

PLUS: DENTAL SURVEY / MEDICARE / COMPLIANCE

CALIFORNIA BROKER

VOLUME 40, NUMBER 10

Serving California's Life/Health Professionals & Financial Planners

JULY 2022



From Screens to Sun

Employees Seek Dynamic
Light Protection and
Premium Vision Plan Benefits
for Increased Demands on
Their Eyes
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From Screens to Sun

BY JONATHAN ORMSBY

With many workers now preferring remote or hybrid work versus a traditional workspace, increased visual demands on employees' eyes is likely to be an ongoing future of work trend.

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Savvy Companies Invest in Employee Benefits, Even During Times of Uncertainty

BY DR. VALERIE SHEETY-PILON

Why eye health matters to you — as a patient and an employer

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DENTAL

Oral Care is Healthcare

BY JILL KOHLER

Now is the time for traditional cost-sharing dental insurance plans to be upgraded and for the insurance industry to realize that oral care is healthcare. The standard 100/80/50 plan design with the usual \$1,000 to \$2,000 annual maximum has not changed since the inception of dental insurance in the 1950s.

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DENTAL SURVEY

Current Trends in Dental Coverage

We asked representatives from two top carriers in the dental industry to share details about their companies: Guardian Life and Unum & Colonial Life Dental & Vision

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MEDICARE

10th annual Senior Summit Returns to Pechanga Resort

"Medicare: Your Journey to the Top"

BY MAGGIE STEDT

As part of their 'Journey to the Top,' more than 700 agents, company representatives, physician groups and carriers will be gathering at the 10th Annual Senior Summit to share ideas, hear about new products and features on Aug. 23-25 at Pechanga Resort.

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COMMISSIONS

An Option for Medicare Professionals

BY PHIL CALHOUN

A growing trend for health insurance professionals is to look at off-loading some of their commissions to either spend time enjoying other pursuits in partial retirement or gain the time to build their other lines of insurance business.








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For a complete list of the program rules go to:

<http://www.coveredca.com/agents/become-an-agent-for-small-business/CCSB-agents/>



*Insurance companies vary by region and are subject to change.

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DIGITAL SOLUTIONS

Optum Opens New Online Store

BY KATE WOLIN

The new Optum Store is a digital solution that helps save time and money by using health insurance plans or health savings accounts for online shopping and delivery.

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COMPLIANCE

California Employers Need to Comply with Cal/OSHA ETS Act 3

BY BARRY COHN

While it may feel that the pandemic is in the rearview mirror, Cal/OSHA has passed Act 3 of the Emergency Temporary Standards (ETS) which took effect on May 6 and will remain in place until the end of 2022. Clients have been calling and asking, "What do we do now? Do we need another COVID-19 Prevention Plan (CPP)?"

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ACA

Fixing the ACA's Family Glitch

Second of four installments

BY PAUL ROBERTS

The Biden Administration has proposed a rule to fix the longstanding, problematic "family glitch" of the Affordable Care Act (ACA).

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TECHNOLOGY

Laser Focus on Current Book of Business Nets Better ROI

BY JOEL ZWICKER

Personalized automation is the answer.

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COMPANY CULTURE

How to Cultivate a Thriving Company Culture

BY PETER HILL

Whether you own a company or hold a position in leadership, a thriving company culture is the backbone of any organization. Creating a culture that promotes both personal and professional development, focuses on values and purpose, and always welcomes new ideas is a positive step toward building a thriving team.

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MENTORSHIP

Mentorship — Standing on the Shoulders of Giants

We are all unique individuals, but it doesn't mean we need to face life alone
BY TIM KANTER

When you take the time to mentor someone, that person will often take the knowledge and wisdom they've gained and mentor someone else.

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COMPLIANCE

Why Insurance Brokers Should Create Wrap Documents for Clients

BY TOM AVERY

Employers are responsible for complying with ERISA (and the Department of Labor, COBRA, and the IRS). So it's not the broker's problem, right?

FAILURE

To Survive

Failure To Survive:

When traditional term underwriting timetables hinder a business from acquiring death benefits for Key Person, Buy-Sell, and Loan Indemnification situations, Failure to Survive Insurance can be underwritten and issued in a matter of days making last minute deals possible.



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INDUSTRY/NEWS

Maximum Broker Compensation for 2023

Product	Region	Initial			Renewal		
		2022	2023	%	2022	2023	%
MAPD	National	\$573	\$601	4.89%	\$287	\$301	4.88%
	CT, PA, DC	\$646	\$678	4.95%	\$323	\$339	4.95%
	CA, NJ	\$715	\$750	4.90%	\$358	\$375	4.75%
	Puerto Rico, U.S. Virgin Islands	\$394	\$411	4.31%	\$197	\$206	4.57%
PDP	National	\$87	\$92	5.75%	\$44	\$46	4.55%

GOOD NEWS! MEDICARE TO PAY HIGHER COMMISSIONS IN 2023

Brokers enrolling Medicare clients from California will receive a nearly 5% increase in Medicare MAPD and Part D commissions in 2023. Look forward to this reward for your hard work. For details go [online](https://www.cms.gov/newsroom/fact-sheets/2023-medicare-advantage-and-part-d-rate-announcement). <https://www.cms.gov/newsroom/fact-sheets/2023-medicare-advantage-and-part-d-rate-announcement>



FDA: Annual COVID-19 shot being considered

Yearly fall flu vaccinations may be paired with COVID-19 shots to protect susceptible individuals against hospitalization and death. The FDA is considering this possibility and by June 2022 a decision about the vaccine composition is needed, in order to be ready for a potential October for the 2022-2023 season. Full Story: <https://bit.ly/3wWhdBc> or www.RAPS.org

Minimum Wage Increase Can Apply to Remote Workers



On July 1, 2022, several California cities are increasing their minimum wage rates, with some

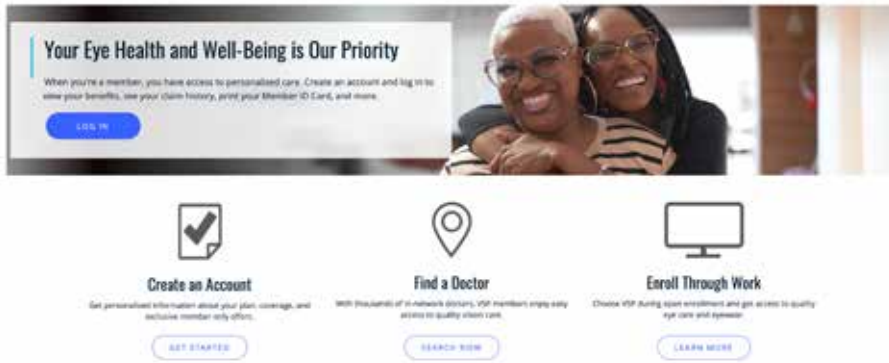
of them (specifically, Fremont, Los Angeles City, Los Angeles County, Malibu, Pasadena and Santa Monica) removing their different minimum wage rates based on employer size. West Hollywood is the only locality that will have different wage rates on July 1 based on employer size.

To comply by July 1, make sure to confirm where remote employees are located, as they may be subject to different local minimum wage rates and ordinances than when they were at their worksite.

Be Careful: Insurers restrictive mental health coverage may be breaking the law

Restrictive interpretation of mental health coverage is technically against federal law — namely, the Mental Health Parity and Addiction Equity Act of 2008, (<https://go.cms.gov/3xb5Zc4>) which required that access to mental health and substance use disorder services is comparable with access to medical and surgical services.

The law is intended to stop plans from choosing to cover only some type of mental health and substance abuse treatments if the same plan covered comparable medical and surgical treatments. Dr. Lawrence Weinstein, chief medical officer at American Addiction Centers notes that the parity act required health plans and insurers to have comparable treatment across categories like emergency care, prescription drugs, in-network and out-of-network care and residential treatment, as well as comparable co-pays, deductibles, out-of-pocket maximums and reimbursements rates.



VSP Vision Recognized as a U.S. Best Managed Company for Second Consecutive Year

VSP Vision™ has been selected as a 2022 U.S. Best Managed Company for a second consecutive year. Sponsored by Deloitte Private and *The Wall Street Journal*, the program recognizes outstanding U.S. private companies and the achievements of their management teams.

The 2022 designees are U.S. private companies that have demonstrated excellence in strategic planning and execution, a commitment to their people and fostering a dynamic, resilient culture, as well as strong financials. This year's designees continued to propel their businesses forward by prioritizing purpose, investing in their workforces, and demonstrating their commitment to diversity, equity and inclusion. Read more: <https://vspvision.com>



Chiquita Brooks-LaSure

Medicare Turns a Profit! Yahoo!

COVID-19 gave the U.S. Medicare Part A hospitalization program a big financial boost in 2021. Because enrollees minimized use of ordinary hospitals, spending on benefits plunged. That drop in spending on hospital bills gave Medicare Part A \$8.5 billion operating profit in 2021 on \$337 billion in revenue, according to the new Medicare Trustees Report. That compares with a loss of \$60 billion on \$342 billion in revenue in 2020. Now, the trustees are predicting that the trust fund will last until 2028, but that operating revenue will cover just 90% of program costs in

2028.

That means: If past trends continue, the program solvency issues may be more likely to lead to big changes in life insurance, annuity, retirement savings program, estate tax and general income tax rules, at some point between now and 2027, than to lead to dramatic changes in the Medicare program.

Chiquita Brooks-LaSure, the administrator of the Centers for Medicare and Medicaid Services, the agency that oversees Medicare, said in a written comment about the report that Medicare needs to continue to provide high-quality, person-centered coverage.

"Medicare trust fund solvency is an incredibly important, longstanding issue and we are committed to working with Congress to continue building a vibrant, equitable, and sustainable Medicare program," Brooks-LaSure said.

Remark's Informative Global Consumer Survey

Take a refreshing global look at topics you care about like insurance literacy, COVID-19, technology and mental health gathered in Remark's Global Consumer Survey (remarkgroup.com). This is the largest global survey on life insurance customers. It gives an insight into major consumer trends on relevant topics like AI, data privacy, health and even COVID-19.



TO PAY OR NOT TO PAY Potential Student Debt Forgiveness Confounds Advisers

Financial advisers find themselves in uncharted territory in the face of the wavering target of student debt forgiveness.

Because student loan debt in any form can't be forgiven through bankruptcy and because many of the loans include multiple generations of co-signers (<https://bit.ly/3NSdASO>), advisers say the issue is front and center with no clear road map available.

Read more: <https://www.investmentnews.com/sharing-the-student-debt-load-211616>

EVENTS

CAHIP Engage, Statewide Leadership Conference,
July 18-19, Universal City, Calif. Register: <https://bit.ly/3M0rvV6>

IEAHU, OCAHU & SDAHU Senior Summit,
Aug 23-25, Pechanga resort and casino, Temecula, Calif.
Register here: <https://guestli.st/706287>
More Info here: <https://theseniorsummit.net/>

InsurTech Connect: The Future of Insurance is Here,
Sept. 20-22, Las Vegas
Info: <https://vegas.insuretechconnect.com>

Women In Financial Services (WIFS) National Conference,
Sept. 29-Oct. 1, Phoenix, Arizona. Info: <https://wifs-losangeles.org/events/>

**National African-American Insurance Association (NAAIA)
2022 Annual Conference & Empowerment Summit,**
Oct. 5-7, in person. Baltimore, MD.
Info: <https://www.naaia.org/conference>

NAHU votes on name change at 2022 Annual Convention

The name/tagline that was voted on at the 2022 Annual Convention in Austin on June 25 is:

**National Association of Benefits
and Insurance Professionals
“Shaping the Future of
Healthcare”**

Says NAHU leadership, “We believe this name/tagline is both inclusive and a far more accurate reflection of who we are than health underwriters.”

