BREAKING DOWN TRANSPARENCY IN COVERAGE RULES | THE HEALTH DISRUPTER MYTH | HOW DIVERSITY & INCLUSION HELPS YOU

CALIFORNIA BROKER

VOLUME 39, NUMBER 5 Serving California's Life/Health Professionals & Financial Planners FEBRUARY 2021

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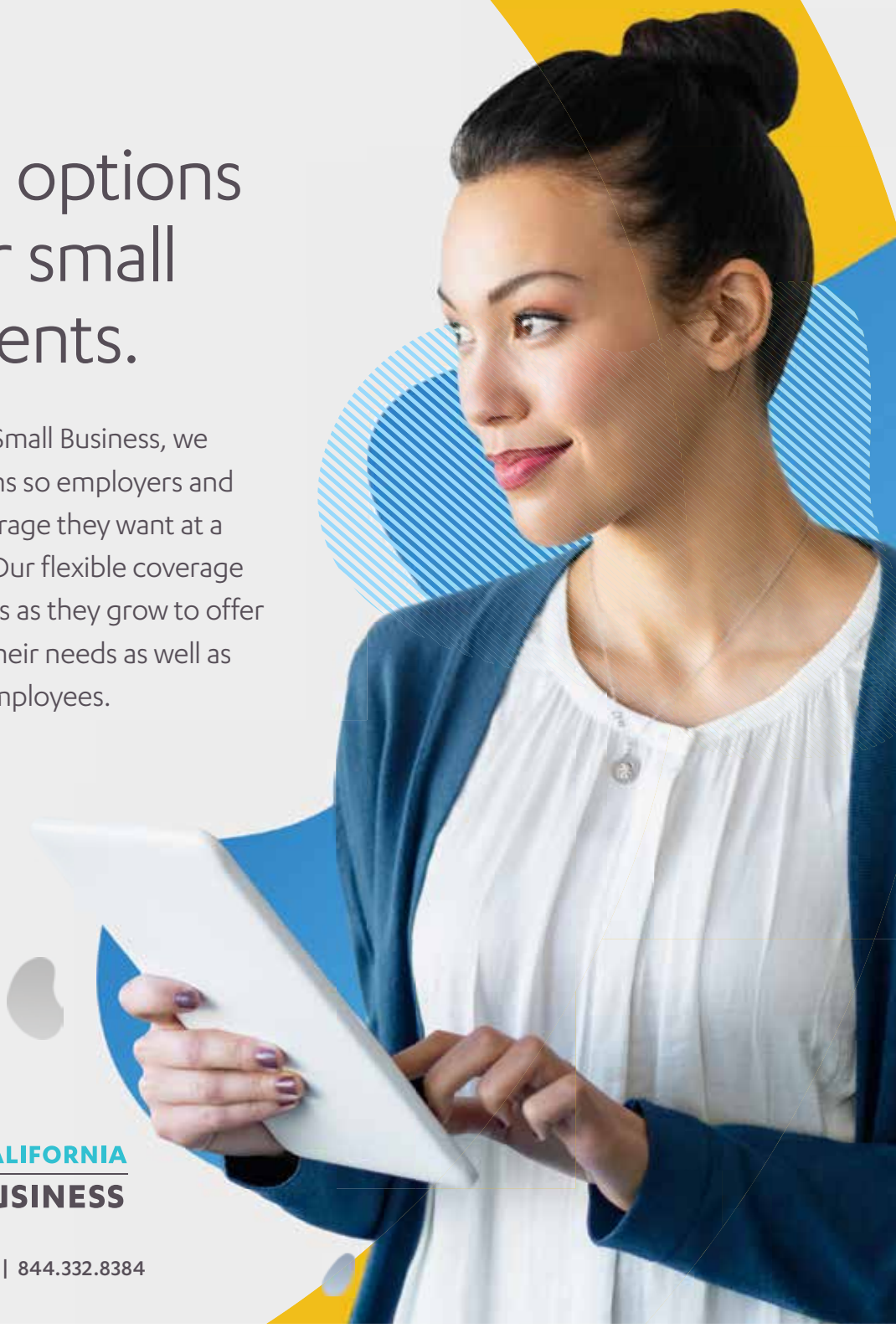

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The secondary market for life insurance gives policyowners powerful options for managing their life insurance policies. Through transactions like a **life settlement** or a **life settlement with a retained death benefit option**, you and your clients now have the tools to tap into the market value of policies that are underperforming or are simply no longer needed. The result is **new estate planning strategies that maximize value.**

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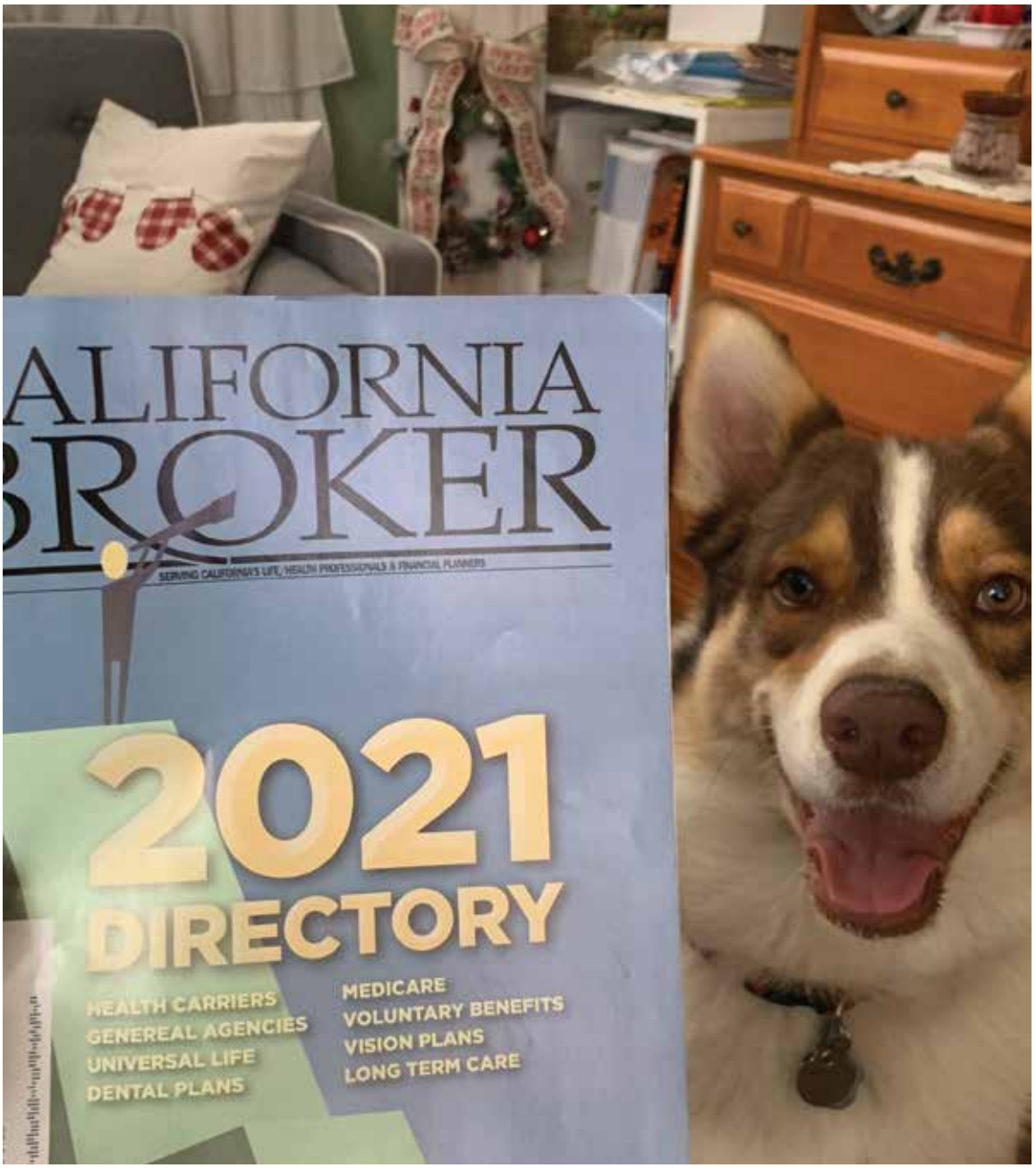
INDUSTRY NEWS



CAL BROKER GPS

Who is that handsome creature perusing California Broker's directory? Well, that's none other than **Baxter McFarland!** He's at home hanging out with mom, Dawn, and he knows great reading when he smells it. If you haven't seen the annual directory yet, find it online at www.calbrokermag.com. You'll also find our monthly magazine and weekly e-newsletter there. If your company isn't mentioned in the Directory, please email lex@calbrokermag.com for a form to fill out to be included.

Remember to send us your photo of reading California Broker wherever you are. We love creative readers so let's see what you can come up with. **Email to editor@calbrokermag.com.**

DMHC Report Shows Health Plans' Prescription Drug Costs Increased $1 Billion(!) Since 2017

The California Department of Managed Health Care released the Prescription Drug Cost Transparency Report for Measurement Year 2019. The report looks at the impact of the cost of prescription drugs on health plan premiums and compares data over three reporting years: 2017, 2018, and 2019. The report reveals that health plans paid an increase of $1 billion — $1 billion! — on prescription drugs since 2017, including an increase of $600 million in 2019.

The report is seen as part of a larger effort by California Governor Gavin Newsom to rein in the costs of prescription drugs. Newsom has proposed leveraging California's purchasing power to increase generic drug manufacturing as one solution to the prescription drug affordability crisis. The state has already begun to identify potential target medications and develop a strategic plan to promote state-led generic drug purchasing and manufacturing. California is also transitioning all Medi-Cal pharmacy services from managed care to direct state payment in 2021, strengthening California's ability to negotiate better prices with drug manufacturers.

