator (TPA) to ensure efficiency and maintain a clear boundary between employer responsibilities and plan administration. This entity is responsible for overseeing the day-to-day operations of the MERP, including the verification of charges for eligibility under the group health insurance plan.

The administrator ensures that only qualified expenses are approved for reimbursement. This includes cross-checking submitted expenses against the plan's guidelines, and if discrepancies or missing information are identified, it's the administrator's role to liaise with the employee to rectify the situation. The utilization of a dedicated TPA serves to alleviate the administrative burden from the employer, allowing them to focus on core business activities while still offering a valuable health benefit to employees.

Utilizing the MERP Card and Substantiating Larger Claims

In the case of most healthcare services and purchases, employees don't need to submit any proof or documentation. They simply use the credit card provided by the MERP, which is pre-loaded with their designated funds. This simplifies the process and avoids the need for collecting and submitting receipts or explanations of benefits for every transaction. However, for larger claims, the MERP may require additional substantiation. In such cases, employees are expected to provide an Explanation of Benefits (EOB) from the insurance carrier of the group health plan. This substantiates that the expense was approved by the insurance carrier, thus allowing the MERP to cover its share of the out-of-pocket costs.

Direct Expense Payment and MERP Management

One of the benefits of a MERP is its ability to simplify the payment process for eligible healthcare services. Employees are provided with a dedicated MERP card, which is pre-loaded with their allocated funds. This card can be used to directly pay for healthcare services at the point of use, avoiding the necessity for the employee to make out-of-pocket payments and then wait for reimbursement.

The MERP administrator manages the operational aspects of the MERP, including activities such as loading funds onto the MERP cards, coordinating transactions, and ensuring compliance with necessary federal regulations. This level of oversight ensures that the MERP operates smoothly, provides employees with a user-friendly experience, and promotes the effective use of healthcare resources.

The Convenience of Medical Expense Reimbursement Plans

Integrating a MERP into a group health insurance plan offers several benefits:

- **Financial Relief for Employees:** A MERP provides an additional layer of financial protection, helping to offset high deductibles and other out-of-pocket costs. This allows employees to seek the medical care they need without undue financial stress.
- **Cost Control for Employers:** By setting annual limits on reimbursements, employers can predict and control their healthcare costs more effectively. Plus, MERP contributions are tax-free, which can result in significant savings.
- **Reduced Administrative Burdens:** Since the MERP administrator handles the verification and approval of expenses, employers can focus on their core business operations.

Harnessing MERPs for Cost-Efficient, High-Quality Employee Healthcare Coverage

MERPs are an exceptional choice for companies aiming to balance cost-effective healthcare management with high-quality employee benefits. Their greatest impact is felt by businesses that already prioritize offering superior benefits. By integrating a MERP, these companies can adopt a less expensive plan with a higher deductible as the base health insurance, and utilize the MERP to bridge the coverage gap. This results in substantial cost savings while preserving exceptional coverage for employees.

The unique strength of MERPs lies in their flexibility — they can be tailored to meet specific coverage needs, regardless of the company size or structure. By defining eligible expenses in line with the group health insurance plan, the administrative process is streamlined. Employers also have the capacity to cap contributions to the MERP, ensuring controlled healthcare spending.

However, for companies with already high deductibles, a transition to a cheaper plan supplemented by a MERP may not be feasible since there may not be a lower cost underlying plan available. Notably, the financial efficiency of a MERP depends largely on the quality of the existing health plan. Businesses offering comprehensive benefits, such as lower deductibles and copays, can realize significant savings by transitioning to a more affordable plan and using a MERP to cover any coverage shortfalls. In these cases, the value of a MERP is realized through its ability to cover nearly all out-of-pocket costs

for employees, facilitated by the cost savings from the underlying health plan.

Alongside the benefits of fiscal control and customization, MERPs offer attractive tax advantages, further boosting their appeal. Thus, a well-implemented MERP can lead to substantial financial savings, simultaneously ensuring employees continue to enjoy quality healthcare coverage — a win-win situation for all involved.