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Health Risks of Mercury Persist Critical levels found in the bloodstream of up to 8% of 16-to-49-year-old women in America. (<https://bit.ly/3NojKd6>)

The 2012 U.S. government target to reduce mercury emissions by 90% have largely been successful (<https://bit.ly/300otlo>) – they have led to less mercury in the environment, and have taken place over a long enough period of time that we can evaluate their health effects.

The 10 years long attempt to dramatically reduce mercury emissions has resulted in: Children born with exposure to mercury declined by half, the average mercury blood level in women declined by over a third, and the measurable mercury levels in lakes, rivers, streams and the land have declined appreciably – all this from an 85% reduction in environmental mercury from coal-fired power plants alone.

According to Coty Perry of Fishing News, (<https://yourbassguy.com/author/coty/>) coal-fired power plants are the main place we should look to reduce mercury emissions, simply because they are the origin of most of the mercury emitted in the United States.

At the very least, any products in your home such as batteries, thermometers and thermostats which might contain mercury need to be disposed of properly and not just thrown out with the rest of the trash.

Read more here: <https://yourbassguy.com/news/mercury-in-fish/>



Brian Sullivan receives LAAHU 2022 Paladin Award

BenefitMall's Market Director for Southern California Brian Sullivan, received the prestigious 2022 Paladin Award from the Los Angeles Association of Health Underwriters (LAAHU). The award recognizes leadership

over time and service to the benefits industry. This is the first time the award has been presented since 2018.

The Paladin Award goes to the member who most:

- Contributed “directly” to the Association
- Provided service or assistance to others within the Association and or industry
- Acted as a leader or coach who challenged others to aspire to a greater goal or understanding
- Provided leadership, coaching or assistance in more than one discipline (education, legislation, marketing, sales, etc.)
- Provided leadership over a period of time indicating a long term commitment

Beware Investment Funds: No Hiding Behind Greenwashing SEC says NO to misleading fund labels

Stopping fund providers from misleading consumers is top of mind for Securities and Exchange Commission (SEC). They aim to stop investment funds from labeling products as Environmental, Social and Governance (ESG) (<https://bit.ly/3tdh620>) unless their investment process relies on ESG more so than other factors.

Using ESG alongside other factors “but not more centrally” than the other factors “would not be permitted to use ESG or similar terminology in its name,” the agency noted in a factsheet for the proposal, noting that doing so could be misleading or materially deceptive.

A study published by As You Sow (asyousow.org) found that 60 out of 94 funds (<https://bit.ly/3PUV6md>) labeled as ESG products lacked ESG conviction, with many products containing fossil-fuel investments.

“As the saying goes, you should mean what you say and say what you mean,” SEC commissioner Caroline Crenshaw said in her remarks at the public hearing. “A fund’s name is often the first piece of fund information investors see. And while investors should go beyond the name itself and look at the fund’s underlying disclosures, a fund’s name can have significant impact on their investment decisions.” Words like “sustainable” and “green” are often used as marketing tools but play only a minimal role in some products’ investment processes, she noted.

“Clear and standardized disclosures allow investors to compare products and accurately price risk and opportunity with ESG practices,” Crenshaw said. “Investors have a right to know what they are investing in.”



Blue Shield Vital Signs poll reveals positive outlook

An increasing number of Californians are feeling positive about health care, even as the COVID-19 pandemic continues, according to a new poll commissioned by Blue Shield of California. The poll of 1,000 Californians was conducted in February of this year. Read more.

Brand Name Drugs Skyrocket 20% annually from 2008 to 2021

Average launch prices for new brand-name prescription drugs in the U.S. increased by more than 20% annually from 2008 to 2021. According to the AMA researchers, trends for 548 name drugs with annual cost of >\$150K rose by 9% from 2008 to 2013 and by 47% from 2020 to 2021. Where's it going to stop? Source: UPI.com



RETIREMENT

CalSavers Reminder - June 30 deadline looms

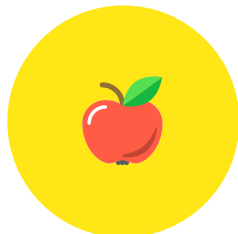
The state of California has grown increasingly concerned about Californians' lack of retirement savings. To help combat this, the state created the CalSavers retirement savings program.

Health benefits professionals who have clients with businesses of five or more employees in California will be required to offer a retirement savings plan by June 30, 2022. Are you prepared? Know that employers have a 90-day grace period.

To properly advise your clients, read more in CalBroker Magazine Jan. 22, 2022:

“CalSavers MANDATE – How to Turn a Problem into an Opportunity.”

Search <https://www.calbrokermag.com/in-this-issue/calsavers-mandate/>



FOCUS ON PREVENTION

Address health problems before they start

Chronic disease is on the rise and screaming to be addressed. Exacerbated by the COVID-19 pandemic, preventing disease than reacting to it is called for, writes Newtopia Inc.'s Lara Dodo. Preventive treatment, including programs in genetic testing, personal coaching and nutrition,

can help populations be happier, healthier and more productive, Dodo said.

Build 5 Skills to Lead with Emotional Intelligence

1. **Self-awareness** — Understand your emotions, strengths and weaknesses. Take time to process information without immediately reacting, or overreacting, in difficult situations.
2. **Self-regulation** — Stay in control of emotions without lashing out and stay calm in the face of chaos.
3. **Motivation** — Demonstrate a passion for work that goes beyond money and status. Leaders understand what they want to do and why they want to do it.
4. **Empathy for others** — Put yourself in someone else's shoes. Listen actively, deliver feedback with equanimity to build a positive workforce that fosters loyalty and collaborative problem-solving.
5. **Social, or “soft” skills** — Skilled communicators can resolve conflict and meet change with a diplomatic, encouraging attitude.

Read more at Chiefexecutive.net

COMPENSATION

Broker Compensation – Ethical or borderline?

Are the countless incentives offered preventing brokers from what would ordinarily be annual due diligence? Are they placing business where producers are better off instead of selling the solution their client actually needs?

“Along with where the money is coming from, a larger question is brewing among those in our community: Is it unethical for advisers to be paid more every year if they deliver poorer results?”

Explore this moral dilemma with Emma Fox on Employee Benefit News.



COVER STORY

From Screens to Sun

Employees Seek Dynamic Light
Protection and Premium Vision Plan Benefits
for Increased Demands on Their Eyes

BY JONATHAN ORMSBY

With many workers now preferring remote or hybrid work versus a traditional workspace, increased visual demands on employees' eyes is likely to be an ongoing future of work trend.

According to PEW Research, 60% of workers with jobs that can be done from home say when the COVID-19 outbreak ends, if they have the choice, they'd like to work from home all or most of the time. This is up from 54% who said the same in 2020. Among those who are currently working from home all or most of the time, 78% say they'd like to continue to do so after the pandemic, up from 64% in 2020 (Pew Research Center. "COVID-19 Pandemic Continues to Reshape Work in America." Feb. 16, 2022. <https://www.pewresearch.org/social-trends/2022/02/16/covid-19-pandemic-continues-to-reshape-work-in-america/>).

As employees continue to prefer to work in remote or hybrid situations, harsh indoor lighting in the workplace, sun glare from increased time spent outdoors and on digital screens may lead to unwanted side effects — such as increased exposure to harmful blue light, a rise in digital eyestrain and corresponding symptoms — which may take a toll on vision and may ultimately impact employee productivity and retention.

EMPLOYEES' EYES ARE IN OVERDRIVE

A recent Transitions Optical survey found that since the beginning of the COVID-19 pandemic, over half of employees report spending more time in front of their computer screens now than in previous years. Among these employees, nearly nine in 10 (85%) are experiencing more digital eye strain — with many also experiencing corresponding symptoms, such as headaches (51%), dry eye (48%), and light sensitivity (29%).

[Transitions Optical, 2021 Workplace Wellness Survey, Wakefield Research, N=1,300 U.S. adults, ages 18+, employed full-time or part-time, whose employer offers vision benefits].

Additionally, 22% of employees report spending more time going outside into bright sunshine now than before the pandemic. [Transitions Optical, Global Consumer Sentiment and Behavior, Multi-country survey (AR, AU, CO, FR, IT, SG, ZA, UK, US), Q4 2020, People Research, N=6,403/N=700 per country. Eyeglasses wearers agree - Top 2 Box responses].

Facing increasing visual demands, employees are

becoming more aware of the important role lenses and premium vision plan benefits play in helping to protect and preserve their eye health. According to Transitions Optical's 2021 Workplace Wellness Survey, one-third of employees are actively seeking out information about blue light eyeglasses, updating their prescription, and/or buying new glasses. Beyond this, many employees are now seeking eyewear

solutions, even without considering the financial cost. In Transitions Optical's latest survey, 86% of employees say they are willing to pay more than their insurance allowance for a new pair of eyeglasses, with 59% saying they are likely to spend \$100 or more over their coverage.

Not only that, 96% of employees surveyed say they are also willing to pay above what their insurance fully covers for premium lens options — with more than half (55%) of employees willing to pay more for UV protection. Additionally, nearly half (49%) of employees report they are willing to pay more for blue light protection and 44% are willing to pay above what

their insurance fully covers for photochromic lenses.

Photochromic lenses, which adapt to changing light, indoors and out, while helping to offer protection from harmful blue light and ultraviolet rays, continues to influence employee interest in premium vision plans. ("Harmful blue light" is calculated up to 455nm, with the greatest toxicity between 415-455 nm). In fact, 70% of employees say they are much/somewhat more likely, with 44% indicating they are much more likely, to enroll in a vision plan that covers Transitions brand lenses specifically — which block 100% of UVA and UVB rays and help filter harmful blue light indoors and outdoors (Transitions® Signature® GEN 8™ block at least 20% of harmful blue light indoors & over 87% of harmful blue light outdoors except Transitions® Signature® lenses style colors which block over 75% outdoors. "Harmful blue light" is calculated between 380nm and 460nm.)

The survey also found that while almost three out of four employees (73%) would see care from an eyecare professional because of blurry vision, over half (52%) would seek care because of light sensitivity, half (49%) because of eyestrain from digital device usage, and more than a quarter (30%) would visit their eye care professional because of interest in blue light protection.

Eyecare professionals have also taken note of the pandemic's effect on their patients' eye health as more than 70% of them



TRANSITIONS® LENSES INFLUENCE EMPLOYEE INTEREST IN PREMIUM VISION PLANS

70%

of employees are likely to enroll in a vision plan that covers Transitions lenses—which block 100% of UVA and UVB rays and help filter harmful blue light indoors and outdoors.

UV & HARMFUL BLUE LIGHT FILTERING

Transitions
High light lenses

Transitions Optical, 2022 Workplace Wellness Survey, Workplace Research, n=1,302 (11 adults age 18+ employed full-time, part-time or contract), whose employer offers vision benefits.
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EMPLOYEES FEELING EYE FATIGUE

78%

Report their work productivity and performance has been impacted due to these factors

	50%	Eye strain/eye fatigue
	39%	Headaches
	36%	Blurry vision
	33%	Discomfort looking at bright screens
	33%	Difficulty focusing on distance objects upon looking up from the screen

Transitions
High light lenses

Transitions Optical, 2022 Workplace Wellness Survey, Workplace Research, n=1,302 (11 adults age 18+ employed full-time, part-time or contract), whose employer offers vision benefits.
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agree that their patients have become more sensitive to eye care and protection since the pandemic began. Research from Transitions Optical substantiates this finding, as 75% of consumers surveyed say that lenses should help to protect from both ultraviolet light and harmful blue light.

News reports that companies gain \$7 for every \$1 they invest in their employees' vision coverage. This equates to savings of over \$2,700 per employee annually. (<https://www.ameritasinsight.com/wellness/vision/5-reasons-why-employers-should-offer-eye-care-benefits>).

PREMIUM VISION PLANS BENEFIT EMPLOYEE HEALTH, RETENTION & PRODUCTIVITY

The increased occurrences of light sensitivity and digital eye strain that employees are facing can lead to many problems for employees while at work, ranging from trouble seeing, to headaches, to even taking excessive breaks.