Other key findings from the recent DMHC report include:

- Health plans paid more than $9.6 billion for prescription drugs in 2019, an increase of almost $600 million from 2018, and $1 billion from 2017.
- Prescription drugs accounted for 12.8% of total health plan premiums in 2019, a slight increase from 12.7% in 2018.
- Health plans' prescription drug costs increased by 6.3% in 2019, whereas medical expenses increased by 5.2%. Overall, total health plan premiums increased by 5.3% from 2018 to 2019.
- Manufacturer drug rebates totaled approximately $1.205 billion, up from $1.058 billion in 2018 and $922 million in 2017. This represents about 12.5% of the $9.6 billion spent on prescription drugs in 2019.
- While specialty drugs accounted for only 1.5% of all prescription drugs dispensed, they accounted for 56.1% of total annual spending on prescription drugs.
- Generic drugs accounted for 88.5% of all prescribed drugs but only 20.9% of the total annual spending on prescription drugs.

New Year, New Laws

California Insurance Commissioner Ricardo Lara says there are six new insurance laws that went into effect January 1, 2021. Here's the info:

- **Senate Bill 872**, authored by Senator Bill Dodd, removes barriers for future wildfire survivors to get critical insurance benefits and streamlines wildfire recovery processes for homeowners who suffer wildfire losses. The new law will require an advance payment for no less than four months of Additional Living Expenses (ALE) and no longer require an itemized inventory form for content claims, among other consumer protections. As of July 1, 2021, the law will expand ALE benefits, including for policyholders whose homes are rendered uninhabitable due to wildfire damage to essential infrastructure.
- **Assembly Bill 2756**, jointly authored by Assemblymembers Monique Limón and Richard Bloom, provides additional insurance for disaster survivors to rebuild and requires more transparency when a new policy is sold that does not cover losses from wildfire.
- **Assembly Bill 2658**, authored by Assemblymember Autumn Burke, protects domestic workers from employer retaliation, including firing, if they refuse to work in hazardous conditions. It also prevents an employer from ordering an employee, including a household domestic service worker, to remain in or enter a mandatory evacuation zone as a result of wildfires or a local public health order, which would include circumstances caused by the COVID-19 pandemic.
- **Senate Bill 1192**, authored by Senator Steven Bradford, creates department oversight of public safety workers' benefit associations to ensure these associations provide financially sound insurance benefits and are transparent to their members.
- **Assembly Bill 2049**, authored by Assembly Member Ken Cooley, incorporates the National Association of Insurance Commissioners (NAIC)-approved revisions to the Credit for Reinsurance Model Regulation into California law, thus preventing federal preemption of California's existing law regarding credit for reinsurance and retaining the state's accreditation by the NAIC.
- **Senate Bill 1255**, jointly authored by Senator Lena Gonzalez and the Senate Insurance Committee, remedies several issues identified by the department and stakeholders to clarify and clean-up various technical Insurance Code sections. This new law also includes the Equal HIV Insurance Act which, starting January 1, 2023, will prohibit an insurance company from declining an application or enrollment request for coverage under a policy for life insurance or disability income insurance based solely on the applicant's HIV status.

INDUSTRY NEWS

Alera Helps Some Californians Say Buh-bye to Medical Debt

We received an email from our friends at L.A.'s Dickerson Insurance Services that made us truly understand the power of this industry when it's determined to do something good. In a nutshell:

Orion Risk Management, Dickerson Insurance Services (GA), Centennial Group and Armstong, Robitaille, Riegle — all affiliates of Alera Group, Inc. — announced the alleviation of $3.1 million of healthcare debt in Orange, Los Angeles and Riverside counties. This gift is part of more than $18 million in healthcare debt being relieved by Alera Group employees for struggling households across the country. Alera worked directly with the debt-forgiveness nonprofit RIP Medical Debt to identify people with outstanding healthcare-related bills in the markets they serve. RIP is able to purchase medical debts for those most in need in bundled portfolios for a fraction of their face value.

Thousands of Americans have received letters of debt forgiveness because of Alera employees. These letters will be delivered throughout the winter targeting those living below 200% of the poverty level. Hallelujah! We encourage you to tweet some praise to **@AleraGroupUS.**

Sunglasses and the Fight Against Mental Illness

Hats off (and sunglasses on) to Daniel Hack and his San Diego-based company Gr@titude Lenses. The sunglass company features inspirational messages on the stems of the glasses and offers purchasers of the glasses membership to the Gr@titude Community, where they get exclusive access to a Daily Gr@titude Affirmation app and an online community of positive-conscious people who provide encouragement and reminders to slow down and be grateful. Hack launched the company and movement in the wake of his father's suicide. The aim, says Hack, is to encourage people to look at life through the lens of gratitude.

Odie Pet Insurance Seeks to Expedite Growth in Pet Insurance Market

Agoura Hills-based **Odie Pet Insurance** announced big plans for 2021: the nascent company (we assume named after Jon Arbuckle's dog in Garfield) is raising an investment round to fund its growth strategy. The company says that over the next 18-24 months funding will be used to enhance Odie's consumer facing technologies, continue business development and marketing efforts, and acquire top-tier talent. The raise is being led by Bridge Point Capital based in New York City. Odie has already gained traction with enterprise level partners such as large employee benefits providers looking to expand their services within the fast-growing pet sector. Some of Odie's key platform features include:

Affordable Pricing - Their plans on average are 15%-30% less expensive than equivalent products and offerings.

Transparent Policies - Addressing a major problem of pet insurance, Odie provides customers with easy-to-understand coverage and transparent policies.

Flexible Plan Options - Pet owners can fully customize their plan according to their budget and pet's specific needs.

Vertical Integration - The platform vertically integrates marketing and distribution, underwriting, program management, and its carrier.

CA Department of Insurance Issues Letter Protecting Youth Gender Dysphoria Treatment

California Insurance Commissioner Ricardo Lara directed the Department of Insurance this week to issue a General Counsel Opinion Letter clarifying that under existing California law, health insurance companies may not deny coverage for male chest reconstruction surgery for female-to-male patients undergoing care for gender dysphoria based solely on a patient's age. Lara says that people diagnosed with gender dysphoria have had to battle a host of challenges to access gender-affirming care." Social stigma, misconceptions about gender dysphoria and its treatment, and outdated medical criteria create barriers to necessary medical care that can lead to tragic results for individuals with gender dysphoria, especially for our transgender youth," says Lara. California law already provides protections meant to reduce these barriers to gender-affirming care for gender dysphoria. However, due to complaints from young Californians and their parents, some health insurance companies may still use coverage criteria and processes that wrongfully deny coverage, and place the burden on consumers to pursue their legal rights to transgender health services through time-consuming appeals and independent medical reviews. To be proactive, health insurance companies should evaluate their coverage criteria for gender dysphoria treatment and eliminate any noncompliant practices to avoid needlessly delaying and interfering with medical care recommended by a patient's doctor. The Department's General Counsel Opinion Letter, issued pursuant to Insurance Code section 12921.9, was prepared in response to an inquiry from San Diego's TransFamily Support Services regarding several denials of coverage for male chest surgery for patients under 18 years old who are transitioning from female to male. The Department determined that denying coverage for mastectomy and reconstruction of a male chest based solely on age is impermissible under state laws requiring coverage of reconstructive surgery. Health insurance companies must consider a patient's specific clinical situation in determining medical necessity.

UNUM Revamps Hospital Insurance

Employers can now get Unum hospital insurance with more funding options and greater flexibility in how the coverage is offered. The new hospital insurance is available for quotes with coverage starting in 2021. The revamped hospital product better complements health insurance with fewer coverage gaps and less duplication for employees. Other features include more options in coverage level with varying price points, compatibility with health savings accounts, a well-child benefit for newborns who get routine check-ups, and coverage for mental health hospital confinement. Hospital insurance pays a lump-sum benefit for qualifying hospital visits, such as trips to the emergency room, in-patient surgeries, or childbirth. Employers can offer the coverage to employees on an employer-paid or employee-paid basis — or a mixture of both. It's offered on the same administrative platform as Unum's other group benefits — like disability and life insurance — for streamlined onboarding, billing, and management for plan administrators. Companies with 100 or more employees can purchase the coverage, and at least 10 employees must be enrolled. Hospitalizations due to COVID-19 may be covered under Unum's hospital insurance depending on the terms of the policy. More info at **UNUM.com**.

Could Employers Mandate COVID-19 Vaccinations?

Employers may already be asking benefits folks if they can mandate that their employees get the COVID-19 vaccination. Below, veteran labor attorney Elaine Turner, shareholder/partner at the national law firm Hall Estill, weighs in.

"The Equal Employment Opportunity Commission (EEOC) has not yet spoken to whether employers may mandate that all employees take a COVID-19 vaccine when one becomes available. However, during the H1N1 public health crisis, the EEOC determined that, during an influenza pandemic, employers could not mandate that all employees take a flu vaccine regardless of employee medical conditions and religious observances. Courts have reviewed similar issues related to mandatory vaccine policies for the flu and for other diseases as well. Under federal law, courts have found that employees were not exempt from mandatory vaccine policies when their medical condition did not rise to the level of a disability under the ADA or their anti-vaccine philosophy was not a sincerely held religious belief. Courts determining federal law claims have also not exempted employees from mandatory vaccine policies when to do so would impose an undue hardship on employers such as healthcare providers whose patients would be placed at risk if exposed to employees with a contagious disease.

While we wait for the EEOC and other government entities to speak to the issue, employers should begin evaluating whether their business is legitimately in need of a mandatory COVID-19 vaccine policy or should merely encourage employees to take the vaccine. Under federal law, employers must have a reasonable belief that a mandatory vaccine policy is required because an employee's ability to perform essential job functions will be impaired by COVID-19 or an employee will pose a direct threat due to COVID-19. This is likely an easy determination for healthcare providers, but not so easy for other kinds of employers who are outside the healthcare industry. Employers should also closely examine applicable state law requirements. Many states have laws relating to vaccine requirements. In the context of other vaccines, a small number of states have allowed individuals, such as school age children, to be exempt from mandatory vaccines based solely on their parents' personal beliefs or the belief of the child.