Guiding Employees in the Usage of MERPs

When introducing a MERP, it's vital to ensure employees understand its use and benefits. Here are key areas for focus:

1. **Clear Communication:** Explain the concept, benefits, and the difference between MERP-covered and insurer-covered expenses.
2. **Using MERP Cards:** Teach employees how to use their MERP cards for medical services, emphasizing it is a straightforward payment method for eligible expenses.
3. **Reimbursement Guidance:** If employees pay upfront for services, walk them through the reimbursement process, including submission procedures and timelines.
4. **Substantiating Large Claims:** For significant medical costs, employees may need to provide Evidence of Insurability to validate the expense. This ensures transparency in the reimbursement process.
5. **Interactive Sessions:** Organize sessions where employees can ask questions and discuss concerns, promoting better understanding and efficient use of the MERP.

A smooth transition to MERPs will empower employees to leverage these benefits fully, resulting in cost savings and improved satisfaction.

Case Study: Huge Savings with a MERP Strategy

As discussed earlier in this article, MERPs are going to be a better fit for companies that already offer strong benefits to their employees. This allows the company to move employees to a lower cost underlying plan with higher deductibles and out-of-pocket maximums and then fill in the gap in coverage with the MERP.

My company, New City, was approached by a 250 employee company that had recently received an outlier renewal increase of 50% from their insurance carrier. They offered \$0 deductible plans with low out-of-pocket maximums, so they were a great candidate for a MERP strategy. By moving all of the employees to a high deductible health plan with their same carrier and then providing a MERP to cover the costs of deductibles and other expenses, the overall increase went from 50% down to zero percent while providing better coverage for the employees.

So rather than the business having to absorb a very large increase, they were able to keep their rates flat at renewal while allowing employees to keep the exact physician networks with the same carrier to avoid any disruption and simultaneously reduce out-of-pocket costs for employees.

Most businesses don't receive outlier increases at renewal, and in those scenarios, these companies can see significant cost decreases compared to current rates while improving employee coverage. That's the beauty of MERPs.

To learn more about MERPs

Request a Health Benefit Proposal | The Difference Card

www.differencecard.com/contact-us/

To find partners who can collaborate with you to help your Group Benefits clients with MERPs contact:

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Action

Required by Employers by October 14 on Another Annual Group Health Plan Compliance Deadline

BY PAUL ROBERTS

All employers offering prescription drug benefits to employees are required to provide annual notifications to Medicare-eligible employees and dependents before Oct. 15, regarding the drug status of their plan(s).

These notices help Medicare-eligible individuals make informed decisions about their health insurance and drug benefit options, so they may obtain the best coverage for their needs. It also helps Medicare consumers avoid potential Medicare penalties.

The employer's required notification discloses whether the prescription drug benefits provided by the group health plan are "creditable" or "non-creditable," when compared to the prescription drug benefits provided by Medicare Part D drug plans.

A "creditable" drug plan provides benefits that are at least equal to, or richer than, the drug benefits provided by Medicare Part D. Conversely, a "non-creditable" drug plan provides pharmacy benefits that are less rich than the drug benefits provided by a Medicare Part D plan.

Medicare-eligible individuals use this information during Medicare's Annual Election Period (AEP), which runs Oct. 15 through Dec. 7 each year. During the AEP, Medicare enrollees can change their Prescription Drug (Part D) plans and/or can join or change enrollment in a Medicare Advantage (Part C) plan – with or without built-in drug coverage.

Medicare-aged individuals who do not obtain and maintain "creditable" prescription drug coverage, beginning with the date they first become eligible, will be penalized when they inevitably enroll in Medicare's prescription drug Part D coverage. The penalty generally applies in perpetuity, i.e., for the entire period one is covered by Medicare Part D.

Employers should heed the Oct. 14 deadline and compliance requirements for two reasons.

- **First, federal law requires it.**
- **Second, employers do not want their senior employees to be hit with noncompliance penalties – especially during retirement.**

Determining the drug status of a group health plan

If you work with Word & Brown General Agency or another GA, you may want to ask what resources are available to help you provide compliance aid to your clients – especially when determining the prescription drug benefit statuses of fully-insured group health plans.