Transitions Optical's 2022 Workplace Wellness Survey found that 78% of employees report their work productivity and performance has been impacted by either eye strain/eye fatigue (50%), headaches (39%), blurry vision (36%), discomfort looking at bright screens (33%), and/or difficulty focusing on distance objects upon looking up from the screen (33%). Additionally, in 2020, a Transitions Optical survey found 67% of employees take breaks throughout the day to help alleviate discomfort from sitting behind a screen

The silver lining? Premium eyewear options, often covered in full or in part by vision benefits plans, can help to alleviate symptoms — further boosting employee wellness and productivity, while improving an employer's bottom line.

It's also important to note that annual comprehensive eye exams, typically included in a vision benefits plan, not only identify common problems with vision — such as trouble seeing up close or far away — but eye exams also detect eye diseases and serious overall health issues earlier on to help ensure better patient outcomes. This can save not only an employee or employer stress and time, but also money in the long run. Employee Benefit

As employees continue to prefer to work in remote or hybrid situations, harsh indoor lighting in the workplace, sun glare from increased time spent outdoors and on digital screens may lead to unwanted side effects...

Loss in vision and health benefits could also lead to a loss of employees. The Great Resignation is affecting companies, according to the 2022 Transitions Optical Workplace Wellness Survey, as 38% of employees are reporting they are likely to leave their current job in the next year. Additionally, 74% of employees who receive vision benefits say the loss of those benefits would be a very important factor in choosing to resign.

With seven out of 10 employees indicating that protecting their eye health is more important today than it was before the global pandemic — employers who offer premium vision benefits that cover both

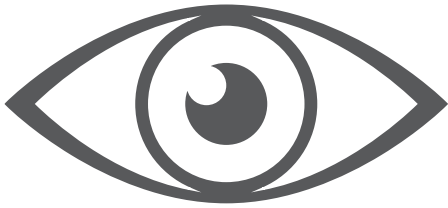
annual, dilated eye exams and eyewear options that employees both want and need can help them stand out in the crowd.

Offering comprehensive premium vision benefits plans, especially at a time when employees report they are increasingly experiencing the effects of light sensitivity and digital eye strain, can help an employer address the increased need for dynamic light protection. **CB**



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www.transitions.com

SAVVY COMPANIES INVEST IN EMPLOYEE BENEFITS, ESPECIALLY DURING TIMES OF UNCERTAINTY



**BY
DR. VALERIE
SHEETY-PILON**

Why eye health matters to you — as a patient and an employer

As inflation continues to squeeze employers, companies are exploring cost-cutting measures as a strategy to prepare for the future. While it's prudent to reduce unnecessary expenses, cutting the wrong programs or initiatives may have unintended long-term financial consequences.

Take employee benefits for example. At first glance, some may think vision care is a 'nice to have' as a part of their employee benefits offerings but scaling back on this critical coverage might not be as cost effective as it may first appear.

Consider this: according to the American Diabetes Association (ADA), one of the largest impacts on the health care system — and on employers who pay for a significant portion of health care costs — are chronic conditions. They range in severity and treatment and can require constant and expensive medical care.



Most people don't realize that an eye exam goes far beyond just testing for clear vision. In a comprehensive eye exam, an eye doctor may be able to detect signs of more than 270 systemic conditions – many of which may be chronic afflictions that carry significant risk to an individual's overall health.

According to the Partnership to Fight Chronic Diseases, more than 190 million Americans – or about 3 in 5 people – have one or more chronic conditions such as diabetes, high cholesterol, or heart disease. **(Source: www.fightchronicdisease.org)**

According to the ADA, diabetes alone accounts for \$1 in every \$4 spent in the U.S. health care system and people with diabetes average medical costs 2.3 times higher than those without. **(Source: www.diabetes.org)**. The CDC estimates health care spending associated with high blood pressure costs the nation nearly \$50 billion each year, and predicts by 2030, that chronic diseases could cost American businesses more than \$2 trillion in medical costs plus an extra \$794 billion annually in lost employee productivity. **(Source: www.cdc.gov)**.

So how does vision care tie in?

Most people don't realize that an eye exam goes far beyond just testing for clear vision. In a comprehensive eye exam, an eye doctor may be able to detect signs of more than 270 systemic conditions – many of which may be chronic afflictions that carry significant risk to an individual's overall health. **(Source: www.aoa.org)**

For more than 15 years, VSP® Vision Care has partnered with eye doctors across the country to identify and engage VSP members with chronic conditions through our claims system. What we have found is VSP network doctors are twice as likely to be the first touch point for patients seeking care, compared to other plans. Patients who underwent a WellVision Exam® often reported chronic conditions, like diabetes, before any other health care plan according to a November 2021 study published by Workpartners®, a leader in human capital management that analyzed the health outcomes of VSP members against those from other vision plans based on its proprietary research reference database of

more than 4.3 million employees and their dependents. **(Study: <https://visionbenefits.vsp.com/dms-inline/pdfs/workpartners-case-study.pdf>)**.

But what do you look for in a vision plan?

Looking at leaders in the U.S. economy, 64% of Fortune's 100 Best Companies to work for in 2021 chose a stand-alone vision plan, according to VSP data. Of those, 52% chose a stand-alone VSP plan— five times more than the next leading carrier. Why? As the only national not-for-profit vision care company, VSP Vision Care's focus is on people, not profits. We structure our plans and programs to encourage utilization.

VSP is also the only carrier that offers urgent and medical eye care as standard on all full-service plans. For members with diabetes, VSP vision plans also cover of the costs for critical screenings and additional medical eye exams to monitor their eyes because we know it's important to ensure a vision plan is designed for eye health and overall health.

Importantly, employees save, too. According to the same study by Workpartners:

“VSP members with a chronic condition incur fewer health care costs in the first year after diagnosis than members of other vision plans. More specifically, VSP members with diabetes avoided annual medical and drug costs of nearly \$1,800 compared to members of other vision plans. For VSP members with high blood pressure, also known as hypertension, the savings were even greater. They avoided annual medical and drug costs of more than \$2,600 compared to members of other plans.”

The cost businesses incur for offering employer-provided vision benefits is much less in comparison to the cost of employer-provided health insurance – especially for those living with chronic conditions – meaning

vision care is a relatively small investment for a potential big return for employees' long-term health.

Most importantly, in addition to the cost-savings and productivity gains, preventive care like an eye exam helps employees live healthier, better lives. Our focus at VSP is to help our members see well and be well so they can reach their full potential. VSP members are generally healthier, according to Workpartners, leading to the conclusion that the identification of a chronic condition through a comprehensive eye exam leads to better health outcomes.

So take the time to review your vision benefits – and see how vision care can help your employees and your bottom line. **CB**

Visit www.offervsp.com or call 800.216.6248 (option 4) for more information about VSP Vision Care plans today!



DR. VALERIE SHEETY-PILON is Vice President of Clinical & Medical Affairs at VSP Vision where she helps drive strategic initiatives aimed at raising awareness about

eye health and its connection to overall wellness while providing insight into medical advancements that seek to benefit patient care. With more than 15 years' experience as a Doctor of Optometry, she has dedicated much of her time to clinical research across numerous ophthalmic subspecialties and has an established a history of helping patients through the use of novel therapeutic agents and clinical adoption of transformative technology in the areas of digital health, pharmaceuticals, and medical devices.



oral care *is* healthcare

1950s style benefits need more bite

N

ow is the time for traditional cost-sharing dental insurance plans to be upgraded and for the insurance industry to realize that oral care is healthcare. The standard 100/80/50 plan design with the usual \$1,000 to \$2,000 annual maximum has not changed since the inception of dental insurance in the 1950s. There have been major advancements in oral health technology and science over the past few decades, but dental plan designs remain in the 20th century. Our healthcare system further segregates medical and dental care, creating a silent epidemic of diseases that could be detected during an oral examination — potentially saving hundreds of millions of dollars in unnecessary comorbidity costs.

**BY
JILL KOHLER**

Dental is often the part of a company's employee benefit program and wellness strategy that is overlooked. This begs the question, "How can the insurance industry change its philosophy toward dental coverage to improve the benefits while providing the plans their employees want, need and value since oral care is part of their overall health?" The answer is: through innovative dental plans and broker-client education.

Companies do not need to settle for the plain, vanilla dental coverage of the past and can offer innovative plans that include some of the following options:

- A dental plan that increases the coinsurance overtime for Type 2 and/or 3 services when the employee goes in for their preventive services at least once a year. The traditional 80% for Type 2 could increase up to 100%.
- Creating a Type 4 (Specialty) tier that carves out Implants or Crowns at a higher coinsurance amount than the traditional 50% to lower member out of pocket expenses.
- Rolling-over benefits that allow members to use the unused portion of the dental maximums towards orthodontia, vision, LASIK, and hearing benefits.
- Excluding Type 1 (Preventative) services from applying towards the annual maximum. This will allow members to use their entire maximum toward Type 2 (Basic) and 3 (Major) services.
- Coverage that allows members to use a portion of the dental annual maximum toward eye care needs. This is an excellent option since according to the National Association of Dental Plans only 2.8% of members use their entire annual dental maximum (\$1,000 average) annually leaving money on the table that could go toward stylish frames or extra contacts.

A recent American Dental Association (ADA) survey revealed that 95% of Americans regard their oral health as an important part of their well-being. It is one reason the national dental care expenditures in 2020 amounted to \$142.4 billion (about \$440 per person in the U.S.) and that 156 million Americans signed up

for dental insurance according to the National Association of Dental Plans. All signs point to the importance of dental coverage to our health. Yet, it continues to get the rap of being an "ancillary" plan. It is second to medical coverage among the insurance industry and companies, even though we know dental (and vision) are part of a person's overall wellness.

Like other areas of the body, your mouth teems with bacteria. Most are harmless but your mouth is the entry point to your digestive and respiratory tracts, and some of these bacteria can cause disease. According to the U.S. Department of Health and Human Services, the lack of interoperability between medical and dental records further segments overall healthcare delivery.


During a dental exam, your dentist looks for tooth decay, cavities, gum disease and other oral health problems. Dentists are also trained to detect signs of more than 100 diseases through a routine exam (such as diabetes, heart disease, certain cancers, osteoporosis, anemia, and kidney diseases to name a few). A person's oral health is often the first indication of certain diseases and conditions that the dentist may find even before a patient goes to their medical doctor. Over 90% of diseases have symptoms that appear in the mouth first, such as ulcers, swollen or bleeding gums, dry mouth, or discolored teeth. That is the reason the American Dental Association encourages regular dental exams at least every six months. There is an abundance of information that could be useful in diagnosing and developing a treatment plan if dental was part of a holistic wellness plan.

The connections are not fully understood and are still being researched. The Mayo Clinic reports that the following comorbidities are related to oral health:

1. Heart disease, clogged arteries and stroke may be linked to inflammation and infection from oral bacteria.
2. Periodontitis is linked to premature birth and low birth weight.
3. Certain bacteria in your mouth can be pulled into your lungs, causing

pneumonia and other respiratory diseases.

4. Gum disease and Periodontitis are more frequent and severe among people with diabetes.

Change is obviously needed for dental plans that have not evolved in 70 years! Additionally, the insurance industry needs to remember that total health and wellness cannot exist without dental care since they are intricately linked. Oral disease impacts the quality of life for an individual, affecting their physical, psychological, social and economic health and well-being. Going to the dentist regularly is a major part of healthcare, especially since they can detect health issues long before someone goes to their doctor. The dentist may be the only healthcare professional an individual sees annually, further proving that dental coverage needs to become a major part of an individual and company's wellness program. **We all need to embrace the fact that oral care is healthcare and improved plan designs are needed!** 



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Kohler has
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insurance industry for almost 30 years. She began her career while in college at California State University, Sacramento, where she earned her bachelor's degree in Journalism. She has worked with major medical, dental, vision and voluntary benefits for small and large-size companies. She lives with her family in Northern California and works with brokers and clients through-out the San Francisco Bay Area in sales for the Ameritas benefits division.