EVENTS

LAAHU's Zoom Happy Hour
is the first Wednesday of the month from 4-5 p.m.
Members and nonmembers welcome. Register at LAAHU.org

NAHU Power Hour
4th Wednesday of the month from 4-5 p.m. Pacific.
Members and nonmembers welcome. Register at NAHU.org.

OCAHU Virtual Sales Symposium
Feb 11 &12, Navigating the New Normal, 7:30 a.m. to 12:30 p.m. both days. Info at OCAHU.org.

NAIFA-Los Angeles 68th Annual Will G. Farrell Award & Leadership Recognition Event
Virtual, Feb. 18. More info at NAIFALA.org.

CAHU Women's Leadership Summit
Green Valley Ranch in Las Vegas, April 7-9. Email questions to info@cahu.org.

Transamerica Thinks We Could Have A Very Good 2021

Transamerica recently issued the **Transamerica 2021 Market Outlook: Where We Stand** written by Tom Wald, Chief Investment Officer for Transamerica Asset Management, Inc. This is just one of the takeaways:

"While U.S. economic growth could be challenged in 1Q 2021 as COVID-19 cases continue to rise, we look for the economy to accelerate meaningfully in 2H 2021 as vaccine accessibility dovetails with an accommodative interest rate environment and eventual fiscal stimulus, driving pent-up demand by consumers and businesses. This could result in annual gross domestic product (GDP) growth of 4% in 2021 helping the economy return to pre-virus levels of real aggregate GDP by year end."

Download the whole report at **Transamerica.com**.

LIMRA: COVID-19 SPURS EMPLOYER INTEREST IN PROVIDING EMERGENCY SAVINGS ACCOUNT

According to LIMRA research, 14% of consumers say they have lost their job due to COVID-19 and 32% are earning less because their hours or pay were reduced. Almost half (45%) of workers indicate the pandemic's economic downturn has negatively affected their retirement savings and 56% are worried about the long-term impact the pandemic will have on their financial security. The pandemic, however, is just exacerbating a problem that already existed. Almost 1 in 4 Americans have no money set aside for emergencies and another 26% have less than three months of emergency savings. But, according to LIMRA, more employers are interested in offering emergency saving vehicles. Nearly two-thirds of employers are somewhat or very interested in offering employees access to an emergency savings account. Also, 3 in 10 defined contribution (DC) plan advisors would like to see recordkeepers offer workplace emergency savings alongside retirement plan recordkeeping.

There are a few different approaches to the emergency savings gap:

Use an in-plan option. This approach supplements an existing workplace retirement plan, and it is intended to prevent employees from dipping into their actual retirement savings. Employees designate a percentage of their paycheck towards an emergency savings account within their DC plan.

Add a "sidecar" solution. Employers offer a program separate from their DC plan to enable their workers to save for emergencies.

Take it online. There are apps — like Twine, Acorns and Qaptial — specifically built to help consumers improve their savings habits.

Turn to insurance. One less formal (and also likely not well-known) option is to tap into a whole life policy. For people who own this product and have a cash balance, they are able to access those funds during difficult financial circumstances.

The good news is LIMRA research finds more than 6 in 10 workers are interested in a workplace emergency savings account. Innovation in this area can help create more stability today and a more certain tomorrow for employers, their employees, and families across America.

COULD YOU USE ANOTHER TOOL IN YOUR TOOLBOX?

Help clients diversify while adding additional revenue to your practice — all by just using your life license in a new way

BY BRIAN J. CLARK

Did you know that it has now been over 20 years since California passed Senate Bill 1837? Do you even know what CA SB 1837 did for you and your clients? Perhaps not, but after you read this article, you will. Then you may have a new way to use your California life insurance license to help your clients add meaningful diversification to their portfolios while adding significant revenue to your business. Hopefully I have your attention!

If you are an independent life agent or a registered investment advisor with a California life license, and you have California clients with a net worth of at least $250,000 — not counting their primary residences, cars or home furnishings — this article is for you. In the year 2000,

California passed CA SB 1837. It modified California law such that it exempts the offering of certain investments from securities licensing, and provides for regulation of these investments. It says who can offer these unique, non-correlated investments, who can invest in them and what all must be done and disclosed to be compliant with the law. If you don't have your FINRA licenses, like the Series 6 or 7, you are limited in what you may offer clients when it comes to investments. So life insurance and certain annuities may be a large part of your practice.

Wouldn't it be nice to be able to have an additional tool in your toolbox to help clients add meaningful diversification while giving them attractive performance potential? No matter what is happening with the stock or real estate markets or how low interest rates might be? Wouldn't it be nice to offer something that won't be affected by geopolitical events like elections, pandemics, oil prices or conflicts? Well, as you now know, you do! With just your California life license, you can help your California financially qualified clients and prospects with an investment that is essentially immune to all of those things. Life settlement investments is that tool.

You may already be familiar with life settlements as a concept from the recent article by Lisa Rehburg, a well-known life settlement broker, as a way to help clients sell unneeded, unwanted or unaffordable life insurance policies, usually later in their lives (Cal Broker's September 2020 issue, page 18). Once a policy is sold, historically to large institutional investors like hedge funds, it becomes a non-correlated investment for them as part of their overall portfolio. CA SB 1837 allows you to offer this asset class to some of your California clients, rather than leaving the profitability and diversification they can provide just to the 'big, smart money.'

Because it is a California law that

With just your California life license, you can help your California financially qualified clients and prospects with an investment that is essentially immune to all of those things. Life settlement investments is that tool.

regulates the investment, it is prudent to only work with California residents. Additionally, the phrase, 'financially qualified' has a specific meaning in the law. The investors that may participate must either be (i) accredited, meaning they have a net worth of at least $1 million not counting their primary residence or (ii) be 'qualified' and have a minimum net worth of at least $250,000 not including their primary residence, cars and home furnishings. If they are 'qualified' but not accredited, they are limited to investing no more than 10% of their stated net worth as defined here. Since this type of investment is primarily meant to be a hedge to an investor's other 'primary' holdings anyway, this 10% rule isn't a bad one to apply to most everyone. There are other ways to qualify financially using certain income tests, but for the purposes of this article, we'll stick to the asset-based qualifications since you always want clients to have adequate liquidity.

With all of this said, it is critical that you choose a trusted partner in this space with the knowledge and experience to help you and your clients access this unique opportunity. Make sure you understand how the policies are owned and how the investment works. Make sure the client understands these things and that it is an appropriate option for them.

A brief note on the financial qualifications standards that are spelled out in the law: They are not meant to keep the little investor out to prevent them from participating in a potentially attractive and rewarding investment, but rather, the requirements are meant to help ensure that an investor has the liquidity and sophistication to understand and properly service such an investment while they own it.

Time horizon is another important consideration for an investor in life settlements. Life expectancies are estimated from a review of the insured's medical records by an underwriting laboratory as part of the process. We therefore have an idea of when policies may mature and gains realized. As we all know, nobody knows for sure when an insured individual will actually pass away. Since that is the triggering event for the maturity payout, this investment is a bit like a zero-coupon bond with an uncertain maturity date. The investor knows how much they will be receiving, and they have an estimate as to when they may receive it, but it could be much sooner or later than the estimate. And since we all know that premiums must be paid on life insurance policies until maturity to keep them in force, this uncertainty on the long end results in probably the most significant risk to this investment: longevity risk of the insured. Some policies that an investor may own might mature quite early, resulting in outsized, rather fantastic rates of return, while others may mature later than anticipated and will thus temper the overall average return from life settlement investments. Thus, a portfolio approach may be better than just owning an individual policy as an investor.

Speaking of performance, using data from 2001 to 2011, the London Business School conducted an empirical study published in 2013 and concluded better than a 12% average annual return from a large pool of policies. This partly explains why large investors like Warren Buffett, Blackstone and national pension funds have utilized life settlement investments for many years. But it isn't just the performance potential of the asset class that they like. They certainly like the non-correlation to all the risks their other investments have. They also appreciate the fact that the payouts are not a matter of if, but when, and that those payouts are coming from some of the strongest and largest companies in the world: highly-rated U.S. life insurance companies. Some of your clients may also appreciate what this type of investment can bring to their portfolios. You will appreciate the new revenue stream from being able to work with additional money, like IRA or Roth IRA funds, perhaps to help clients diversify with life settlement investments.

You may or may not be a fan of all the work California legislators do in Sacramento, but CA SB 1837 can be quite meaningful for your clients and your business, especially at this time with all that is going on in our world. You may wish to consider learning more and leveraging this new tool today!

BRIAN J. CLARK is the CEO of Alternative Strategies Resource Partners. Brian has more than 20 years of experience helping agents and advisors with solutions that assist their clients in getting to and through retirement in a more comfortable and efficient manner. Contact: 1-760-668-5440, brian@asrp12.com or www.asrp12.com.

TRANSPA

IN COVERAGE RULES

Breaking it all down for real-world understanding

By
Dorothy M. Cociu

ARENCY

n October 29, 2020, the Department of Health & Human Services, Department of Labor, and Treasury Department collectively issued proposed and final rules on "Transparency in Coverage." These will require most employer-sponsored group health plans to disclose price and cost-sharing information to its plan participants upon request, before services are provided. The proposed rule was issued alongside a new Final Rule that will require hospitals to provide patients with information about the hospital's "standard charges" beginning in 2021. The provisions of the rules will be implemented through 2024, but health issuers, insurance companies, third party administrators and vendors creating the necessary tools should be working now on the requirements, because they are tedious and complicated. This is definitely not something to put off.

I asked Marilyn Monahan, attorney from Monahan Law Offices, what she thinks employers should start doing now to prepare for the transparency rules. "Understand what the rule requires, and begin planning," commented Marilyn.