CMS Model Notice for drug status disclosure

The Centers for Medicare & Medicaid Services (CMS) provides model notices (in English and Spanish) that employers can use to comply with this requirement. Employers must customize the model notices to include their own information, such as the name of their plan and the contact information for their plan administrator.

CMS online reporting requirement – for employers

Employers providing prescription drug coverage to Medicare-eligible individuals must also disclose their plans' drug statuses to CMS. This disclosure is required whether the employer's group plan pays primary or secondary to group coverage.

Employers must disclose this information to CMS using an online disclosure form. It must be submitted within 60 days of a group plan's effective date, within 30 days of terminating prescription drug coverage (if applicable), or within 30 days following any change in "creditable" drug status.

Best practices

Employers are encouraged to document disclosure and receipt of these notices when given to Medicare-eligible individuals. For general Medicare information, refer to CMS's Medicare website.



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Established in 1985 and headquartered in Orange, Calif., Word & Brown is one the state's largest independently owned general agents.

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Three Strategies for Tailoring Employee Benefits

Employers must be ready to meet employees' physical, mental, social and financial well-being needs through total benefits programs that attract and retain top talent.

BY JESSICA GILLISPIE

A Prudential study showed that mental, physical, and financial wellness are intertwined — illness or injury can lead to mental and financial crisis; financial stress can cause mental and physical conditions. Workplace benefits programs that fail to support customers holistically can negatively affect an organization's bottom line, workforce productivity, and the retention and attraction of top talent.

Brokers play a pivotal role in helping clients navigate the increasingly complex and evolving benefits landscape. Understanding challenges, opportunities, industry trends and which solutions best serve your clients are good for your business.

Here are three things to consider as you and your clients shape benefits programs of the future.

1 Holistic wellness is here to stay.

The pandemic forced a fundamental shift in employee mindset, bringing into clearer focus the importance of work-life balance. According to Prudential's holistic wellness trend study, 3 out of 4 employees agree that employers play an important role in the overall wellness of their workforce. And so, the concept of holistic wellness — financial, physical, social and mental well-being — has moved from lifestyle trend to workplace trend over the last few years.

As a result, we see more employers prioritizing holistic wellness — with mental health at the top of the list — as they seek to ensure their employees and members are staying healthy and productive. That is no surprise given that 90% of employees agree that their employers “have a responsibility to make sure employees are mentally healthy and emotionally well.”

Successful holistic well-being programs use capabilities and products that:

- improve employee physical and mental well-being
- decrease financial concerns that arise from uncertainty
- offer greater equity, inclusion

and sense of community at work and in society.

2 Changing workforce demographics demand improved, personalized experiences and capabilities.

Employers report confusion when it comes to selecting cost-effective benefits for their personal needs, which change over time and generation to generation. LIMRA research shows 63% of workers don't fully understand their benefits options, which means they may be missing out on achieving holistic wellness. That is why employers need to meet their workers in the moment and simplify the experience to assess and access benefits solutions that fit their individual wellness journey.

A one-size-fits-all approach is becoming increasingly harder to offer — at value — as new generations enter the workforce. Designing a benefits program for engagement continues to grow in importance, especially with historic inflation, interest rates, and cost of living forcing many workers at all income and earnings levels to rely on their benefits packages in times of need.

Consider segmented strategies tailored to different populations in the workforce with inclusive solutions and resources, and personalized experiences, to help deepen connections and empower employees to make confident benefit decisions.

For the benefits selection and decision-making process to be even easier, experiences should leverage technology that combines simplified capabilities with the right human

3 touch — offering solutions in the medium that makes the most sense for the individual employee.

Design benefits programs and strategies that help both employers and employees achieve goals.

Employers rely on their employees to help achieve their financial goals, with 92% of employers saying that a healthier employee base benefits the company's bottom line. Meanwhile, a FINRA

study showed that nearly two-thirds of employees expect their organizations to help them achieve their financial, mental and physical wellbeing. As a result, integrating wellness solutions into core benefits is becoming more and more valuable to employees, as well as employers.

Employers are leaning into wellness programs, acknowledging that offering holistic wellness solutions improves productivity and talent retention, and helps to reduce stress and burnout. For example, offering mental health resources to disability claimants can play an important role in improving employee health, and reducing turnover and absenteeism. Employees also see the value in wellness programs, with the vast majority indicating they would stay with an employer that provides financial and mental health resources.