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CURRENT TRENDS IN
Dental
Coverage

People want more than just clean teeth



We asked representatives from two top carriers in the dental industry to share details about their companies.

**Stacia
Almquist**

VP, Network & Market
Development,
Unum and Colonial Life
Dental & Vision

**Jill
Purcell**

Head of Dental & Vision
Products, Guardian Life

1. What are the current trends in Dental coverage? Are claims showing any trends in care, or revelations of instances of predicting health issues early?

JILL PURCELL, HEAD OF DENTAL & VISION PRODUCTS, GUARDIAN LIFE

Dental benefits continue to be recognized for the impact they have on employees' overall well-being and for helping them come to work feeling, thinking, and performing better. Our most recent dental study, "Dental Fundamentals: In-demand dental benefits that support well-being," found that consumers want dental plans that help them save while making preventive care more accessible. Based on these insights, Guardian delivers modern dental benefits that are flexible, easy to understand, and offer a variety of benefit options that balance cost and access to care.

There has been increased attention to the importance of preventive care. In fact, poor dental health has been attributed to higher incidence of heart disease, dementia, diabetes, rheumatoid arthritis, and pregnancy complications, while good oral care and dental health has been linked to better overall physical and mental well-being.

STACIA ALMQUIST, VP, NETWORK & MARKET DEVELOPMENT, UNUM & COLONIAL LIFE DENTAL & VISION:

During the pandemic some members skipped or delayed preventive services, resulting in fluctuation and increases in utilization of services such as periodontal treatments. We do expect to see utilization trends come back to a normalized level over time.

As many other industries, some provider offices are working hard to recruit and retain staff. The impact could affect services available to members.

2. Has COVID-19 changed any of your offerings or had a substantial impact on any of your plans, like a change in claims or use of benefits due to postponing care during the pandemic?

PURCELL, GUARDIAN LIFE:

The last few years have brought renewed consumer appreciation for dental benefits. Although dental visits were down overall in 2020, they rebounded in 2021 to exceed pre-pandemic levels, and nearly a third (30%) of patients with dental insurance say the pandemic caused them to value their dental benefits more.

Guardian offers options to ensure members have access to dental care when and where they need it. These include virtual care options through our partnership with Teledentistry.com, a service that allows patients to connect virtually with an emergency dentist, and Byte,® an innovative option for at-home aligners and teeth whitening. Jet Dental, an onsite provider that is part of our network of dentists, brings dental care directly to employees at their place of work.

ALMQUIST, UNUM & COLONIAL LIFE DENTAL & VISION:

Throughout the pandemic, many providers offered teledentistry as an option to help allay members' fears of not being able to access dental care, especially during emergencies. We have virtual dental visits available through TeleDentistry.com. Dentists perform video examinations and prescribe medicines, if needed. Members can meet virtually with a dentist 24 hours per day, 7 days per week if there is a dental emergency or cannot visit in-person.

3. What types of plans do you offer? How do the offerings for individual and small group compare to large group plans? Are more individuals selecting to self-insure who may not have employee coverage?



There has been increased attention to the importance of preventive care. In fact, poor dental health has been attributed to higher incidence of heart disease, dementia, diabetes, rheumatoid arthritis, and pregnancy complications, while good oral care and dental health has been linked to better overall physical and mental well-being.

PURCELL, GUARDIAN LIFE:

Guardian offers an array of plan types and options to meet the needs of employers/employees and individuals/families. Employer plans can be customized according to needs and price points. Dental PPO, Managed Dental Care (Prepaid/DHMO), Indemnity, Dual and Triple Choice, Monthly Switch (between a DHMO and PPO), and Administrative Services Only Plans can be offered as voluntary, contributory, or on an employer-sponsored basis. Individuals/families can buy direct from www.guardiandirect.com.

ALMQUIST, UNUM & COLONIAL LIFE DENTAL & VISION:

Unum and Colonial Life offer plans that fit all size groups whether fully voluntary, contributory or employer sponsored. Our product portfolios include group dental PPO plans, DHMO plans (available in southern California) and individual plans offered through the worksite. Group dental PPO plans may be customized to meet the unique needs of the employer and employees.

NUMBER OF DENTISTS AND PERCENT OF DENTISTS TAKING NEW PATIENTS IN 2021

Type of Dentist	Dentists	% Accepting New Patients
General Dentists	8,298	91.99%
Oral Surgeons	803	97.04%
Endodontists	744	97.73%
Orthodontists	1,160	97.61%
Pediatric Dentists	650	94.26%
Periodontists	663	97.83%
Total Specialists	4,020	100.00%

Source: Guardian Internal Reporting

4. What changes in plans or benefits should brokers be aware of for open enrollment this year? Are more employers offering or making their plans richer?

PURCELL, GUARDIAN LIFE:

We have recently introduced innovative plans in 23 states and hope to be able to bring them to California in the near future. The products, some of which are the first of their kind, focus on preventive and corrective care and can help reduce physical and mental health risks tied to poor oral health.

In our Guardian Inflection Point report, 44% of respondents making changes to their dental plans are looking to add coverage.

ALMQUIST, UNUM & COLONIAL LIFE DENTAL & VISION:

Unum and Colonial Life Dental Plans Offer:

- A national network of more than 120,000 unique providers
- A recruitment team enhancing the quality and availability of in-network services for members
- A carryover benefit designed to reward employees who take care of their teeth
- Extra cleanings for pregnant women in the 2nd or 3rd trimester
- Adjunctive pre-diagnostic testing for members 40+ years old who demonstrate risk factors for oral cancer
- Online wellness tools - provider search, digital ID card, member benefits, dental cost estimator and access to claims information
- Access to virtual visits available 24/7 when employees have a dental



Throughout the pandemic, many providers offered teledentistry as an option to help allay members' fears of not being able to access dental care, especially during emergencies. We have virtual dental visits available through TeleDentistry.com.

emergency or cannot visit the dentist in-person

- Combined billing and administrative service with other Unum or Colonial Life products, including Life, Disability and other group and voluntary benefits.

5. How many provider locations do you have?

PURCELL, GUARDIAN LIFE:

For PPO, we have 133,040 dentists.

For DHMO, we have 10,919 dentists.

ALMQUIST, UNUM & COLONIAL LIFE DENTAL & VISION:

Our PPO dental network has more than 425,000 access points nationally with over 88,000 unique locations and 120,000+ unique providers. In California, there are 12,000 unique locations and more than 16,000 unique providers.

We started marketing DHMO in Southern California in 2021. The network currently has 661 unique locations, 663 unique providers and continues to grow.

6. Do you reimburse for out-of-network dentists if an insured chooses to go outside of your network?

PURCELL, GUARDIAN LIFE:

Reimbursement for out-of-network dentists would depend on the plan chosen. However, generally, non contracted dentists are reimbursed using Guardian's reimbursement schedule. Reimbursements are calculated using a combination of industry, third-party and internal claims data for each CDT code and geographic location.

Reimbursement amounts are calculated using the dentist's submitted amount and the number of times a specific service is submitted in a zip code area. We use Guardian's 90th reimbursement schedule as our standard. We can pay claims using different percentiles of Guardian's reimbursement schedule, such as the 50th, 70th, 75th, 80th, 85th, or 95th percentile. We update our reimbursement data every six to 12 months.

ALMQUIST, UNUM & COLONIAL LIFE DENTAL & VISION:

Yes. PPO plan members can access the provider of their choice, in or out-of-network. Members will have lower out of pocket costs with an in-network provider.

Our DHMO plans have in network benefits only, with emergency services available out of network as needed and approved.

7. What percentage of your network is open to new enrollment? How many offices does this represent?

PURCELL, GUARDIAN LIFE:

For PPO, in 2021, we had 133,249 dentists, and 93.6% of those participating dentists were accepting new patients.

ALMQUIST, UNUM & COLONIAL LIFE DENTAL & VISION:

Our PPO network is 99% open to new patients, while our DHMO network in Southern California is approximately 90% open to new enrollment.

8. What happens if a member is in the middle of orthodontic treatment and they lose their coverage due to a job change or other circumstance?

PURCELL, GUARDIAN LIFE:

If a member's coverage ends while treatment is in progress, benefits will be paid to the end of the month in which the coverage ends.

ALMQUIST, UNUM & COLONIAL LIFE DENTAL & VISION:

If a member has a PPO dental plan, it pays the lesser amount of 25% of the orthodontia lifetime maximum or 25% of the total billed amount upon initial banding. Remaining



In our Guardian Inflection Point report, 44% of respondents making changes to their dental plans are looking to add coverage.

benefits are paid in monthly installments at 50% of the allowed amount until the plan orthodontia maximum benefit has been met or the braces are removed, whichever comes first. If a member were to leave the dental plan mid-treatment, coverage would be discontinued, and they would move to a new dental carrier to pay the remaining benefit.

We will resume orthodontic benefits from the prior plan and continue to pay the benefit until the lifetime maximum is met. A new member's history of orthodontic benefits is obtained from the previous carrier's report or by requesting the information directly from the provider. For plan members without prior orthodontic coverage, waiting periods for orthodontia may apply.

If a member has a DHMO plan that includes an orthodontia benefit, the member responsibility is based on the copayment.

9. What are your annual and lifetime maximums if any? What is the plan deductible?

PURCELL, GUARDIAN LIFE:

Guardian offers annual maximums ranging from \$500 to \$5,000. Historically, the most common annual maximums are \$1,000 and \$1,500.

If a plan covers orthodontics, Guardian will pay a separate lifetime orthodontic maximum for the orthodontic services. The lifetime orthodontic maximum ranges from \$1,000 to \$2,000. A lifetime maximum is the maximum amount that Guardian will pay for covered services for a member while he or she is insured on the plan.

Individual deductibles range from \$0 (or no deductible) to \$300, with \$50 historically being the most common.

Note: Annual and lifetime maximums and plan deductibles are determined on a case-by-case basis.

ALMQUIST, UNUM & COLONIAL LIFE DENTAL & VISION:

On PPO plans, our annual maximums vary from \$500 to \$5,000, depending on the group's needs and size. Deductibles can also vary, including no deductible, annual flat dollar per insured or per family, and flat lifetime deductible per insured.

We also offer the ability to include a Carryover Benefit as a standard plan feature. The Dental Carryover Benefit is designed to incentivize and reward members with an opportunity to increase their individual annual maximum for taking care of their teeth with preventive services. We will credit the Carryover Benefit to the member's account for the next year if they submit claims for preventive services and if the member's total benefits received are less than the group's threshold amount within one benefit year.

There is no annual or lifetime maximum on DHMO plans.

10. What percentage does your plan cover for: preventive costs, root canals, crowns?

PURCELL, GUARDIAN LIFE:

The percentages for the listed services vary by the selected plan design and request for benefits by each planholder. Historically, the most common percentages are 100% for preventive, 80% for root canals, and 50% for crowns.

ALMQUIST, UNUM & COLONIAL LIFE DENTAL & VISION:

Preventive Costs

- Preventive care is covered at 100% in PPO plans. We offer various options such as covering preventive care at 100% in network and 90% when visiting out of network providers.
- DHMO plans cover most preventive services with no copayment.

Root Canals

- In PPO plans, root canals are covered as a basic service. The coinsurance percentage for basic services is most sold at 80%. Our plans are flexible, and we can offer varying coinsurance percentages based on the employer's needs.
- DHMO plans cover many root canal procedures at copayment levels that will vary based on the plan selected.



**We provide
online tools to
help members
take better
care of their
oral and
overall health,
available at
guardianlife.
com.**

Crowns

- In PPO plans, crowns are covered as a major service. The most common coinsurance percentage for major services is 50%.
- DHMO plans offer a variety of crown procedures covered at various copayment levels based on the plan selected.