"The planning steps will differ depending on whether the employer offers fully insured or self-funded benefits," she continued. "Determine how each requirement will be met — by the insurer, an outside vendor or a TPA. If you will be contracting with an outside vendor to perform the services, remember that it will take time to find the right service provider, to set up the system, and to test the system, so that you ensure the system is fully operational on time. Creating a timeline and a budget will be essential parts of the process."

Along these same lines, I asked MaryAnn Wessel of Orange County, California-based EBA&M Corporation what advice would she give self-funded employers who are just now starting to think about these rules. EBA&M is a TPA specializing in self-funded health plan administration that we do a lot of self-funded business with. What did she think their first steps should be, and what role will they play in the early stages?

"As a TPA, we will begin communication with our clients through their broker/consultants — however, what we learned from HIPAA Privacy, ACA and even before those major regulations like COBRA, is that we will have to take the lead with some brokers to assist their clients. Not all broker/consultants are informed on these subjects and therefore we as the TPA must provide very informative communications to them for their clients. We definitely had to do this for HIPAA and ACA," she commented.

"Not all broker/consultants are informed on these subjects and therefore, we as the TPA must provide very informative communications to them for their clients."

~ MaryAnn Wessel of EBA&M Corporation

Third party administrators and other service providers for the most part are just beginning their implementation process. Many TPAs, for example, are just now starting to learn about the rules, so that they can make the determination as to whether they will offer services in-house or subcontract with a vendor. Although the Final Rules make it sound (in my opinion) as though everyone will jump on the "do-it-yourself" project, I seriously doubt it. The creation of the tools will be too time-consuming and too expensive for most. I could be wrong, but if I were still in the TPA business, I'd definitely be looking for partners on this project!

Also along these lines, I asked MaryAnn where they were on this project, and where she thought others are. "Most TPAs in our opinion are at the same stage EBA&M is at — in the learning period right now and discussion internally on how to fully comply." With the early phases due in a year, time is of the essence.

The effective date of the final rules are 60 days after publication in the Federal Register, or 1/11/21.

Understand what the rule requires, and begin planning … Determine how each requirement will be met — by the insurer, an outside vendor, or a TPA … Remember that it will take time to find the right service provider, to set up the system, and to test the system … Creating a timeline and a budget will be essential parts of the process."

— Marilyn Monahan, attorney from Monahan Law Offices

Some groups are anticipating a delay or possible removal of these rules by President Biden's administration -- but, folks, it's not that easy to get rid of federal rules once they are executed and finalized. Look how long it's taking for Texas v. U.S. in the ACA matter, which was a primary task of the Trump Administration.

These rules will bring on a huge burden to certain plan sponsor employers; particularly self-funded employers.

These rules will bring on a huge burden to certain plan sponsor employers; particularly self-funded employers. I asked Marilyn if she anticipated this being an expensive undertaking for plan sponsors, particularly those with self-funded health plans? "Plan sponsors with self-funded plans, in particular, will find this to be a time consuming and expensive undertaking," Marilyn noted. "While many self-funded employers will contract with a TPA or ASO to provide these services, these vendors will undoubtedly charge additional fees."

I will attempt to break down the requirements for you, in real-world terms, to assist you in understanding the pending rules.

Brief Summary – Final Rule (CMS 9915-F)

Brief timelines

The Final Rule will apply on a phased-in basis, with requirements over the period between January 1, 2022 and plan years beginning on or after January 1, 2024. In the most simplistic view, the requirements will be broken down as follows:

- 2022: Issuer/Plan Data Files required to be released to the public
- 2023: Website self-service tool for 500 shoppable services due to be available to public
- 2024: Website – all services required to be completed

In general, applicability of dates are as follows:

The requirements would be applicable for plan years (or in the individual market, policy years) beginning on or after one year after the finalization of the final rules. The requirements to publish the machine-readable files will become effective for plan years (or in the individual market, for policy years) beginning on or after January 1, 2022. The applicability of the internet-based self-service tool requirements and providing the pricing information for a minimum of 500 shoppable services and items beginning with plan years (or in the individual market, policy years) on or after January 1, 2023. Plans and issuers will be required to provide the pricing information through the internet-based self-service tool for all items and services by plan years (or in the individual market, policy years) beginning on or after January 1, 2024. All in all, it's a four-year implementation period.

I will provide more detailed information throughout this article on each of these requirements.

BACKGROUND AND SUMMARY

The final rules set forth, according to the Final Rule (CMS 9915-F) the "requirements for group health plans and health insurance issuers in the individual and group markets to disclose cost-sharing information upon request to a participant, beneficiary, or enrollee (or his or her representative), including an estimate of the individual's cost-sharing liability for covered items or services furnished by a particular provider."

This information must be made available on a public website in a manner which allows the participant, beneficiary or enrollee, herein referred to as participant, to obtain an estimate and overall understanding of the individual's out-of-pocket expenses, and have the ability to shop those services and prices across the market. In other words, select your upcoming surgery, hospitalization or service across multiple providers to find out the differences in price, just as we would for any other consumer good. This, my friends and readers, is the entire idea behind health insurance transparency — to be able to shop for health care like we shop for a home, a car, a computer, or anything else. What a concept!

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like we shop for a home, a car, a computer, or anything else. What a concept!

This summary makes it sound simple, and although the broad concept is a simple one, the rules and how they will implement them, are anything but simple.

On June 24, 2019, President Trump issued Executive Order 13877, which called for "Improving Price and Quality Transparency in American Healthcare to Put Patients First." The order directed the Secretaries of the Departments, simply stated, to issue rules and ask for feedback from commenters on health care transparency.

The final rules also require plans and issuers to disclose in-network provider negotiated rates, historical out-of-network allowed amounts (such as usual and customary rates) and drug pricing information through three machine-readable files posted on an internet website, allowing the public to have access, and hopefully keep future prices down due to competition and full disclosure.

Also included in the Final Rule were final amendments to HHS's medical loss ratio (MLR) program rules, to allow issuers offering group or individual health insurance coverage to receive credit in their MLR calculations they share with enrollees, which would hopefully result in the enrollees shopping for and receiving care from lower-cost, higher-value providers.

The intended outcomes include providing for consumers to determine costs prior to treatment, to increase timely patient payments, to provide relief from Surprise Billing, to provide better plan choices for individuals shopping for health coverage, to issue compliance enforcement to the state, and review potential antitrust and potential collusion issues. I'll of course get into these issues throughout this article.

BACKGROUND & RELATIONSHIP TO THE ACA

The Patient Protection and Affordable Care Act was enacted, as we all probably remember, as well as the Health Care and Education Reconciliation Act of 2010, known collectively as PPACA. PPACA was

EXEMPTIONS

There are some important exceptions to who has to comply, including:

- **Grandfathered Health Plans**
- **HRA/HSA Plans**
- **Excepted Benefits (such as dental and vision plans)**
- **Healthcare Sharing Ministries**
- **Short-Term, Limited Duration Insurance (STLDI)**

First, grandfathered health plans (those with grandfathered status under the ACA as of March, 2010, as previously discussed in the Background & ACA section of this article). It's important to note, however, that "grandmothered" health plans do have to comply. In the Final Rules, just as the departments specifically discussed the non-grandfathered health plans, they also discussed the grandfathered health plans.

According to the Final Rules, "grandfathered health plans are health plans that were in existence as of March 23, 2010, the date of the enactment of PPACA, and that are only subject to certain provisions of PPACA, as long as they maintain their status as grandfathered health plans under the applicable rules. Under section 1251 of PPACA, section 2715A of the PHS Act does not apply to grandfathered health plans. Therefore, the proposed rules would not have applied to grandfathered health plans …"

So how many groups are currently grandfathered today? Our block of business is likely somewhat different than most. All but one of our self-funded groups, as of now, are grandfathered, but that is certainly not the norm in the self-funded business. I believe we only have one or two fully-insured groups that are grandfathered as of now, which is certainly more common. I asked Maryann Wessel at EBA&M, who offers self-funded claims administration and other services, what percent of her groups were grandfathered vs non-grandfathered. "75% of our traditional self-funded accounts are non-grandfathered," Maryann replied. I know that our groups make up part of that 25% that remain grandfathered with them!

The rules went on to state that they also "do not apply to any group health plan (or group health insurance coverage offered in connection with a group health plan) or individual health insurance coverage in relation to its provision of excepted benefits. Excepted benefits are described in section 2791 of the PHS Act, section 733 of ERISA, and section 9832 of the Code. Section 2715A of the PHS Act is contained in title XXVII of the PHS Act, and therefore, the proposed rules would not have applied to a plan or coverage consisting solely of excepted benefits."

"The departments also proposed that rules would not apply to STLDI … therefore, the proposed rules would not have applied to STLDI coverage."

The departments also proposed that "the rules would not apply to health reimbursement arrangements, or other account-based plans …"

In contrast, the departments proposed that the final rules "would apply to grandmothered plans, meaning certain non-grandfathered health insurance coverage in the individual and small group markets with respect to which CMS has announced it will not take enforcement action even though the coverage is out of compliance with certain specified market requirements."

The Final Rules adopted these provisions as proposed.

Who do the **rules** apply to?

The Transparency Final Rules apply to all group health plans and health insurance issuers in the group and individual market, which includes applications to employers who sponsor group health plans. In other words, they do not just apply to health insurance companies. They apply to plan sponsor employers as well, even though they generally don't even have access to their health plan's pricing information, assuming they are non-grandfathered under the ACA. This, of course, will cause confusion and expense to employers, as they navigate how to find vendors to help them with the disclosure requirements.

In the Final Rules, they specifically discussed how the departments acknowledged that section 2713 of the PHS Act requires non-grandfathered group health plans and issuers offering non-grandfathered coverage to provide coverage without cost-sharing (such as preventive services). However, if the same items or services are furnished for non-preventive services, the participant may be subject to cost-sharing terms of their plans. The departments stated that the issuer must display the non-preventive cost-sharing liability in the newly required self-service internet tools, along with a statement (disclosure notice, to be discussed later in this article) that the item or service may not be subject to cost sharing if it is billed as a preventive service.