Each wellness journey for an employer and their workforce is unique. With a knowledgeable broker to guide them — who spots the trends, sees the challenges and opportunities, and listens to their clients' needs — a holistic benefits program can yield long-lasting and meaningful results for all stakeholders.



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Exploring the Promise of Telepsychiatry and Teletherapy

By Dr. Rachna Saralkar

Welcome to the ever-evolving world of mental healthcare, where telepsychiatry and teletherapy have brought about remarkable changes. In this article, we'll take a journey to explore how effective these telehealth solutions are today and what they might hold for the future. Whether you're a seasoned broker or new to the field, these insights will help you better understand this dynamic landscape and how to assist your clients effectively.

Telehealth's Current Effectiveness

Think of telepsychiatry and teletherapy as powerful tools in the mental healthcare toolbox. You and I know we are capable of having a heart-to-heart chat with a friend over FaceTime. It's time to extend this ability to a therapist. While some still prefer in-person rapport building, technology-savvy therapists and patients can bridge that gap. Telehealth offers clients convenience, privacy and outcomes comparable to traditional in-person sessions. The American Psychological Association endorsing teletherapy's effectiveness at par with in-person therapy speaks volumes about its potential.

Over the last decade, research into telepsychiatry and teletherapy has surged, especially in the past three years, partly due to the COVID-19 pandemic. A notable 2022 study by Prescott et al, involving over 1,000 patients, found that patients who engaged with both therapy and medication management saw better odds of improvement in depressive symptoms compared to those relying solely on medication providers. Access to digital mental health care increased the likelihood that patients would engage

with both therapy and medication management, thereby improving overall health outcomes.

In 2021, the Substance Abuse and Mental Health Services Administration (SAMHSA) released an evidence-based guide on telehealth for treating serious mental illness and substance use disorders. It offered strong evidence for medication management and pharmacotherapy using a hybrid approach combining telehealth and in-person visits, although some clients did face technical challenges. The guide also highlighted strong evidence for the effectiveness of various therapies delivered via telehealth, — like behavioral activation, cognitive behavioral therapy (CBT), cognitive processing therapy (CPT), and prolonged exposure therapy (PE) — all supported by at least two randomized controlled trials or quasi-experimental designs.

Challenges to Widespread Adoption of Digital Mental Healthcare

The primary barriers to engaging in effective telehealth are a lack of professional guidance and clinician reluctance to engage using telehealth, according to an expansive literature review published in 2023 studying the effectiveness of telepsychiatry. Advancements in technology have paved the way for digital platforms to automate and streamline patient care. These platforms not only provide mental health providers with valuable insights into patients' progress between appointments with self-assessments, enabling more tailored treatment, but also play a role in reducing provider burnout. Additionally, many of these platforms offer extra features like automated summarization

of sessions, billing support, ability to asynchronously share information between patient-provider and dashboards that track patient outcome measures over time.

As mental health issues continue to rise globally and a shortage of trained professionals persists, virtual mental healthcare delivery has become a necessity rather than an option. Experts in the field agree that while technology won't immediately replace mental health providers, clinicians who effectively use technology will replace those who don't. Virtual mental health care is here to stay, but hybrid models will be necessary to overcome challenges.

One of the key concerns in telehealth revolves around ensuring equitable access to telehealth services, particularly for individuals with low technology literacy, disabilities or severe mental health issues. The reality is that not everyone has seamless access to high-speed internet or possesses the technical proficiency needed to navigate virtual appointments independently. Studies and data have unveiled disparities in health equity. Factors such as poverty, race, and ethnicity — particularly for Black or Hispanic individuals — have been associated with lower rates of smartphone ownership, limited digital literacy and limited access to broadband internet. In light of these challenges, it's imperative not to assume that a family member can effortlessly manage appointments for clients facing these complex issues. We all harbor our own implicit biases and addressing them requires active awareness, humility and a proactive approach to bias-checking as you work with clients. **Be humble and check your biases.**

Another consideration is potential regulatory changes. While Medicare

currently permits phone appointments without video, this policy is expected to evolve. Clients comfortable with phone consultations should prepare for the possibility of needing video or in-person sessions to maintain coverage when regulations change. Additionally, regulations pose limits on providing medication-assisted treatment via telehealth, as practitioners must navigate state and federal prescribing laws.