11. Do you provide dentist cost and quality transparency tools?

PURCELL, GUARDIAN LIFE:

Yes. We provide online tools to help members take better care of their oral and overall health, available at guardianlife.com. Guardian offers a convenient Dental Cost Estimator tool to empower dental plan members to make better decisions to help improve their oral health and use their benefits wisely. With just a few clicks of the mouse, members can receive cost estimates on dental procedures – before treatment – and compare the financial impact of visiting dentists either in or out of their network.

ALMQUIST, UNUM & COLONIAL LIFE DENTAL & VISION:

For plan participants, the personalized, secure plan member website accessed through **www.UnumDentalCare.com** or **www.coloniallifedental.com** provides access to an array of online tools and information necessary to manage coverage.

The sites feature a Dental Cost Estimator tool that members can use to find the costs for dental procedures in their zip code area. The costs displayed provide an idea of what providers may charge but does not specifically provide the reimbursement amount used when processing claims. Members can also view their Benefit Summary, which provides specific information about plan coverages. The California required Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC) provides a summary of the benefits and coverage.

12. Who can readers contact for more information?

PURCELL, GUARDIAN LIFE:

Contact: Jill Purcell, Head of Dental & Vision Products, Guardian Life.

Jill_Purcell@glic.com, or visit **<https://www.guardianlife.com/dental-insurance/group>**.

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ALMQUIST, UNUM & COLONIAL LIFE DENTAL & VISION:

Contact: Group Dental Insurance Plans and Coverage | Unum
Individual & Group Dental & Vision Insurance for Employees | Colonial Life

CLA:

- Plan administrator support – 800-256-700

Unum:

- Los Angeles, CA Field office: 800-772-3081
- San Diego, CA Field Office: 800-431-3838
- San Francisco, CA Field Office: 800-367-6166

If you would like to be included in upcoming industry surveys, contact: Thora@calbrokermag.com



Annual Senior Summit Returns to Pechanga Resort

Medicare: Your Journey to the Top” Aug. 23 - 25, 2022

As part of their ‘Journey to the Top,’ on Aug. 23-25 more than 700 agents, company representatives, physician groups and carriers will be gathering at the 10th Annual Senior Summit to share ideas, hear about new products and features. At the Pechanga Resort, participants will be able to complete training, including educational certifications, and learn of legislative issues and concerns affecting the Medicare focused marketplace. Agents and companies have shared that this meeting is vital to their preparation and kick off for the upcoming Annual Enrollment Period (AEP) Oct. 15 to Dec. 7, 2022.

There is so much to share that the event has expanded to three full days! The program kicks off on Tuesday with “Companies First Look and Product Trainings” that will continue into the next day. Companies include Aetna, Alignment, Anthem Blue Cross, Blue Shield of CA, Brand New Day, Central Health Plan, Centene, SCAN, UHC, WellCare, and more.

And, to finish up the day, a fun cocktail party swings into action on the first evening on the rooftop! On Wednesday, the program is jam packed with speakers and presenters. Thursday will be dedicated to education and break-out sessions (some with CE’s).

This year we are pleased to present our keynote Dan Clark, motivational speaker extraordinaire and author of many inspirational books including “Chicken Soup for the Soul.” He will also be leading a workshop addressing leadership and more!

This year is important for legislative issues on both the state and federal levels and especially addressing the just released CMS Marketing Guidelines for the upcoming AEP. A legislative panel will feature NAHU SVP of Government Affairs Marcy Buckner, Legislative Advocate at California Advocates Faith Borges, and Principal Nick Uehlecke of Todd Strategy Group. The panel will share insights, key issues and concerns for Medicare beneficiaries and agents.

Our educational break-out sessions will address a number of key topics that have been requested by our previous attendees. While being finalized at the time of the writing of this article, topics will include these and more:

- Determining the right structure of your business (sole proprietor or LLC or C corp);
- Addressing senior needs
- Understanding and offering ancillary and supplemental benefits
- Helping clients with the challenges of drug coverage
- succession planning

The exhibit hall opens on Wed. morning and continues through to Thurs. It promises to offer everyone the opportunity to visit with up to 70 exhibitors to learn more about their products and services. It is always a must to visit with the exhibitors and see what is new in our industry and to connect with our carriers, medical groups and ancillary and supplemental benefit providers.

This major event would not be possible without our partners and exhibitors, noted below.

Gold Ribbon Partner: Applied General Agency

Red Ribbon Partners: Alignment Health Plan and Humana

White Ribbon Partners: Jack Schroeder and Assoc., Centene, Optum and Golden Outlook

Blue-Ribbon Lunch Partners: Aetna Medicare and Senior Market Sales

Welcome Reception Partner: SunFire.

Sponsor Partners: HRBC, Financial Grade, SCAN Health Plan, The Brokerage, Inc, Prospect Medical, Van Berg Insurance Services, Green Leaf Financial Services, Altmed, Dickerson Insurance Services, Warner Pacific, Blue Shield of CA, AFUSA, Central Valley Health Plan, Regal Medical Group, Retire with Renewals, Rehburg Life insurance Settlements, UnitedHealthcare and Anthem Blue Cross

**Thanks to all for supporting our 10th Annual Summit!
Come and join us at this great event to learn, mingle, share ideas and just to get away and have fun!**

For golfers, tee times will be available at special rates for Mon. afternoon, Aug. 22, at the Journey at Pechanga golf course. This course offers a challenging and fun playing experience.

For more information: <https://theseniorsummit.net/>

Register: <https://guestli.st/706287>

Information for reserving a room directly with the Pechanga Resort and Casino is also included.

Questions? **Contact Dawn Carroll at ieahu.adminstration@gmail.com**. See you there!



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A

BY
PHIL CALHOUN

growing trend for health insurance professionals is to look at off-loading some of their commissions to either spend time enjoying other pursuits in partial retirement or gain the time to build their other lines of insurance business. The cases below involve two actual scenarios where health insurance professionals made the move to exit the Medicare Advantage Prescription Drug Contracting (MAPD) business, and one where they chose a complete exit.

People are individuals and so are health insurance professionals. One solution for all is often not the best solution for you. We've outlined four examples that illustrate options.

SCENARIO ONE

Becky has a Medicare only practice with a 50/50 split between MAPD and Medicare Supplement. She realized she was tired of the annual cycle. She was exhausted by mandatory AHIP and carrier certification process required each year to be active in the MAPD business and retain residual MAPD and PDP commissions. If she stayed with Medicare supplements only, Becky would have the opportunity to avoid this certification process and win back time in the fourth quarter. When she did her income analysis, she realized she would reap an annual time savings of several weeks each year. Becky liked the fact that this change would open the option to travel more in the Fall. She also knew about the drug plan concern should she no longer certify annually.

Becky began searching for a friendly buyer for her MAPD clients. She wanted someone who could successfully manage her Medicare supplement client's drug plan review process every annual election Period.

With her focus shifting to finding a buyer, Becky interviewed buyers. She found several:

SCENARIO TWO

A second wanted to be paid a split of commissions to handle her service work in exchange for a transfer of clients and commissions

A third offered to purchase her commissions over several years. They would pay 50% annually while also agreeing to manage the annual PDP work in a friendly and helpful role for her Medicare Supplement clients, and perform the essential work to protect her Medicare Supplement clients in all life events with a formal Commission Protection Agreement.

In her final buyer review, she realized the one-time payment would be both the lowest payout amount and the most tax intensive. It would result in a lower after-tax amount. She then studied the shared client role and realized once her commissions were transferred to a broker, the clients would be won over and her negotiating position would be weaker when she wanted to sell.

She also concluded that her buyer might not positively impact her payout as the clients would be at risk without a solid retention program that was proven over time and backed by a team of experienced Medicare professionals. She wanted a buyer with a proven track record to both manage the transfer of commissions from each MAPD carrier, handle the service work required to reach the highest possible retention, and agree in writing to have at least two employed Medicare specialists commit to certify with all carriers each year to cover her book of business. She wanted them to cross cover one another in the event anyone had a life event during her payout period.

So, her research led her to the one buyer who could provide both the client service and support, commit in writing to a long payout period, and show her a history of success in doing just this type of work for over ten years.

The Commission Protection role to protect her Medicare Supplement commissions weighed heavily in her final decision. Becky realized that while she stayed active enrolling people in Medicare supplements, her commissions were 100% at risk. The solution was in the agreement the buyer offered her.

Now she has her Medicare supplement commissions covered in any life event, and she has the buyout deal points set should she decide to retire. This agreement outlined how her commissions would be paid with terms she agrees are favorable. With this decision Becky stays in contact with clients, enjoys enrolling referrals, but mostly she cherishes the free time in the fourth quarter to travel and relax.

SCENARIO THREE

Larry has a voluntary benefits book of business and small book of Medicare. Larry also wanted to sell his Medicare book of business to focus on voluntary benefits while gaining time in semi-retirement to spend with his wife, grandchildren, and friends. He followed the same path as Becky and decided to hold onto Medicare supplement while selling MAPD clients and commissions. After completing the agreement and looking into the Commission Protection process and agreement, he decided to sell all his Medicare clients and commissions. He

negotiated a solid buyout amount and used a payout period that suited his planning needs. Larry enjoys working with small business clients and finds voluntary benefits to be rewarding as he educates clients on methods to cover health risks.

SCENARIO FOUR

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

EMBRACING THE ANNUAL CYCLE

Some health insurance professionals love the annual cycle of open enrollment and the annual commitment to the client management process. They like how the client's needs require them to be available for service and support when needed.

When Medicare specialists look hard at their book and decide to explore what it would be like to have an exit plan for some or all their commissions, it pays in many ways to research the options: Full or partial retirement, sell some—keep some and add new lines are options. Health insurance commissions give the freedom to keep going for a long time or retire fully or partially. **CB**



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Email phil@commission.solutions to receive the free report: "Best Practices in Selling MAPD Commissions – How to Retain Medicare Supplement Commissions."

OPTUM OPENS NEW ONLINE STORE

Use health insurance to pay for goods and services online **BY DR. KATE WOLIN**



problems — so easy that you can go online to order products, groceries, prepared food or do banking. But there hasn't been a similar solution for shopping for healthcare or health products and services.

Now, you telephone your doctor to make an appointment, walk into a pharmacy to pick up prescriptions, separately pick up vitamins and health aids. All while not exactly knowing what insurance covers and what you will have to pay out of pocket until you get separate unrelated bills. That is now about to change.

The new Optum Store is a digital solution that helps save time and money by using health insurance plans or health savings accounts for online shopping and delivery.

Members can schedule a doctor or mental health professional visit, order prescriptions, COVID-19 tests and other

health products online and have them delivered to their home.

Following online banking model

Remember how banking was 10 years ago? We used to go into the bank to deposit money, or make a withdrawal. Now many people never step inside a bricks and mortar bank, because they have the convenience of doing their banking online.

In the same way, with the Optum store, users can order certain healthcare services online including telehealth and mental health therapy visits. The new online store accepts UnitedHealthcare medical plans* or pharmacy insurance** as a payment option, allowing people to see what things will actually cost at the time of purchase — with their coverage from health plans factored in. People without health insurance can also buy from the store.

Even with employer sponsored health insurance, people are increasingly responsible for managing their health dollars and forced to navigate a highly complex health care system, resulting in millions of people not receiving necessary care. The Optum Store simplifies things, allowing members to input health

You and your staff, or client's employees may be working from the office or working from home. Either

way, people are busy trying to juggle home and work life. The world has created digital solutions for everyday

insurance information once. Then based on coverage, discounts are automatically calculated for covered medications. That way when members shop, they see the actual price they have to pay, simplifying the process.