One of the largest concerns is receiving a bill from an out-of-network provider when they thought an in-network provider was treating them. In my historical terms, we called this "forced providers." For example, you have a surgery, you choose the PPO facility and PPO surgeon, but you find out later that your anesthesiologist was non-PPO, or when your doctor sends your lab work out to a PPO lab, who then can't perform that testing and sends it elsewhere, resulting in a non-network lab. Hence, the plan participant had no control; it was a forced provider.

The hope is that while pricing transparency is not the complete solution alone, the disclosure of pricing directly to consumers could help mitigate some of the unexpected costs. Another important hope in this is that by disclosing pricing up front on a public website, consumers can shop, and will of course be drawn to lessor-cost providers; hence, natural competition of providers, which would hopefully drive down costs.

DISCLOSURE ELEMENTS & DISCLOSURE NOTICE

The departments state in the Final Rules that they concluded that requiring group health plans and health insurance issuers to disclose to participants, beneficiaries, or enrollees, cost-sharing information in the "manner most familiar to them is the best means to empower individuals to understand their potential cost-sharing liability for covered items and services provided by particular providers." This, in turn, resulted in them modeling the price transparency requirements on existing notice requirements.

The PHS Act and ERISA requires non-grandfathered plans and issuers offering non-grandfathered coverage in the individual or group markets to provide a notice of adverse benefit determination, which is typically satisfied by the Explanation of Benefits (EOB), to plan participants. EOBs typically include the amount billed by a provider for items and services, negotiated rates or underlying fee schedules with in-network providers or allowed amounts for out-of-network providers, the amount the plan paid to the provider, and the individual's obligation for deductibles, copayments, coinsurance, and any other balance under the provider's bill. As consumers are familiar with and used to seeing the EOB, the rules were intended to similarly require plans and issuers to provide the specific price and benefit information on which an individual's cost-sharing is based. The departments felt the participants would also benefit from understanding the price of items and services, even in circumstances when their cost-sharing liability is not based upon a negotiated rate or underlying fee schedule rate. Therefore, the rule requires disclosure of the negotiated rate, even if it is not the amount used as the basis for cost-sharing liability.

SEVEN CONTENT ELEMENTS

There are 7 content elements that a plan or issuer must disclose upon request to a plan participant, beneficiary or enrollee, for a covered item or service:

1. Estimated cost-sharing liability
2. Accumulated amounts
3. Negotiated rates
4. Out-of-Network allowed amounts
5. A list of items and services subject to bundled payment arrangements
6. A notice of prerequisites, if applicable
7. A Disclosure Notice

These 7 content elements generally reflect the same information that is included in an EOB after health care services are provided.

Another key element is that of the "Plain Language" requirement, which means that it must be written and presented in a manner calculated to be understood by the average participant, beneficiary or enrollee. Therefore, issuers and health plans are required to limit the use of "technical jargon" and long, complex sentences, so that the information provided will not have the effect of misleading, misinforming, or failing to inform participants.

Of course, I have to ask, as a former executive for a third-party administrator, why not just add additional requirements to the EOB and be done with it? Because an EOB won't result in full transparency is the simple answer.

The Final Rule also requires a Disclosure Notice. Such notice requires a complete description of the prerequisites, but also determined that all of that detail would create "unnecessary complexity and impose significant burdens on plans and issuers regarding information that is already available in Plan Documents." Therefore, they decided it best to require a notice, but with modifications.

The seventh of 7 content elements is a notice that communicates certain information in plain language, including several specific disclosures, including:

- A statement that out-of-network providers may bill participants for the difference between providers' billed charges and the sum of the amount collected from the group health plan or health insurance issuer and the amount collected from the participant, in the form of cost-sharing (the difference referred to as balance billing), and that these estimates do not account for those potential additional amounts.

The actual charges for the covered items and services may be different than those described in the cost-sharing estimate (for example, a simple surgery becomes more complicated when they discover additional medical concerns during the procedure, or complications that occur).

- A statement that the estimated cost-sharing liability for a covered item or service is not a guarantee of coverage will be provided for those items and services; and any additional information, including other disclaimers that the plan or issuer determines appropriate, so long as the additional information does not conflict with the information they are required to provide.

In simpler terms, the disclosure notice must include information in plain language that discloses whether the copayment assistance and other third-party payments are included and counts toward deductibles and out-of-pocket maximums (for example, RX copay assistance from the pharmaceutical company is not included), and a statement that the item or service may not be subject to cost-sharing if it is billed as a preventive service (for example, if someone is getting a mammogram but it's actually beyond the preventive services allowed number of mammograms, such as three or four in a single year).

To satisfy these requirements, the departments created a model notice that plans and issuers could use, but are not required to use, to satisfy the disclosure notice requirements. A copy of the draft model notice can be found at the Department of Labor website: DOL.gov.

I would like to say that most industry experts, including myself and attorneys I work with, as well as the National Association of Health Underwriters, have recently stated that they do not recommend use of the model notice without substantial additional information being added to it. Keep in mind also that in the disclosure notice, if balance billing is permitted under state law, the Final Rule will not override the state law.

Now the question becomes, how do we do all of this disclosure? The simple answer is by requiring, as mentioned previously above, issuer/plan data files be released to the public (by 2022), by creating an internet website that discloses the prices of 500 shoppable services in a self-service tool (by 2023) and adding all additional website services by 2024. Easy peasy, right? Not so much....

WEBSITE SELF-SERVICE TOOL FOR 500 SERVICES & DELIVERY OF COST-SHARING INFORMATION

Table 1 of the Final Rules contains a list of 500 items and services list. The table includes the Code, Description, and Plan Language Description. This table can be found on page 93 of the Final Rule, at **CMS.gov.**
Keep in mind, this table is much more extensive than the prior hospital requirement to post their "standard charges" for 70 shoppable items as of Jan. 1, 2019. Under the Hospital Price Transparency final rule, hospitals are required to disclose 5 types of standard charges:

- *The gross charge*
- *The discounted cash price*
- *The payer-specific negotiated charge*
- *The de-identified minimum negotiated charge*
- *The de-identified maximum*

This is an expensive requirement, and health plans and issuers will absolutely have to increase premiums to pay for it, and TPAs will have to increase their administrative fees to employers as well."

When choosing a service provider, a plan fiduciary must perform adequate due diligence, and should consider the vendor's experience, performance history, and fees. Each step in the process should be documented."

~ Marilyn Monahan, attorney from Monahan Law Offices

negotiated charge

So let's talk about the Internet-Based Self-Service Tool that the Rules require, and how that information may be delivered.

Health plans and issuers must make cost-sharing information available for the 500 items and services on or after January 1, 2023, and for all items and services for plan years beginning on or after January 1, 2024.

Plans and issuers must make the required information available, without fees, in two ways:

1. Through an internet-based "self-service tool"
2. In paper form by mail upon a customer's request

INTERNET SELF-SERVICE TOOL & DELIVERY OF INFORMATION

The Final Rule states that the departments agree that the self-service tool requirements should ensure all people enrolled in group health plans and health insurance coverage have access to the same baseline functionality, while providing enough flexibility for plans and issuers to develop and iterate on innovative internet-based self-service tools. The departments also agreed that certain additional content elements could be beneficial to participants, including general benefit summary information and quality metrics. In addition, the departments also agree that plans and issuers should have flexibility to design tools that can maximize consumer utility and acknowledge that the suggested additions to search functionality could be beneficial to consumers, but they decline to require the adoption of some of the suggestions to avoid being overly burdensome and prescriptive.

This internet method of delivery allows for a search by billing code (CPT code) or a descriptive term. Keep in mind, most consumers will not be aware of CPT codes, and will likely more often use a descriptive term. It should also allow users to enter a specific in-network provider, along with the CPT code or descriptive term. If the plan or issuer utilizes a multi-tiered network, the tool would be required to produce the relevant cost-sharing information for the covered item or service for individual providers within each of the tiers.

If an estimate varies based on factors other than the provider, the tool would also be required to allow users to input sufficient information to disclose meaningful cost-sharing data. For example, a participant should be able to make the distinction between whether a service is preventive or diagnostic.

If the cost-sharing liability estimate for a prescription drug depends on the quantity and dosage of the drug, the tool would be required to allow the user to input the quantity and dosage into the tool.

If an estimate varies based on the place of service, such as a hospital setting versus an outpatient setting, the variance must be shown. The rules also allow users to search for the out-of-network allowed amount or other metric for a covered item or service, such as a zip code or the location of the out-of-network provider. The tool must be able to allow users to refine or reorder the results with sorting and filter options, for geographic proximity and amount of estimated cost-sharing. The departments also encourage plans and issuers to also provide a mobile application version, in addition to the website tool, although it is not required.

Health plans and issuers must make cost-sharing information available for the 500 items and services on or after Jan. 1, 2023, and for all items and services for plan years beginning on or after Jan. 1, 2024.

For internet delivery, there can be no subscription or other fees to access data. It needs to be delivered to the consumer free of charge. Health plans and issuers must provide real-time responses based on cost-sharing information that is accurate at the time of the request, such as out-of-pocket limits and amounts applied to date, deductible amounts and the amounts applied to date.

PAPER DELIVERY

Most of us realize that it is not feasible to assume that all plans and populations of participants will be able to use the website self-service tool. There are language barriers, low economic areas in which families may not have access to computers, etc.

Because of these concerns, plans and Issuers must also offer an alternative, paper delivery upon request. For the paper versions, once again, plans and issuers may not require a fee. They are required to refine or reorder the results if the result request returns more than one result. The paper delivery must be provided no later than 2 business days after the request is received, which is by most industry expert standards, nearly unattainable, and difficult and burdensome at best.

The plan or issuer may also limit any results for a paper request to 20 providers per request, and they must be able to sort in a way that is meaningful to the participant searching. This includes by cost, location, etc.

If a participant requests an alternative means of disclosure, such as by phone or email, the plan or issuer is permitted, as long as the request is delivered in the same time-frame as the paper method.