The Need for Caution and Awareness

Studies on virtual mental health services come with certain biases. Many are funded by B2B companies focused on their results, often involving patient populations that may not represent the entire U.S. demographic in terms of mental illness severity or socioeconomic status. Furthermore, the outcome measures used in these studies, such as WHO-5, PHQ9 or GAD7, were initially designed as screening tools, not comprehensive outcome measures. These studies are important and a big step in the right direction, but it is important that brokers do not generalize the results for their entire client population. **Look beyond the headline.**

It's vital to acknowledge that telehealth isn't a one-size-fits-all solution. Patients grappling with severe mental health conditions, like profound depression or schizophrenia, often necessitate in-person interventions, including crisis management and comprehensive assessments.

Drawing from my experiences as a psychiatrist, I've witnessed firsthand the complexities of delivering high quality care via virtual platforms or audio-only appointments. For some patients, digital literacy can be a barrier, while others are burdened by severe illnesses that hinder timely attendance, device operation or even camera visibility.

While it's reasonable to argue that some care is better than none, our commitment should be to always strive for superior care, especially for disadvantaged populations. Some patients simply prefer in-person mental healthcare visits, and experts concur that the future of high-quality mental healthcare must embrace hybrid models. These models offer both brick-and-mortar access and virtual visits.

A recent RAND Corporation study underscores the importance of patient preference. It revealed that one-third of patients receiving therapy or medication visits did not receive care in their preferred modality. This preference is especially crucial in mental health, where a patient's belief in their care delivery system significantly impacts their outcomes. **What patients want matters!**

A Glimpse into the Future

The future of telepsychiatry and teletherapy holds immense promise. Advancements in artificial intelligence (AI) and digital interventions are set to transform the quality of mental healthcare through telehealth. AI-powered tools will enhance assessments, monitoring and personalized treatment plans, ultimately improving the effectiveness of virtual care.

Imagine a future where AI seamlessly reports patient progress during virtual sessions or interacts with patients at home between appointments through computational agents. Integrating various screenings like EEG and blood draws could lead to a hybrid model that optimizes the preferred high-touch, frequent engagement style of care for patients seeking mental health support. Future platforms will also evaluate the therapeutic alliance between patients and their clinicians (a measure of how good the relationship is has been shown to have significant impact on outcomes). This helps therapists enhance care delivery and empowers patients to find therapists with whom they genuinely connect.

Empowering Informed Decisions: Top Three Takeaways

As insurance brokers, you play a pivotal role in helping clients make informed decisions about their mental health coverage. Here are the top three takeaways to convey to your clients regarding the effectiveness of telepsychiatry and teletherapy.

Assess Severity: Encourage clients to assess the severity of their mental health conditions. While telehealth generally works well for mild to moderate cases, it may not be the best choice for severe or complex conditions. Clients should consider their specific needs when selecting their care approach and ensure that plans provide access to hybrid care models and local intensive care options.

Stay Informed: Stress the importance of staying informed about the latest telehealth advancements. As AI and digital interventions progress, virtual mental healthcare's effectiveness will continue to improve. Clients should be open to exploring these innovative options when suitable, and gentle education can help them make the leap into virtual care.

Client-Centered Approach:

Advocate for a client-centered approach to mental healthcare. Tailoring treatment plans to individual needs and preferences is crucial. Telepsychiatry and teletherapy are not one-size-fits-all solutions, and clients should feel empowered to make informed decisions about their care, and have the ability to choose a brick and mortar option.

Navigating access to mental health care can be a complex journey, but having a well-informed broker who educates clients in an empowering manner can result in not only happier customers but also more empowered patients with a greater likelihood of positive mental health outcomes.



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Group Medicare Advantage Plans Explained

How Group Benefits Brokers can bring solutions to their Employer clients

You may have noticed the increase in interest and enrollment in Medicare Advantage plans but may not understand how Group Medicare plans work for employers.