According to the Centers for Medicare & Medicaid Services (CMS), Americans spent \$3.8 trillion on healthcare in 2019. This is expected to grow at an average rate of 5.4% per year. Rising costs have already caused nearly 44% of Americans to skip a doctor's visit when they were sick or injured and nearly half to skip medication or treatment.

Solution: The Optum Store

The Optum Store is a consumer-focused answer to this problem. It can help your employees or clients' employees save time and money on healthcare and related services. Once members sign up for the Optum Store online, they enter their insurance information only once. After the insurance information is submitted, prescription and virtual care service costs will reflect the plan's coverage. It's easy to compare the cost of paying with insurance to the Optum Store's everyday low prices to help users decide how they want to pay.

The Optum Store makes the health care experience frictionless. The online store takes out another step, making it easier for a person to get health care necessities.

Booking is easy online

Find therapists you personally connect with and book therapy appointments straight from your phone or online. Switch therapists at any time, without a penalty fee. Licensed mental health specialists are available in every state. Free assessments are available at <https://store.optum.com/virtual-care/mental-health/pre-assessment>.

Starting at just \$29 for the first month and \$309 a month after that, members can book weekly 50-minute virtual therapy sessions or unlimited medication management appointments with doctors and nurse practitioners. Members can find a therapist, doctor or nurse practitioner who is available at their convenience. With virtual health care appointments, members can get convenient healthcare designed to support them, wherever they are. Whether traveling out of town or in a bind for time, users can schedule an appointment with one of our licensed providers.

There are same-day appointments available and cancellation is free. A wide selection of providers are available, and pricing is simple. Each appointment is \$55 flat, with no extra or hidden fees.

While right now the Optum Store only accepts United Healthcare for this feature, the store plans to add other carriers in the future.

The Optum Store also offers prescriptions without having to go to a doctor's visit for products to address things like birth control,

erectile dysfunction, hair loss and latisse eye lash builder.

Addressing COVID-19

Have COVID-19 symptoms? Speak with a professional who can teach you how to treat symptoms at home, give guidance on self-isolation, when to retest, and determine if you need to seek in-person treatment. New laws also allow health insurance to cover up to eight FDA-authorized, at-home over-the-counter COVID-19 antigen tests every 30 days (or per calendar month) for covered family members. These tests can be ordered online and delivered free directly from Optum Store.

UnitedHealthcare Medical Insurance members can apply for eligible Optum Store purchases by taking the following steps:

1. Visit store.optum.com
2. Click the dropdown menu next to 'Sign In' and select 'Create Account.'
3. Click on the dropdown menu next

4. Select payment and provide the requested insurance information

It's as simple as that!

No matter your health care needs, the new Optum Store offers a one stop shopping experience. We plan to continue adding services to make the shop an even more seamless experience.

The following company-sponsored medical plans are eligible: UnitedHealth Group HSA-eligible plans, Accountable Care Plan, Choice Transition, Hawaii PPO, Kelsey-Seybold Primary Care Plan, M Health Fairview Primary Care Plan, WellMed 1st Tier and OptumCare HSA Plan Options 1 and 2, OptumCare National Network Plan, OptumCare Plan and OptumCare Doctors Plan.

Plans that are not eligible: UnitedHealthcare of Nevada HMO, UnitedHealthcare of Nevada POS, SignatureValue, SignatureValue Advantage, SignatureValue Harmony and the Bind Plan.



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has been an advisor to start-ups and enterprise organizations on bridging clinical and behavioral science with commercial product strategy and execution. Wolin earned her doctorate at the Harvard School of Public Health and completed her fellowship training at Northwestern, where she continues to mentor entrepreneurship students. Wolin is a Fellow of the Society of Behavioral Medicine and the American College of Sports Medicine.

Contact: support@store.optum.com

California Employers Need to Comply with Cal/OSHA ETS Act 3

Written COVID-19 Prevention Plan required

BY BARRY COHN

While it may feel that the pandemic is in the rearview mirror, Cal/OSHA has passed Act 3 of the Emergency Temporary Standards (ETS) which took effect on May 6 and will remain in place until the end of 2022. Clients have been calling and asking, “What do we do now? Do we need another COVID-19 Prevention Plan (CPP)? Can you help us make sure we are in compliance?”

As a health insurance agent or broker, you can help your clients with COVID-19 compliance including the requirement for all employers, no matter how many employees they have, to have a written CPP in place. If they do not follow the ETS rules or have a CPP, all it takes is one employee and one attorney to spell disaster for your client.

Here is a summary of the new ETS regulations and should provide you with ammunition to check in with your clients and provide much needed guidance and value.

What has NOT changed: Exclusion Pay

Employers had hoped that an end to the obligation to provide exclusion pay for employees that have been excluded as COVID-19 cases or close contacts — especially since California has brought back COVID-19 Supplemental Paid Sick Leave. However, the third adoption retains the same exclusion pay requirement — meaning you will continue to have to pay employees that have been excluded from work unless an exception applies.

New key definitional changes that will lead to changed employer practices:

- **COVID-19 Test** – The definition of “COVID-19 test” has been amended to provide that a test may be both self-administered and self-read only if another means of independent verification of the results can be provided (such as a time-stamped photograph of the results).
- **Face Coverings** – The definition of “face coverings” has been amended to delete the requirement that light does not pass through the mask when it is held up to a light source. This is an improvement since some N95 masks could not meet this requirement.
- **Fully Vaccinated** – The definition of “fully vaccinated” has been deleted. This is largely in response to the fact that the face covering provisions of the ETS no longer make a distinction between fully vaccinated employees and

unvaccinated employees.

- **Returned Case** – The new language contains a new defined term of “returned case” to largely describe employees who previously had COVID-19 and now have natural immunity. “Returned case” is defined to mean an employee who previously had COVID-19 who returned to work and did not develop any COVID-19 symptoms after returning. A person shall only be considered a “returned case” for 90 days after the initial onset of symptoms or the first positive test (if no symptoms developed).

More testing of symptomatic employees

Under the current ETS, employers only need to make testing available to those employees with COVID-19 symptoms who are not fully vaccinated. The new language eliminates this limitation, meaning you will have to offer testing to all employees with COVID-19 symptoms regardless of vaccination status. This could significantly increase testing costs, so employers should have a plan in place to comply with this testing obligation.

Respirators must now be offered to all workers

The current ETS requires employers to provide respirators for voluntary use to all unvaccinated employees upon request. The new language eliminates the linkage to unvaccinated employees. Therefore, you will be required to provide respirators upon request to all employees, regardless of vaccination status.

Face coverings no longer mandatory for unvaccinated workers

The new language conforms the ETS to recent developments regarding face coverings. The California Dept. of Public Health (CDPH) changed its face covering guidance to no longer require masks indoors regardless of vaccination status for most employers.

Face coverings are mandatory in the ETS when CDPH requires their use, which currently includes the following indoor settings, regardless of vaccination status: healthcare settings and long-term care settings and adult and senior care facilities

Keep in mind that other face covering provisions of the ETS remain in effect. This includes language that allows employees to voluntarily wear face coverings unless it would create a

safety hazard.

The new language also deletes the requirement that employees who are exempted from any applicable face-covering requirement (such as returning to work following a case or close contact) maintain six feet of social distance from others or be tested weekly. Now the language will merely require such employees to be tested at least once a week.

Cleaning and disinfection rules eliminated

The current ETS requires employers to implement specified cleaning and disinfection procedures, including regularly cleaning frequently touched surfaces and objects. The new language eliminates these requirements in their entirety.

Exclusion and return-to-work criteria streamlined

The new language generally eliminates any specific language in the ETS regarding “close contacts.” Instead it merely cross-references CDPH guidance, simply requiring employers to review current guidance and develop policies to prevent transmission by close contacts

However, more changes could be afoot in the near future. On April 6, CDPH released revised Isolation/Quarantine guidance (<https://bit.ly/3NLMuw4>) that states that all individuals who are asymptomatic close contacts do not need to quarantine as long as they test within three to five days after their last exposure. For now, check local public health orders, as several counties have indicated that they will not be following the new CDPH guidance and instead continue to insist that unvaccinated individuals quarantine for five days after a close contact, consistent with CDC guidance.

With respect to COVID-19 cases, the new changes delete the current language in the ETS and instead provide the following, which conform to current CDPH guidance:

COVID-19 cases, regardless of vaccination status or previous infection, who do not develop symptoms or whose symptoms are resolving, shall not return to work until

- (1) at least five days have passed,
- (2) at least 24 hours have passed without fever, and
- (3) a negative test is obtained on the fifth day or later (10 days if the employee is unable or chooses not to test).

COVID-19 cases, regardless of vaccination status or previous infection, whose symptoms are not resolving may not return to work until

- (1) at least 24 hours have passed without fever, and
- (2) symptoms are resolving or 10 days have passed since symptoms began.

Regardless of vaccination status, previous infection, or lack of symptoms, a person with a COVID-19 case shall wear a face covering in the workplace until 10 days have passed since symptoms began or the date of their first positive test.

New obligations if COVID-19 outbreaks occur

The new changes to the ETS section on multiple COVID-19 infections and outbreaks generally make conforming changes to reflect the amendments to the ETS described above.

However, the new language also makes the following changes:

During an outbreak, employees who had close contacts should have a negative COVID-19 test result within three and five days after the close contact or shall be excluded and follow the return-to-work criteria of the ETS.

During an outbreak, an employer shall evaluate whether to implement social distancing. Where six feet of social distancing is not feasible, the employer shall evaluate implementing as much distance as possible between persons (as opposed to the current language which requires consideration of the use of cleanable solid partitions).


Testing required after major outbreaks

The changes to the ETS “major outbreak” requirement generally conform to the changes noted above. There is also one notable change, however. Under the current ETS language, an employer must make COVID-19 testing available to all employees in the exposed group at least twice a week during a major outbreak. This language always caused a bit of confusion. While employers needed to make testing available, do they have to test? The new language clarifies that employers are required to do so in such situations. Employees in the exposed group shall now be tested or shall be excluded and follow the return-to-work requirements of the ETS.

Testing after exposure slightly changed

Under the current ETS, an employer is generally required to make testing available to all employees who had a close contact to a COVID-19 case in the workplace with an exception for employees that previously had COVID-19 within the last 90 days. The new language simply replaces this exception language with the new term “returned cases” described above.

Keep in mind that, other than the changes discussed above, the rest of the ETS will remain in effect as well. This includes notification requirements following a COVID-19 case in the workplace and the obligation to maintain a Written COVID-19 Prevention Program.

Sitting down with your clients and sharing this important information can only solidify your relationship as a trusted advisor. 



BARRY COHN CEO and Chief HR Guy at JorgensenHR (JHR) was listed as one of The Valley 200, Most Influential Leaders in the San Fernando Valley area for 2021 and 2022. Cohn also leads the LA & Ventura County Employee Benefits practice for Really Great Employee Benefits (RGEb), a division of Heffernan Insurance Brokers. He is very active in his community, both professionally and personally.

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FIXING THE ACA'S FAMILY GLITCH

BY PAUL ROBERTS

The Biden Administration has proposed a rule to fix the longstanding, problematic “family glitch” of the Affordable Care Act (ACA). The ACA pain point prevents many employees’ spouses and dependents from obtaining affordable health coverage on the federal or state individual health insurance exchanges, including Covered California or Nevada Health Link.

While solving the “family glitch” is supported by most members of Congress and the health insurance industry, the White House’s proposed approach to fix it is controversial and goes against typical procedural protocol. Because of this, we might not see the fix enacted the way it has been proposed. If we do, it will likely be challenged in federal court.

Comments on the White House’s proposed rule are due by June 6, 2022 (not completed by the time of this

writing). Word & Brown is participating in the comment period with the National Association of Health Underwriters (NAHU) and others in the industry. If the “family glitch fix” proposal does not encounter major court barriers, it would go in effect Jan. 1, 2023. Because of the aforementioned troubles, which are explained further in this column, the “fix” will likely be altered and/or delayed.