DIFFICULTY FOR EMPLOYERS TO MEET THE REQUIREMENTS & USE OF OUTSIDE VENDORS

The Final Rules state that based on 2019 Census data, there are 183 million Americans enrolled in employer-sponsored health plans at some point during the year. This means that more than 56% of the nation's insured population has employer-sponsored coverage. The Transparency Rules have no intention of negatively impacting employer health plans and encourages the competition in the employer-based health care market.

The Final Rules allow for health plans, fully insured or self-insured, to enter into a contract with an issuer or vendor for administration and compliance of the transparency rules. Self-funded employers may enter into such contracts with issuers or vendors for administration, but remain liable for the compliance requirements.

I asked Marilyn what types of things the self-funded employer plan sponsor should be doing to protect themselves. "Under ERISA," Marilyn stated, "hiring a service provider is a fiduciary function. When choosing a service provider, a plan fiduciary must perform adequate due diligence, and should consider the vendor's experience, performance history, and fees. Each step in the process should be documented. The DOL's booklet, 'Understanding Your Fiduciary Responsibilities under a Group Health Plan,' provides a summary of the actions plan fiduciaries should take when choosing a service provider."

MEWAs (multiple employer welfare arrangements) that are employee welfare benefit plans assume liability and retain all related responsibility. For those that are not itself a plan, each employer providing benefits is separately responsible for compliance. The same applies to association health plans.

REQUIRED DATA FILES

Three files are required from issuers and group health plans in 2022. They include:

- *In-network rate file*
- *Allowed amount file*
- *Prescription drug file*

Although many commenters requested real-time updates, the Final Rules require monthly updates. This information must be provided by all health plans and issuers, including employer plan sponsors of non-grandfathered health plans, unless they contract these services with an outside vendor or administrator. The reality is, employer plan sponsors don't really have access to this information, and yet they are still liable for it.

The use of these data files may not require the establishment of a user account, password or other credentials. This information is literally available to all of the general public. The files must include a "place of service code" and a provider TIN.

The In-Network Rate File must include the name and identifier for each coverage option (i.e. employer tax ID and health insurance oversight system (HIOS) ID, billing codes used by a plan or issuer for "purposes of billing, adjudicating, and paying claims for a covered item or service" (i.e. a CPT code, healthcare common procedure coding system (HCPCS) code, DRG, National Drug Code (NDC), or ICD-10 code. Each code must include a plain language description, for all 500 shoppable services). I ask, how many employers even know what these codes

One of the most important things to keep in mind while shopping for these vendors is to work with one who will accept indemnification language, because ... the employer is liable for the compliance, yet has no access to the rates, so they must rely on qualified parties. They will want to ... transfer that liability to the vendor that is actually performing the work."

This is an expensive requirement, and health plans and issuers will absolutely have to increase premiums to pay for it, and TPAs will have to increase their administrative fees to employers as well.

are? I was senior management in a self-funded health plan TPA for 12 years early in my career and I barely know what they are!

Also in the in-network rate file, you must provide the in-network applicable rate, which could be negotiated rates (i.e. fee for services), amounts in underlying fee schedules (such as PMPM models, or a base rate attached to that service), and derived amounts.

These rate files are extremely complex. I'm only touching on the requirements here.

The Allowed Amount File includes unique amounts that a plan or issuer allowed, as well as associated charges, for covered items or services furnished by out-of-network providers during a specified time period. That period, incidentally, is defined as the 90-day time period that begins 180 days prior to the publication date of the Allowed Amount File.

Allowed amounts must be reflected as a dollar amount, not a percentage or other amount. This is important and highly relevant for Reference-Based Pricing plans without a network. RBP plans generally tie their payments to a set percentage of something like Medicare, but do not have contractual arrangements with the providers. An example is 150% of the Medicare rate. That is not allowed under the allowed amount file. You must state the exact amount for that service, not the percentage of Medicare.

The Prescription Drug File is probably the most complicated, in my opinion, of all the required data files. Prescription drug negotiated rates are complex. These are the amounts a group health plan or health insurance issuer has contractually agreed to pay an in-network provider, including an in-network pharmacy or other prescription drug dispenser, for covered items or services, whether directly or indirectly, including drug rates through a TPA or PBM, which can be very complicated.

This data file must include prescription drug historical net price disclosures, which means a retrospective average amount a plan or issuer paid for a prescription drug, inclusive of any reasonably allocated rebates, discounts, chargebacks, fees and additional price concessions received by the plan or issuer, which can be very complicated, but can save the plans considerable cash.

EMPLOYER CONTRACTING OF SERVICES — PROTECTIONS FROM LIABILITY

Obviously, most employers will need to contract these services out to a qualified third-party vendor. One of the most important things to keep in mind while shopping for these vendors is to work with one who will accept indemnification language, because as I said, the employer is liable for the compliance, yet has no access to the rates, so they must rely on qualified parties. They will want to (I think need to) transfer that liability to the vendor that is actually performing the work.

I asked Marilyn Monahan about that liability, indemnification and other protections, and how important they were to employers. "Review the terms of the service provider's contract carefully," she stated. "To begin, the contract should clearly specify the duties and responsibilities of each party and, through representations and warranties, set expectations for the level of service that will be provided. Also consider how certain contract terms might impact you in the event the service provider fails to perform. For example, review (or add/delete) the indemnification, limitation of liability, termination, arbitration, venue, choice of law, and attorney's fees clauses, which could all become very relevant if the vendor makes a mistake. Understand, and be clear about, the cost for the service."

PRIVACY, SECURITY & ACCESSIBILITY

The Final Rules state that group health plans and insurance issuers are required to provide cost-sharing liability estimates and related cost-sharing info that operates in tandem with existing state and federal laws governing the privacy, security and accessibility of the information that will be disclosed under the disclosure requirements. For example, the content to be disclosed by plans and issuers may be subject to the privacy, security and breach notification rules under HIPAA or similar state laws. Nothing in the final rules are intended to alter or otherwise affect plans', issuers' and other entities' data privacy and security responsibilities under the HIPAA

rules or other applicable state or federal laws.

ENFORCEMENT & GOOD FAITH COMPLIANCE

The Final Rules state that the states will generally be the primary enforcers of the requirements imposed upon health insurance issuers by the final rules. The rules include a special applicability provision to address circumstances in which a group health plan or health insurance issuer, acting in good faith, makes an error or omission in its disclosures. A plan or issuer would not fail to comply with the rules solely because it, acting in good faith and with reasonable diligence, made an error or omission in a disclosure, provided that the plan or issuer corrects the information as soon as practicable. Additionally, to the extent such an error or omission, according to the Final Rules, was due to the good faith reliance on information from another entity, the rules include a special applicability provision under which, to the extent compliance would require a plan or issuer to obtain information from a third party, the plan or issuer would not fail to comply because it relied in good faith on information from the other entity, unless the plan or issuer knew, or reasonably should have known, that the information was incomplete or inaccurate.

The departments are finalizing the "good faith" safe harbor. Good faith is an established legal and business term that is generally understood to involve honesty in fact and observance of reasonable commercial standards of fair dealing, according to the Uniform Commercial Code.

I should mention that states do not have authority to require such disclosures by plans subject to ERISA, which compose a significant portion of the private market.

HIGH COSTS OF IMPLEMENTATION

The cost of implementing these rules is expected to be astronomical. However, the departments anticipate that a number of TPAs and issuer-TPAs will seek to coordinate their efforts and take advantage of any resulting economies of scale to reduce their overall costs. However, I personally feel that if the companies are financially able to do this on their own and be one of the first to the market to offer it cost-effectively and on a wide-spread basis, they will definitely reap the rewards of market share and get a head start on the competition.

A number of tables were presented in the Final Rules on estimated costs to implement items such as the internet-based self-service tool. Table 4 summarizes the High-End First Year Estimated One-Time Cost and Hour Burden for the Internet-Based Self-Service Tool for Each Issuer or TPA, which resulted in the total cost per respondent of $5,295,680.

Table 5A shows the Low Range first Year One-Time Cost and Hour Burden for the tool requiring a complete build at $1,037,423,712. Table B was Low-End for a Partial Build at $2,801,044,022. There are several tables with several variations of first-time costs, second year costs, and ongoing maintenance in the Final Rules.

I don't expect the average TPA to be able to incur these costs. I assume most are already looking at vendors to subscribe to. So, let's hope some surface soon!

The bottom line is, this is an expensive requirement, and health plans and issuers will absolutely have to increase premiums to pay for it, and TPAs will have to increase their administrative fees to employers as well.

NAHU has an informative webinar on this subject in the Compliance Corner section of their website. I highly recommend it for anyone interested! www.nahu.org

Author's Disclaimer: The information contained herein should not be construed as legal advice of any kind. I've gathered public information to assist readers in understanding the new rules. I always recommend seek the advice of your own legal counsel, as things change rapidly and situations vary.

DOROTHY M. COCIU, *RHU, REBC, GBA, RPA, LPRT is VP of communications, California Association of Health Underwriters (CAHU) and president of Advanced Benefit Consulting & Insurance Services, Inc.*

" ... why not just add additional requirements to the EOB and be done with it? Because an EOB won't result in full transparency is the simple answer. ...

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HELP
ADVICE
SUPPORT
TIPS
INFORMATION
GUIDANCE

Are you Doing your Part?

Serving in leadership roles supports your growth, helps protect our industry, and we are ALWAYS looking for more people to jump in and serve a higher purpose

BY DAWN McFARLAND

Yep — admittedly, I have gulped more than my fair share of the National Association of Health Underwriters (NAHU) Kool-Aid. And you know what? If I hadn't I would have missed out on so many things.

I came into this industry post Affordable Care Act (ACA) — actually licensed in 2012. My first full year in the industry involved soaking up so much conflicting information. From the rookie perspective I saw so much good — no pre-existing health issues for people that so desperately needed help?!

On the other side ...

But at an affordable price — for who? Agents did not believe Covered California, Obamacare, Healthcare.gov or ACA would actually happen — up until the very day of going live!