Medicare Advantage plans are available to retirees on an individual enrollment level, but they can also be offered by plan sponsors to current and former employees. These plans may be referred to as Group Medicare Advantage plans, Employer Group Waiver Plans (EGWPs) or — more commonly — as Group Medicare plans. The purpose of Group Medicare plans is to enable employers to provide health plans to their retirees.

How they work

Historically, Original Medicare would cover about 80 to 85% of claims for Medicare-eligible retirees. Then, retirees and eligible employees could search for a Medicare secondary plan (sometimes also referred to as Medicare Supplemental) to cover the rest.

In contrast, Group Medicare plans provide traditional Medicare benefits through a private carrier such as Humana. The plans can also include enhanced benefits, like health and wellness programs, dental, vision and hearing benefits, and expanded drug

coverage. Additional services offered varies by plan and can even include coverage for pre-65 retirees who aren't yet eligible for Medicare. Providing these benefits to retirees under a single administrator helps retirees avoid the frustration and confusion that can often accompany the coordination of benefits between multiple carriers/plans.

CMS subsidizes private carriers for the administration of their plans. All plans have a STARS Rating, which reflects their quality based on the Five-Star Quality Rating System which is managed by CMS. Plans are rated on a scale of 1-5 stars, with 5 being the best.

Enrollment trends

The popularity of Medicare Advantage plans is growing. According to Kaiser Family Foundation, in 2022, more than 28 million people were enrolled in a Medicare Advantage plan, accounting for 48% of the eligible Medicare population. (<https://bit.ly/3rth0p1>)

As baby boomers retire, the eligible population — and opportunity — for these plans will continue to grow. The Census Bureau says that by 2031, the U.S. population over the age of 65 will number an estimated 75 million, almost double what it was just in 2008. (<https://bit.ly/460Wbk0>)

Advantages of Group Medicare

Employers can also benefit from offering their employees a Group Medicare plan. According to Forbes, statistics show that 62% of employees will consider the availability of a retirement plan when deciding whether to accept or remain in a job, and some studies have found that when deciding whether to change jobs, 82% of employees say that their benefits — specifically their retirement benefits — are important. (<https://bit.ly/3rftUqR>)

On top of the positive impact retiree benefits can have on your talent pool, Group Medicare plans can also have a positive financial impact for plan sponsors. Some Group Medicare plans are fully insured, which means that any financial risk is borne by the carrier rather than the plan sponsor, passing on additional financial benefits to plan sponsors.

The take away

In conclusion, Group Medicare plans can be beneficial to both employers and their retirees. Employer plan sponsors can reduce costs by selecting a Group Medicare plan for their retirees. Fully insured plans can help to reduce the cost to plan sponsors, while the extensive coverage and additional benefits offered to retirees give them access to a wide array of tools and services to effectively manage their health and wellness. Group Medicare plans can also provide more peace of mind.

Humana looks forward to working with Group Health Benefits brokers to assist them to address the needs of their client's retirees. Humana works hand in hand with Group Benefits Brokers to give them the confidence their employer clients will be able to address retirees with a high-quality plan that has been vetted as opposed to searching through the many options for a Medicare plan on their own.

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Level-Funded Health Plans: A Broker's Guide to Combat Rising Health Insurance Costs for Employers

By Mike Lambert

In an era marked by soaring healthcare costs and uncertainty, insurance brokers face the challenge of guiding their employer clients through a complex benefits landscape. With a median health care cost increase of 7% projected for 2024, employers are desperate for solutions that offer affordability and flexibility. This is where level-funded health plans come into play, offering a financially sustainable and customizable option. Here's why brokers should have this option at the top of their recommendation list.

The Rising Tide of Healthcare Costs: A Broker's Concern

The Inflation Equation

With a 7% cost increase on the horizon for 2024, following a similar increase in 2023, brokers have to act fast. According to new data from the International Foundation of Employee Benefit Plans (IFEFP), a nonpartisan group with more than 31,000 members, U.S. corporate employers project a median health care

cost increase. It's the second year in a row that employers have projected a 7% hike. The IFEFP survey highlights how inflation is impacting multiple dimensions of healthcare, from labor costs to medical supplies, thereby pushing the costs onto employers. (www.ifebp.org/store/employee-benefits-survey)

Specific Cost Drivers

Factors contributing to this spike include chronic conditions, catastrophic claims and costly treatments and therapies. With 22% of employers in the IFEFP survey pointing to chronic conditions as a main driver of costs, the urgency for a sustainable solution has never been greater.