What is the “Family Glitch”?

The family glitch centers around employees’ costs for spouse and/or dependent premiums on an employer-sponsored plan. It also focuses on those spouses’ and dependents’ inability to access alternate, affordable Individual and Family coverage on a state exchange.

Under the ACA’s employer mandate, applicable large employers (ALEs) must offer employees affordable coverage. ACA affordability is based on the

employee’s cost for “employee only” coverage, even if that employee has a spouse, dependents, or family members in need of coverage.

When an employer of any size makes an offer of “affordable” coverage under these standards — and offers spouse/dependent coverage (at any cost) — then no one in the entire family may access “Premium Tax Credits (PTCs)” to obtain alternate “affordable” coverage on a state’s individual health insurance exchange.

PTCs are federal “subsidies,” advanced to qualifying individuals to help pay for individual premiums for coverage purchased on a state’s individual exchange. PTCs are intended to be made available to taxpayers whose health insurance premiums exceed a certain annual affordability threshold, which is 9.61% of their total income in 2022. The ACA’s affordability threshold hovers at about 9.5% annually.

“Family Glitch” Example

Mike is an employee with a spouse, Carol, and they have six children. Carol is a full-time mom, and therefore does not have her own offer of employer-sponsored coverage as an active employee. Mike and his entire family need health coverage. Mike’s employer offers coverage to employees, spouses and dependents.

Mike’s employer offers him a bronze-tier health plan that costs him 9.61% of his income for his premium only. Mike’s employer offers spouse and dependent coverage but pays zero percent for spouse/dependent premiums.

Under this “family glitch,” the offer of employer-based coverage to Mike is considered “affordable” for Mike and his entire family. As a result, neither Mike nor anyone in his family are eligible to obtain PTCs to pay for alternate, individual coverage on their state’s Individual health insurance exchange. Alternatively, Mike could waive the group plan offered to him and his family and get an Individual plan on the state exchange — but he would be responsible for 100% of the family premium(s).

Therefore, Mike’s only other option to cover his family today is through the group health plan. Mike would have to pay for his spouse and six dependents’ premiums entirely on his own, while also paying 9.61% of his income for his own bronze-tier coverage.

Conversely, if Mike had received no offer of coverage from his employer (for any reason), then Mike and his entire family would be eligible to obtain PTCs to purchase Individual coverage on the state exchange — if the costs to cover the family exceed 9.61% of the family’s household income and/or if Mike’s family’s household income falls within a certain range of the Federal Poverty Level (FPL).

White House’s controversial “fix” proposal

The Biden Administration is looking to reinterpret Obama-era statutes and regulations that created the “family glitch” in the first place. It is proposing to base PTC eligibility for spouses and dependents in this situation on “total family cost”— rather than solely on the cost of the employee’s “employee only”

premium when employer coverage is offered.

Under its “fix” proposal, the employee who has been made an offer of “affordable” coverage under the aforementioned standards would not qualify for a PTC — which is standard practice today.

However, under the proposed fix, using the previous example with Mike, his family would be eligible for a PTC, if the cost of their collective premiums exceeds the affordability threshold for the corresponding year. Mike, however, would not be eligible because his employer made him an offer of affordable coverage, based on his employee-only premium.

While a “fix” is certainly needed, working through the White House might not be the best way to go about it. Changes to fiscal matters, such as PTC eligibility and payments, are usually created by Congress — not the White House. If an Administration can reinterpret long standing statutes and existing rules from the IRS and Department of Treasury on previous administrations to do it again in the future — for any area, including those outside of insurance.

Processes are very important in a democracy and are usually followed to the letter of the law. This proposed “fix” would break that mold if it even makes it that far.

While Congress generally agrees a fix to the “family glitch” is necessary, it has not agreed on how to do it. The concern with the proposal is not about preventing people from obtaining affordable coverage. Instead, it’s about maintaining the process for rule making — and that the rule of law is upheld to the letter of law.

Other considerations to repairing the glitch

Most families prefer to be on the same health plan — or at least have access to the same providers, hospitals and networks. More importantly, they also prefer to take advantage of aggregated deductibles and “out-of-pocket maximums” for the family, where applicable. While the fix to the glitch would be welcomed, employees will

still weigh the extra burdens and costs involved with having one family member on an employer plan, and the others on individual plans. Some may find that the loss of aggregated deductibles and out-of-pockets would make splitting the family more expensive — even with the savings a PTC would provide.

Another big concern is employer reporting for dependent coverage. In order for this “fix” to operate, state exchanges and the IRS would need to know the type of, and costs for, employer-sponsored spouse and dependent coverage in order to determine PTC eligibility. Employers currently do not report this information. Furthermore, this fix might require employers of all sizes to report on the costs and offers of dependent coverage made. There are currently two bills moving through the federal House and Senate, which would simplify employer reporting (currently conducted by large employers only). This proposed fix would appear to make employer reporting more burdensome, which is something legislators are looking to repair — not complicate. This may lead to further challenges to this fix by both legislators and employers, etc.

Lastly, it’s important to note that this proposed fix would not change the “affordability” of the employer mandate whatsoever. ALEs would still be required to offer eligible full time employees’ affordable coverage, based on the “employee-only” rate. An employee who receives a qualifying offer of coverage by an employer of any size will not be able to get a PTC for individual coverage on a state exchange, even if his or her family does. **CB**



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Laser Focus on Current Book of Business Nets Better ROI

PERSONALIZED AUTOMATION IS THE ANSWER

BY JOEL ZWICKER



When agents think about growing their book of business, growth is often assumed to mean “new customers.” Thousands of dollars are spent each year on lead-generation tools, lists and other exciting initiatives to chase down new clients. Most businesses spend much more time and dollars on client acquisition than on retention ([invespcro.com/blog/customer-acquisition-retention/](https://www.invespcro.com/blog/customer-acquisition-retention/)). Agencies focusing on lead-gen might close 10-15% of those deals, but have no way to cultivate the relationships with those whom they did not land. This means they are trapped in a cycle of having to pay for new leads with an 85% failure rate.

This constant churn cycle is unnecessary. Most agents are already sitting on a gold mine of possibility: their current client base. Investing time and effort into one’s existing book of business could double revenue when agents approach their current clients with a laser-focus on service and relationship building.

Lead-gen might not be the most strategic path toward increased revenue. It’s simply not sustainable nor realistic for most, who end up right where they started with little to show after all the time and money spent.

Strategically leveraging digital marketing that nurtures an authentic connection offers a higher ROI within one's existing book through cross and upselling, referrals and return business.

What marketing tools and strategies really get the results you need? If you're investing resources to marketing your agency, prioritize your existing book of business.

Sustained success and growth is attainable for agents who invest in building deeper existing client relationships. Strategically leveraging digital marketing that nurtures an authentic connection offers a higher ROI within one's existing book through cross and upselling, referrals and return business.

Customer relationship management tools, while great for on-boarding newly acquired clients, don't provide the framework for nurturing relationships with existing customers. These tools bring clients to the top of the funnel, but don't manage the relationship for long-term success. Marketing solutions that go beyond "bringing them in the door" will keep your current clientele satisfied while allowing you to scale.

While a sizable book of business can make personal servicing difficult, leveraging technology to automate some of these touchpoints in a personalized manner makes it simpler. Clients need more than a once-a-year check-in. Communicating with customers only when it's time for renewal doesn't convey care and attention that turns into new sales. Agents need to be on top of every customer's changing insurance needs and life milestones that require different protection.

Automation is the answer to making sure your entire book of business is provided on-point concierge treatment. While automation may seem impersonal, it doesn't have to be. Digital marketing solutions integrated with customer management systems generate tailored communications that are timely and useful to clients.


People have clear and unique interaction styles — clients who like to communicate through email will expect their agent to reach them through email. Others prefer phone calls. You will see a growing number of your clients expecting to reach you through text.

One of the most important factors in client communications is understanding how they want to interact. Relationships can be made or destroyed by an agent not using the communication channel preferred by their clients once that relationship has been established.

Think of your website as a virtual office, where clients can drop by, ask questions, open their own files, and get advice. A fully interactive client portal on your website benefits clients who want to access their policies, connect with you and file claims quickly. Give them easy access to their own information. The client data you have can be tied to marketing outreach, so you are providing relevant

information when needed, such as timely renewal reminders, options for new insurance protection as they start businesses or buy new property.

Most agencies think they are doing well when they can cite that they have two policies per customer. But think a little more about that statistic: how many policies do you have as an insurance customer? Most of us have at least three personal policies (home, auto and life); businesses have a minimum of four or five policies. Up- or cross-selling to a customer already in your books has a 60-70% success rate, while the success rate of selling to a new customer is 5-20% (outboundengine.com/blog/customer-retention-marketing-vs-customer-acquisition-marketing). Technology helps you identify those gaps and increase the number of policies you service for each individual client — potentially doubling your revenue.

Your current customer base is gold and should be guarded as such. It can cost five times as much to acquire a new customer than retaining an established customer. Remember, your clients have already established a relationship with you for a reason. This is an audience receptive to your advice and expertise. Invest time and money into nourishing that relationship and you will see a much higher ROI than scrambling for new customers who come and go when they do not get that personal attention. 



JOEL ZWICKER is Insurance Evangelist at Agency Revolution and formerly an insurance agent at one of Canada's largest independent insurance agencies. He now works to provide independent insurance agents the best marketing tools for their unique needs.

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HOW TO CULTIVATE A

THRIVING COMPANY CULTURE

BY PETER HILL

Whether you own a company or hold a position in leadership, a thriving company culture is the backbone of any organization. Creating a culture that promotes both personal and professional development, focuses on values and purpose, and always welcomes new ideas is a positive step toward building a thriving team.

In today's world — where employees work and live in different environments — communication is more important than ever in cultivating a stand-out company culture. Communication connects employees to a shared purpose, makes them feel part of a community and fosters a strong sense of obligation to the whole team.

Implementing open communication

Frequent, open communication at all levels of staff is the glue that holds an organization together. Instead of the typical company suggestion-box where employees anonymously report issues, at our firm we keep staff informed with:

- **5-minute daily huddle calls** (via Zoom) where employees quickly report the current status of key projects or department initiatives. For example, green status means on-track while red means currently off-track. Staff members can also ask for help or offer assistance to others. This is an efficient way to interact, keep abreast of the bigger picture and address issues on a company-wide scale.
- **Weekly departmental meetings** focusing specifically on departmental issues and progress towards goals.
- **Weekly e-newsletter** to consolidate

current company news as well as to share milestones, birthdays, anniversaries, reminders, company events, committee updates, new staff member spotlights, share kudos received by staff members and more!

- **Quarterly staff meetings** where each department provides an update on progress toward goals. Here we communicate topics impacting our business, provide company news and updates. We also spotlight a subject matter expert within the company, so others get to know them and their area of expertise better.

- **Recordings of staff members** covering industry related topics and company processes for future reference and for training.

These are just some examples where we work to ensure awareness and company-wide inclusion. These things collectively can make an impactful difference.

Integrating core values

Developing and implementing core values is a crucial aspect of any company culture — not only to ensure values are set in place, but to ultimately encourage team members to emulate them. A company is better able to define its culture by identifying its core values, going beyond the services or products it offers. Try shaping your company's purpose around enriching and fulfilling the lives of others.

Once core values are established, it's important to highlight employees who are working to incorporate, follow and embrace the values set in place. For instance, at our company, employees nominate one another when they observe someone representing

a core value. Those nominated receive recognition and a reward by management.

Another helpful tactic includes integrating core values into the employee review process. When conducting reviews, core values can be utilized to determine if a team member is actively leveraging them for success in their everyday work.

Leverage reading resources to empower company culture

Incorporating a company-wide channel to share new resources can help to improve company culture as well, as they often introduce creative strategies and generate discussions on new ideas. The following books introduced by staff have become required reading and enhance the cultural backbone of our firm.