My perspective as a post-ACA agent was so different from the agents I came to work with and understand better.

I was fortunate enough to learn about the Los Angeles Association of Health Underwriters (LAAHU) from a colleague. After attending one monthly member meeting, I got a call from Sima Reid, the current membership chair for LAAHU. I was a serious industry rookie, going out on commission only for the very first time ever in an industry that was being flipped upside down. I quickly recognized the value of working with brokers in partnership because of the strength of the relationship with their clients and felt getting involved with the association would be a smart networking move. In the conversation with Sima, she made the most meaningful impression on me. She encouraged me to really get involved, and not just see the association as a means of networking and developing business, but to be part of a bigger cause in an industry that would support me.

So, I did.

I jumped in whole heartedly under Dede Kennedy-Simington's leadership, with the chapter historians and supporters Joan Bumgarner (she is sorely missed!) and David Benson. Dede has been such a mentor in leadership — always shooting for the moon! We have grabbed more than a few stars on the way back!

My involvement has given me the best industry education I could ask for, alongside exceptional experience. It has given me a place to land as an entrepreneur for the first time, learning with like minded (AND different minded) business owners. It has allowed me the opportunity to talk with so much acknowledged industry experience.

As you know, the health insurance industry has been in crazy change mode for as long as any of you with 30+ years of service know. Look at how much we have shifted and imagine if we had not gotten as far as we had with technology prior to March 2020. Look at the accomplishments through all of that by CAHU and NAHU!

Then there is this whole other side of membership when you get involved. People coming together for a purpose bigger than themselves, building new relationships and mentorships. Driving a business is hard work. Being around others who drive business is motivating. Serving in leadership roles supports your


Kamala D. Harris
SH-112


NAHU







growth and we are ALWAYS looking for more people to jump in and serve. And once you begin serving, you find lifelong friendships with colleagues across the country.

As a now long time volunteer in the association (where did the time go?) I can attest to three important things;

If you want to see change, you need to get AND stay involved to help turn the ship.

The more diverse our shared experiences, the better educated we can all be at making positive changes in the industry

Your voice matters, but cannot be heard unless you use it

And why am I telling you my "why join AU membership" story? Because we need YOU. From national down to the state and local levels, our membership numbers are declining (tons of reasons why) so we need to draw attention to the value that has been given and the voice that we DO have to make positive impacts on the way our country finances healthcare. You may not notice it now so much, because frankly most of our industry has thrived in this crazy time. But if our numbers continue to decline, the strength of our organization declines with it. And where do you think agents will land if we do not have strength in numbers, as conversations of "Medicare for All" continue to swirl? Communicating the work we do for the American people is important. We need to make sure we continue to explain the "role of the agent" to our governing bodies so they understand that it is not "just a sale" but a relationship of service with our clients. The association gives our collective voice power. I believe that if you really understood the value of membership, it would be the easiest $40ish dollars per month to give.

If you want a peek into the value NAHU has on Capitol Hill, join us for Capitol Conference February 22-24. It will be virtual this year and you can find out more info at NAHU.org. If you would like to be a part of the lobbying efforts that take place at Cap Con, be sure to reach out to your local chapter. We are ALWAYS looking for constituents to attend the legislator meetings. Be careful — that is where many of us catch the fever! Also keep your eyes out for CAHU's Capitol Summit in May where we get to be in touch with California lawmakers — fingers crossed for a hybrid version.

If you don't see any value beyond legislative — pay your dues anyway to support our efforts on your behalf! You don't have to join us at the events (virtual or live) but we would love to see you!

Here's to a new year and prayerfully a healthy one for all of you and your families! For more info go to the membership section of NAHU.org.

DAWN MCFARLAND *is founder and president of M&M Benefit Solutions Insurance Services. She is passionate about helping individuals — especially Medicare eligible — navigate choosing how they receive their health care. She believes in education as one of the means to help change the high cost of healthcare. Dawn currently serves as VP of legislation for CAHU; on the Medicare Advisory Council and the Membership Council for NAHU and is currently a member and past president of the Los Angeles Association of Health Underwriters. Contact:* **dawn@mnmbenefitsolutions.com** *or visit* **www.mnmbenefitsolutions.com.**

Diversity, Equity & Inclusion Drive Opportunity in Diverse Populations

BY TIMSHEL TARBET

Healthcare is personal. Each of us experiences our own health journey, very much influenced by our culture, our experiences, our family and our identities. In ethnically and racially diverse communities, it can be difficult to find adequate healthcare that is consistent with one's unique linguistic, cultural and personal preferences and values. That's because the diverse needs of these populations are often overlooked by the healthcare system, which often leads to poorer health outcomes and missed opportunities for health insurers and brokers not equipped with the right tools to serve them well.

But it doesn't have to be this way. By honoring the different cultural norms and values in diverse populations and working to provide care that is culturally and linguistically competent, health insurers and Medicare brokers have the opportunity to provide excellent care to more people and do it in ways that truly support their needs.

THE VIEW THROUGH A DEI LENS

In the past, there have been numerous efforts to make healthcare more diverse, equitable and inclusive (DEI). But when you look at traditional DEI programs, many are focused internally. "Diversity" is often thought of in terms of a box to check to show you've got a mix of race, genders and cultural backgrounds in your employee ranks. It's a very narrow view: Are we meeting these targets or not? Check the box, yes or no.

The landscape can appear very different, though, when you take a step back and look at it from the perspective of the customer. Customers often look for their reflections in the organizations they choose to patronize. If they don't see people who look like they do, speak their language or understand their culture, they may feel misunderstood, unappreciated and dissatisfied.

Likewise, consider a health plan member who calls their insurer to find out if a medication prescribed by their doctor is covered by their drug benefit. What if they discover that the insurer's customer service representatives don't speak their language? That could lead to a sense of frustration, and they might not follow through with their treatment or ever want to interact with the health plan again.

But what if instead, the member enrolled in a plan fully able to respond to their cultural needs and connect them with someone who can help them in their native language? In that case, it's more likely they'll get the care they need — and have a better opinion of both their health plan and the broker who recommended it.

FORGING A NEW PATH TO DIVERSITY

To meet the needs of people in racially and ethnically diverse populations, we can't travel the path that everybody has travelled before; it needs to be deeper than that. At SCAN, where our mission is to help all seniors remain healthy and independent, we're making a commitment to understand how diversity affects our business and how to serve seniors in ways that are racially and culturally competent. We can't just diversify our member population — we need to be able to serve those people as well. So, we're looking holistically at who our customers are, how we're serving them and how we can better honor their diversity. This requires examining the healthcare process end-to-end through a DEI lens. That means having in place a sufficient population of providers trained to provide high-quality care to an ethnic or racially diverse patient, as well as Member Services staff who can answer calls in a way that respects their unique cultural and linguistic needs. Likewise, we're also working to make sure our employee population reflects the diversity of the seniors in the communities we serve so that we're better able to reach the members of those communities with programs and services that respect their unique cultural and linguistic needs.

Of course, we can't do this alone. We rely on informed brokers and other trusted advisors in the community to help us design products and programs that are appropriate for their clients. After all, nobody knows more about the needs of their clients than you do. And, of course, the broker population needs to be supported in ways that help them understand how our products can benefit their clients. If these kind of back-end pieces aren't in place, the door is left wide open to dissatisfaction and poorer health outcomes.

WITH DIVERSITY COMES OPPORTUNITY

Looking at the healthcare process through a DEI lens and creating culturally and linguistically competent solutions can bring more value to your business, your customers and the communities you serve. Markets with largely ethnic or racial populations are often overlooked by brokers, which presents an opportunity for the advisor who has the tools to speak to the unique needs of clients in these groups.

With more diverse offerings developed for specific populations, you can communicate with racially and ethnically diverse markets in a way that wasn't possible before by being able to introduce them to the plan that best aligns with their values, personal beliefs and other factors that impact their access to care, satisfaction and, ultimately, their health. This can be a key service differentiator to help you grow your business and create longer-lasting relationships with your clients. Because when you make the connection between a client with distinct cultural or linguistic needs and a health plan that respects their differences and meets them wherever they are on their healthcare journey, you'll have a grateful customer who will spread the word about your business' ability to meet their community's needs.

TIMSHEL TARBET *is VP of Business Excellence and Diversity Strategy at SCAN Health Plan. An experienced healthcare executive who served in the United States Air Force, she leads new initiatives to bring SCAN's experience keeping older adults healthy and independent to new, diverse populations. SCAN is one of the nation's largest not-for-profit Medicare Advantage plans, serving more than 230,000 members in California.*

The Disruptor Myth

Over promising and under delivering is as costly as healthcare itself

BY EMMA FOX

As our industry has fractured into its identifiable groups, we are constantly being fed the latest and greatest ideas to curb the cost of insurance in the U.S., but how many consultants know how to control the cost of healthcare instead? And isn't that what truly drives the cost of care?

We hear words like status-quo, innovation, cost-containment, and disruption more than ever as we log into our LinkedIn these days. While all of these terms lend themselves to some very effective strategies, we're finding that it's often not much more than a sales pitch from the new and eager consultant.

Let's cut to the chase — some consultants are selling something they can't back up nowadays. Just this last year we've seen an influx of new consultants entering the market with claims of being the young innovators. Great! We need the fresh ideas and the renewed energy, but some of us have been at this "alternative model" a while and understand what works, what doesn't work, and most importantly how to be transparent and embrace a truly aligned client-consultant partnership when we're venturing into something new. In this same year, I've seen more division in our industry than ever. I've seen wannabe brokers interchanging terms and definitions in an attempt to set themselves apart from what they have been made to believe is 'status-quo'. I've got news for you — status-quo set this stage for you. Those brokers you're looking at as old, dried up, and out of fresh ideas — we laid the very path you're skipping down. Your new attitude doesn't work without the legacy and experience of the old. And boy am I tired of hearing people claim there's only room for one or the other.