Balancing Employee Benefits and Costs

While some employers might consider shifting the financial burden to employees, most are wary of doing so. Competitive labor markets make it essential for employers to offer attractive benefits packages, making it a challenging tightrope to walk for brokers advising their clients.

Level-Funded Health Plans: The Broker's Silver Bullet

A Rising Star Among Options

The Kaiser Family Foundation 2022 Employer Health Benefits Survey revealed that 42% of small businesses opted for level-funded plans in 2021, a dramatic increase from just 7% in 2019. This upward trend is a strong indicator of its growing appeal.

Balancing the Scale: Costs and Flexibility

Level-funded plans offer a middle-ground solution by blending features from both fully insured and self-funded plans. They allow for the predictability of fixed premiums while providing flexibility in plan design, which can be a compelling selling point for brokers to their clients.

The Case for Cost Containment

Level-funded plans enable better cost management through more transparent claims data. This data can inform future premium negotiations and employee education around making cost-effective healthcare choices. **Brokers should highlight this as a significant advantage when presenting options to clients.**

Compliance Demystified

One challenge of level-funded plans is the increased responsibility regarding compliance. However, a skilled broker can ease this burden by helping employers navigate through the intricacies, reinforcing why brokers are valuable partners in the benefits selection process.

Customization and Suitability: Making it Work for Your Clients

The Small to Midsize Business Sweet Spot

These plans are particularly well-suited for small to midsize businesses looking for a blend of cost efficiency and customization. Brokers can carve out a niche by specializing in advising these types of companies.

Versatility for Larger Clients

Don't rule out larger businesses; level-funded plans can also be used strategically to address specific classes of employees within a larger enterprise.

Utilization Insights

By offering detailed utilization data, level-funded plans enable more targeted cost-containment strategies. **Brokers can add value by helping employers analyze this data to make informed decisions that benefit both the company and the employees.**

The Broker's Role: More Than Just a Middleman

As a broker, you're not just selling insurance; you're selling peace of mind and financial sustainability. Leveraging your expertise to navigate compliance challenges and helping employers make sense of utilization data can set you apart from the competition. **It's not just about recommending a health plan; it's about crafting a holistic healthcare strategy that resonates with employer needs while keeping an eye on the bottom line.**

The Future is Level-Funded

Given the ongoing challenges posed by rising healthcare costs, brokers who can proficiently guide their clients towards adaptable and cost-effective solutions like level-funded health plans will be in high demand. Offering an optimal balance between cost containment and plan flexibility, these plans represent a win-win scenario for brokers and their clients alike. By making this option a cornerstone of your advisory portfolio, you can be the go-to broker who not only understands the market but also knows how to adapt to its ever-changing dynamics.



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STRUCTURED FOR SUCCESS

The “5th Quarter” Is a Breeze With the Right Partner

By Kim Gomez, Shahram Homami and Cara Mudgett

The right partner by your side can make or break your business success and sanity. For brokers now in the thick of the 4th quarter — which we’ve redefined as “5th quarter” since it extends beyond the current year through January — you know what we mean.

During this busiest time of year, it’s critical that you have a partner you can count on; one with solid operations and exceptional service to help you quote, sell, enroll and more with speed and accuracy to build lasting relationships with your clients.

At Warner Pacific, we’ve spent decades structuring and refining our operational systems and teams for success and sanity. In fact, when we’re not in the 5th quarter, we’re planning for it: analyzing previous years, forecasting, strategizing resource allocation, optimizing technology tools and more.

If you are considering a general agency (GA) partner to help get you through this 5th quarter and beyond, here are some important things to ask yourself (and your potential partner):

Process Optimization: Does your GA have automation and technology that can be leveraged to streamline processes for you and your clients? Are they constantly optimizing these to make them even better?