"Traction" by Gino Wickman, serves as the roadmap for how we run our business — from goal setting to prioritization of initiatives to the way we run more effective meetings, Traction is foundational to our business and a contributor to our growth and success.

"Ensemble Practice: A Team-Based Approach to Building a Superior Wealth Management Firm," by Phillip Palaveev, primarily written for individuals in the financial planning and advising world, can help leadership teams with decisions on the future direction of their company. This book helped us decide that ownership shouldn't reside with a handful of people and that a seamless transition of ownership to ensure the perpetuity of the company and culture were very important to us.


Another helpful resource for building a flourishing company atmosphere is the book, "Delivering Happiness," by Tony Hsieh, Zappos CEO. This book offers an alternative method to



improving company culture that focuses on the simple concept of making the people around you happy, and by doing this, increasing your own happiness. One strategy in this book that can be incorporated into improving workplace environments includes creating a “Chief of Happiness Officer.” Seeing how Hsieh improved his company culture incentivized us to implement a “Chief of Happiness Officer” within our own firm. Designating an employee for this role will help enhance and grow our culture not only internally but at the community level.

If your company culture is due for some fine-tuning, try implementing some of these strategies to continuously improve and maintain it. When the culture feels a little off track, sometimes

it can be easy to forget about your core values and the importance of integrating them back into the daily environment. Collecting knowledge from other outside sources, such as Million

Dollar Roundtable (MDRT.org) meetings and workshops, can also offer new opportunities to grow and expand your existing culture. 



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the MDRT based on meeting a certain level of premium, commission or income during the year in addition to meeting ethical standards. This recognition is not representative of any investment performance or returns.

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STANDING ON THE SHOULDERS OF GIANTS

We are all unique individuals, but it doesn't mean we need to face life alone

BY TIM KANTER

In the world of business, Bill Gates is arguably one of the most successful people in the United States. But what many people don't realize is that he attributes much of his success to his mentor, Warren Buffett. Bill shared that he learned how to manage his time and prioritize people as a result of his meetings with Buffett, and he refers to him as "one of a kind." Oprah Winfrey, known for her talk show, acting, and her philanthropy, often talked about how critically important her mentor, Maya Angelou, was to her. In an issue of Oprah's magazine, she shares, "When I first met Maya, in the '70s, I couldn't have guessed what the next few decades would bring — or that she would be there for me every step of the way — a wise, loving presence and the greatest mentor I've ever known."

Due to my upbringing, I learned early on that if I wanted to change my circumstances, I had to take steps to make it happen. But at 16 years old, I had no idea where to start. Fortunately, I got my first insurance job in my junior year of high school. My boss, Susan Erkrantz, took me under her wing and mentored me on everything from personal finances to business etiquette and generosity

to timeliness. I firmly believe that I would not be where I am today if not for the patience, encouragement and kindness that she showed me. Not to mention the many mentors in my life that followed, be it one of my best friends, one of my peers, an elder in my church, or my mother-in-law.

As Bill Gates, Oprah Winfrey, and I can attest, our lives are better and more enriched because of people who were willing to give us their time and attention. Every person and every life is unique. You've experienced many situations completely different than I have. And vice versa. You have learned some lessons the hard way and your peer down the road may have learned an even harder lesson. One person may intuitively understand a challenge that they are facing because of their upbringing or past experiences. While another person facing the same challenge can be completely at a loss. That's the beauty of our individuality.

There are no two people that have the exact same experiences or the exact same knowledge. We need each other.

We've all heard of those pay-it-forward chains that sometimes happen at a Starbucks drive through.



Someone buys the drink for the person behind them, and that person buys the drink of the person behind them, and they for the person after them, and so on and so on. That's a little bit of what mentoring is like. When you take the time to mentor someone, that person will often take the knowledge and wisdom they've gained and mentor someone else. And that new mentee will often share with someone else, and so on and so on. In one of those Starbucks pay-it-forward chains, you may get your \$7 Trenta-Quad-Iced-Oatmilk-Vanilla-Latte paid for while you only pay for the person behind you that ordered a \$2 Tall black drip coffee. In this example, you are clearly getting more than you are giving. Mentoring can be like that too. You may have had a mentor who meets with you every week for a year, pouring into you, encouraging you, and helping you grow, and then later, you meet someone and share one small piece of advice you once received, and that person is forever blessed because of it. And the opposite scenario can happen as well. Now, I'm not advocating for those Starbucks pay-it-forward chains. If you're ever in one and you get your drink paid for, accept the gift or pass it along, neither is wrong. But in mentoring, I want to encourage you to ALWAYS pass it along.

The day-to-day of an insurance agent is complicated. No two clients we speak with will have the same need. Is the call you are about to take for a small group or large group? Do they need a fully funded plan or partially self-funded plan? Is it an individual or family plan, or is it for Medicare? Medicare Advantage? Part D? A supplement? Or maybe they just want your help deciding if their child should go on the plan their college offers. We're building a book of business, growing a team, managing hundreds of accounts, all the while staying abreast of new compliance rules and regulations and making sure our clients are doing the same.

The life of an insurance agent can be lonely. We want to grow, but we don't know the next steps we should take. We have a dilemma relating to a client and don't know exactly what the right questions are to ask. Or maybe we just need someone to talk to. Someone who can be a sounding board.

And the responsibility of an insurance agent is great. We help our clients make decisions that can have a huge financial impact on them. We are there for them when they need it, to answer their questions, help them appeal their claim, or pour over hundreds of plans from many different carriers to make sure that they have the information they need to make the right decisions.

We don't need to do it alone

Recognizing that agents sometimes have a difficult time finding a peer to connect with, California Agents and Health Insurance Professionals (CAHIP, formerly CAHU) developed a mentorship program through the CAHU Foundation at the end

of last year. Since then, we have begun to match up mentors with mentees.

Here is some feedback I received about a mentor from a mentee shortly after we launched the program: "Thank you so much for the coaching sessions this week. Your advice and suggestions are so practical and insightful. I am very lucky to have your help. I look forward to learning more from you and other mentors in the future."

This week, Jeff Larsen, one of our newest mentees, shared some of his experiences with his new mentor, Henry Romero: "He's been really helpful and he's willing and able to help. He's shared best practices, concepts and workflow expectations. And also shared how he's grown as well. I know he's going to be an awesome resource."

Mentorship is one of the easiest and most beneficial things a person can take part in. In this industry, when you mentor, or when you are mentored, you become more engaged, educated and informed so that your clients can be engaged, educated and informed.

Before I got that first insurance job, if someone asked me what I wanted to be when I grew up, I can promise you that I never said, "an insurance agent." But here I am today, and I wouldn't change a thing. But I don't think I would feel the same way that I do today, if it wasn't for Susan mentoring me when I was just getting started. Not to mention all of the other mentors I have been blessed to work with over the years. Thank you to Susan, Brian, Beverly, Louis, Curtis, my mother-in-law Linda, and many others. If you have someone who has mentored you, make sure you take a moment to thank them.

A mentor is a person who can shape and change lives for the better. And we need more people to shape lives — and people who want their lives shaped. If you are interested in becoming a mentor to one of your peers, or interested in being mentored, please go to www.cahufoundation.org/ mentor to sign up or to learn more. If your experience is anything like mine has been, it will be one of the best choices you will ever make. **CB**



TIM KANTER is the happily married husband of Angela and together they have two wonderful daughters, Megan and Emma. He is the president of Get Benefits Insurance Services in Thousand Oaks, an insurance agency that helps their clients with all-things insurance. He serves as the head of California Agents and Health Insurance Professionals (CAHIP, formerly CAHU) mentorship program in the role of VP of Community Outreach and is the incoming president-elect for CAHIP 2022-2023.

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Why Insurance Brokers Should Create Wrap Documents for Clients

You can help employers follow ERISA and other regulations

BY TOM AVERY

Employers are responsible for complying with ERISA (and the Department of Labor, COBRA, and the Internal Revenue Service).

So it's not the broker's problem, right?

The recent broker compensation disclosure requirement is changing the way brokers think about the services they provide to clients. When employers begin to question what they're getting out of their broker relationship, "not my

problem" isn't going to cut it.

One of the ways brokers can provide a additional service to clients is by helping them follow regulations related to employee welfare benefits. Wrap document creation ensures all of the employers' plans are compliant.

Keep reading to learn who's responsible for what, what a wrap document can do, and why wrap documents are a service all brokers should be providing their clients.

Just what are employers responsible for?

If an employer provides health and welfare benefits, then they likely have to comply with a host of regulations, namely ERISA. Because nothing is ever easy when dealing with regulations, this can be extra confusing because three government agencies are responsible for enforcing ERISA: the Department of Labor, the Department of the Treasury (especially the Internal Revenue Service), and the Pension Benefit

One of the ways brokers can provide an additional service to clients is by helping them follow regulations related to employee welfare benefits. Wrap document creation ensures all of the employers' plans are compliant.

Guaranty Corp.

ERISA requires that every employee welfare benefit plan have a written plan document. This document must clearly identify certain information about the plan, such as:

- Named fiduciary and allocation of responsibilities
- Description of funding
- Plan name, number and year
- Eligibility rules and benefits included/not included
- Procedures for amending the plan
- What happens if the plan is terminated

Additionally, ERISA also requires that every employee welfare benefit plan have a summary plan description. The summary plan description informs participants and beneficiaries about their rights and benefits. This document must include important plan rules and the benefits available, plus key information such as:

- Plan name
- Employer name, address, and Employee Identification Number (EIN)
- Plan administrator and contact information
- The source of plan contributions
- Information about plan trustees
- A claims procedure
- Information about eligibility for plan participation
- A statement of ERISA rights

These lists are not exhaustive. For a full list of ERISA requirements, visit the U.S. Department of Labor [<https://www.dol.gov/general/topic/retirement/erisa>].

Some employers assume the plan documents their carrier shares fulfill their compliance. They don't. The Summary of Benefits and Coverage (SBC) that employers receive from their carriers is not sufficient for meeting ERISA disclosure requirements. These plans do not include this key

information about the fiduciary, source of contributions, eligibility, responsibilities, etc.

Employers need help filling in the gaps of what they already have to ensure they have a document that meets these standards. Enter the wrap doc.

What is a wrap document?

Finding all of the necessary information for each plan and for each regulation could be a lot of work when handled individually. But not when you have a wrap document.

The wrap document supplements the existing plan documentation with the necessary ERISA compliance information. It literally wraps the entire offering into one package, essentially combining everything into a single plan.

A thorough wrap document includes the necessary plan document and summary plan description information required by ERISA, plus other federal compliance details and necessary benefit explanations. By creating a document that contains all products at once, employers can ensure compliance with all relevant federal regulations.

While a wrap document is a simple solution on paper, it can be time-consuming to build, especially for smaller employers who lack the resources to create the documents and stay in the loop about changing requirements. But with the right help — like from their knowledgeable insurance broker — employers can easily stay in compliance.

Why brokers should help clients with wrap document creation

Yes, all of this compliance and document creation is the responsibility of the employer.

However, as their broker of record, you serve as a trusted advisor. You've positioned yourself as the expert when it comes to their health benefit plans.

You know your client should be in compliance. You are uniquely positioned to understand the regulations and

protect the client from potential fines. They might even assume that the SBC and other plan documents you send them fulfill ERISA compliance (imagine their surprise when they're hit with a fine).

And while this has been the law for years, there's a new urgency to going the extra mile for your clients. The broker compensation disclosure requirement [<https://signal-sync.com/broker-compensation-disclosure-requirements-what-you-need-to-know/>] is going to encourage clients to take a closer look at what exactly they're paying you for. By not helping clients with their benefits compliance, you're putting your book of business at risk — because there is always another broker ready with a solution.

Developing a system for automating wrap document creation makes it easy to go above and beyond for clients and help them remain in compliance — something they'll reward you for with their continued business. **CB**



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