Technology Readiness: What technology tools do they offer as part of their service that can increase your speed, accuracy and efficiency? Are these tools user friendly and do they offer technical support when you need it?

Training and Skills Enhancements: Do they offer training and skills enhancements for their team members throughout the year to fine-tune and improve broker support? Do they offer events for brokers (i.e., webinars to hear directly from experts and carriers)?

Tailored Sales and Operations Support: Is their approach one-size-fits-all or is it tailored to meet individual broker needs? How can it be tailored to meet your needs during the all-important 5th quarter and throughout the year?

Passion and Bandwidth for All Sizes: Are they just looking for a certain case size or is no case too big or small? Do they give the same personalized attention and support to your smallest cases so you can focus on selling more?

Access to Multiple Carriers: Does your GA have relationships with multiple carriers? Do they perform the carrier research for you, have answers to questions (i.e., minimum participation, multi-state guidelines, coverage of a specific drug, etc.) and know different carrier requirements?

Team Model and Continuity: Do they pair you up with a sales consultant who is focused on your success and has

a team also working to support you? Do you feel like you can delegate all your administrative and operational tasks to this expert team?

Frequent Communications: Do they communicate frequently and with impact? Is information easy to access and do they share best practices and tips that make your life easier during this busiest time of year?

At Warner Pacific, the answer is “yes” to all these questions and more because we live for this. Wishing you the right partner to make your 5th quarter a breeze this year!

About the authors...

Kim Gomez is about to celebrate 22 years with Warner Pacific, where she oversees California Small Group Quoting and Large Group Operations, as well as operations in Colorado and Texas. Prior to her time at Warner Pacific, she worked at Starbucks, where she got her caffeine fix while attending Pepperdine. Kim.Gomez@warnerpacific.com

Shahram Homami entered the health insurance space in 1989 when he joined Anthem Blue Cross. In his current role as senior director of Operations at Warner Pacific, Shahram oversees various departments, including RateLoad & Agent Appointments in Calif. Shahram.Homami@warnerpacific.com

Cara Mudgett has spent her entire career in the health insurance industry and currently oversees Warner Pacific’s California Small Group Underwriting and Customer Service operations teams. Prior to Warner Pacific, she worked on the carrier side in various leadership roles, including call center operations, medical management, enrollment and billing and underwriting. Cara.Mudgett@warnerpacific.com



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ANNUITIES

Health Broker Collaborators Can Help You With Annuities!

Tax friendly way to grow funds over time

Bringing annuities to your clients can help them solve their planning issues for retirement. Used as a retirement income vehicle, annuities can be a tax friendly way to grow funds over time and meet your client's needs for financial planning purposes. Here's a basic overview of annuities.

There are several types of annuities, but the three most common ones are:

Fixed and Indexed Annuities: These annuities provide growth based on either a fixed interest rate or on the performance of a index, often the Dow, NASDAQ or S&P 500. With a life and health insurance license you can get appointed and trained to offer fixed annuities or you can work with a subject matter expert (SME) who will work with you and your client to review the options and complete the application. You share in the success through referral fees.

Variable Annuities: Offer the potential for higher returns but come with more risk.

Immediate Annuities: Start paying out shortly after you make a lump-sum payment. They're often used by retirees to create a steady stream of income.

Contact the Collaboration Center for collaborative help with your client's retirement planning issues. From annuities, to long-term care insurance, to life insurance, you will find professional assistance from SMEs who respect health insurance professionals.

For those who desire to learn the annuity business and become an SME, contact us for training and support information.

Annuities are complex financial products, and it is that crucial your clients fully understand what they are buying before committing their money. Consider seeking advice from a financial professional who can help you help your client make an informed decision based on their unique financial situation and goals.

Resources for CalBroker Readers:

The Collaboration Center @ 657-229-2849
Info@healthbrokercollaborators.com

**2
United Healthcare**

uhc.com/saveCA

**3
Covered California**

coveredca.com/forsmallbusiness
844-332-8384

**4
AGA**

Applied General Agency
www.appliedga.com
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SELL: The time it takes to sell a book of business can range from one to five years, and when a broker takes the time to prepare, the average increase in value is 20% to 33%.



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

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

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