STOP USING A FALSE NARRATIVE

For those of you that have been exposed to the 'disruptor' community — I'm glad. We need to move the needle in a big way. Most of us in this circle are working on larger, self-funded groups with independent TPAs and some alternative provider reimbursement ideas. Most of us in this community understand the difference between being self-funded and having a reference-based pricing (RBP) reimbursement structure. We understand that while those two things often have to exist together (i.e. you are usually self-funded if you are also RBP), we also know that self-funding comes in a lot of different shapes and sizes.

The term self-funding should really be self-explanatory, but it would be more accurate to say that most medium and large employers are partially self-funded since there is usually a stop loss layer of insurance involved. But self-funding means that the employer is taking on the funding of the healthcare being consumed by its employees. A self-funded plan design can be administered by a national or regional carrier or a third-party administrator. It can have

a leased network for all care, some of the care, or no network in the plan at all. Self-funding does not automatically equal no-network or reference-based pricing. And, if you're selling something as turbulent as RBP, you also need to know (and communicate) that plan management and the quality of care being delivered are two glaring components that need to be addressed. If you're not able to calculate the balance between savings and friction to best suit your client, you've done your second disservice of the sale — the first being that you told someone being "open-access" is akin to self-funding itself.

Similarly, there seems to be confusion over what referenced-based pricing really is. It is a provider reimbursement method. That's it. Reference-based pricing is the methodology in which we find a reference price for a healthcare service and use that price to determine what fixed cost a health plan will reimburse a provider for their services. It's not a catch-all or solve-all for cost-containment, but it can be a very effective backdrop to a self-funded health plan that wants to employ a lot of other strategies to deliver the transparency tools a consumer would need to actually take charge of their own health outcome. RBP is a challenging and highly effective cost saving measure, but it is not a requirement of self-funding and is not the definition of self-funding. If an employer is being told they are one and the same, or that the only way to be self-funded is to deploy an RBP plan, they should find a new consultant. Maybe they should choose one of the older 'status-quo' consultants who have a good grasp of a thesaurus.

STOP HURTING THE MOVEMENT

We all understand that healthcare costs are out of control. And most of us are also acutely aware that health insurance carriers have contributed to an increasingly worrisome trend into the future for employers trying to keep up with the cost of providing benefits. We know that change has to happen, but that doesn't mean it can (or should) be forced. If you and I are both at a hospital being treated for the same injury, my pain level might be a 6 when yours is a 9. While all employers are struggling with being able to afford coverage for their workforce, some employers' struggle may be more painful and immediate than others. Business owners don't want to unleash a disruptive and difficult new plan design on their employees if they don't have to — yet. That doesn't mean we shouldn't be prepping them for the inevitable day that they will have to. Again, this isn't an all or nothing type of thing. And, let's not forget there are lots of employers that literally cannot self-fund their health plans or engage an RBP-type plan, even if they do really want to because they're too small to even meet the minimum stop loss guidelines. But guess what? Those employers still need benefits and an advisor to help them along the way. I'm tired of hearing the newbies discount those advisors that are working the small group frontlines where choice isn't really an option. Why don't you try hitting the sidewalk and helping the local dry cleaner with their big carrier plan and a chronic condition for next to no commission? Let me know how that goes.

When we tell an employer that they have no other choice but to make a major change, it should be because they really, truly, don't — because their financial line item attached to healthcare is literally unsustainable into the future. The art of consulting is not bringing your prospects something sensational — it's being able to meet your client where they're at and then pushing or pulling a little to get them to a better state that meets their needs as their business grows.

If you're a consultant out there telling your prospects there is only one way to tackle this healthcare cost crisis, you're wrong. And, furthermore, you're hurting a much larger movement made up of consultants that understand the need for fluidity and flexibility. We're not looking to build a small army of lieutenants; we're looking to create a big army of privates and officers.

STOP COMPETING

This brokerage industry is as fit for reform almost as much as healthcare itself. Over the years as the methods we're preaching and selling have evolved, we've managed to divide ourselves into opposing corners. We're not winning when we're throwing pitchforks — we're warring. It has been proven that collaborating with like-minded consultants, even of differing specialties and experience levels, is more effective for achieving the goals we've set for our clients and ourselves. That doesn't necessarily mean you have to enter into a co-consulting environment like we've developed at E Powered Benefits, but it can. There are lots of excellent associations and organizations for us all to exchange value. Just take a look at Health Rosetta, or the National Association of Health Underwriters (NAHU), or the Free Market Medical Association, or our bi-weekly Coffee Break meetings. Each of these organizations and communities is set up to bring us together. Use them! We need to start dropping our egos and this belief that it's us versus them. It would behoove us all to practice a little humility. I promise you'll gain more, know more, and sell more while having a much larger network of friends and colleagues that will only contribute to your future success (and results) from then on.

It's time to bring these corners together into a collaborative middle. We're all aiming for the same net here. So, let's get on the same team.

EMMA FOX *is an employee benefits consultant specializing in advising large employers in a self-funded, open access health plan environment. She dedicates herself to bringing effective strategies to clients and the industry alike, to improve quality of care while lowering costs. Fox is the founder of the Empowered Leadership movement on Linked In that has since become the Empowered Community: an organization dedicated to highlighting resilient leadership and providing a public platform for all voices in the insurance and leadership industry. When she is not working, Fox spends her time between Oregon and North Carolina with her partner, two children and two step-children.*

How to Choose the Right Enrollment Technology

BY JEFF PAPENFUS

Enrollment season is officially over, and now — as we all catch our breath — is the perfect time to reflect on what worked well, what didn't go as planned and what to do even better next year. One especially important aspect to evaluate is your enrollment technology.

Enrollment technology, once a laggard in our industry, is catching up fast. Employers and employees are demanding better digital solutions, and this past year only helped solidify that trend. To meet this demand, numerous companies now offer enrollment technology tools, and these tools are becoming increasingly advanced. As a result, brokers now have a wide selection of options to support their clients' enrollment needs.

But out of all the enrollment technology tools out there, how do you know which one to choose? Maybe you're stuck with a system that leaves something to be desired, but you aren't sure what to try instead. Or maybe you haven't settled on one tool yet and have been experimenting to find something you and your clients like. Even if you're satisfied with your current enrollment technology, maybe you're curious if there's a better option out there. Wherever you are in the process of selecting a digital enrollment solution, there are a few key considerations that can help you find the right tool for your needs.

HOW BIG IS YOUR AGENCY?

The best enrollment technology for your agency will likely depend, in part, on the size and capabilities of your staff.

Some systems are designed to meet the complex and robust needs of large, tech-savvy teams. On the other hand, smaller agencies may be better served by a system that is quick and easy to set up, cost-effective, and user-friendly for employees. Tools that focus on supporting efficiency and speed — for instance by reducing paper and making the submission process faster — can help smaller teams optimize their time and resources.

Regardless of the size of your agency, the roles and capabilities of your team members are also important to consider. For example, a feature-rich, highly customizable system may be more practical if you have IT professionals on staff. Similarly, if your team members are pressed for time, you may want to look for a solution supported by a general agency that will take on most of the labor for you.

WHICH TYPES OF INSURANCE DO YOU SELL?

No matter how great your enrollment technology is, it will be less beneficial if it isn't compatible with your products. With this in mind, it's also important to consider which carriers you work with and what kinds of benefits you sell.

Your carrier partners have their own technology systems. If your enrollment technology delivers information in a format that doesn't integrate well with their existing programs, it will make more work for everyone. On the other hand, some systems make it easy for carriers to directly upload content in their preferred format, streamlining the process and getting ID cards into employees' hands faster.

In addition, it will save you and your clients time and effort if enrollment for all of your products can be completed within a single system. If your clients have to log in to multiple programs to complete enrollment, it can create confusion and delays.

WHAT ARE YOUR CLIENTS' PRIMARY NEEDS?

You don't have to pick just one solution for your agency. One size does not fit all when it comes to enrollment systems. You need to really look at the sizes of the groups, the products being offered and how your clients will use the systems to determine the best options. Even if you've found an enrollment tool that everyone at your agency loves, it won't do you much good if your clients don't love it too.

For example, a certain system may be the best solution for a larger group that is enrolling in products beyond medical, dental and vision — for instance 401(k), HSA, HRA and worksite plans. This group may also want a full-scale HRIS system that can incorporate things like time and attendance, payroll integration, employee onboarding, HR solutions and ACA reporting. But if you also have clients that are just looking for a more efficient way to enroll in their benefits, a robust, complex system like the one previously described would probably not be a good solution. The idea is to keep it simple and offer them the solution that serves their needs most effectively.

Additionally, consider how much time and effort your clients and their employees will need to put into the process. In most cases, the more streamlined and self-explanatory the process is, the better. For example, not all online enrollment systems include a master application, meaning the employer will have to fill out that information by hand before employees can complete their enrollment digitally. Something as simple as selecting a tool that includes an online master application can make a big difference in ease-of-use for your clients.

The simpler the tool is for your clients to use, the less back and forth there will be — which saves time for everyone. There are even tools that don't allow employees to submit their applications if the information is incomplete, further eliminating the need for multiple phone calls and emails to track down essential details.

If possible, it's always a good idea to ask your clients about their enrollment technology needs. Keeping an open dialogue with your clients will ensure that you accurately anticipate their priorities and that your enrollment technology continues to deliver the desired results.

WHAT ARE YOUR TOP PRIORITIES?

Every agency is different, and the technology that works best for your competitor may not be the one that works best for you. Of course, certain concerns, like security, are important for everyone. But other priorities can differ significantly.

When looking at your options, one thing you should consider is how much time it will take you to set up a new group, or renewal, and how much time will be spent staying up to date with ongoing maintenance like adds and terms. You will likely want a system that minimizes the amount of data you have to enter yourself. It is also important to find out what types of support and training are offered on an ongoing basis.

In addition, depending on your other technology tools, you may want an enrollment technology system that integrates well with programs you already use. If this is the case, you'll need to balance compatibility with your other enrollment technology priorities.

Ultimately, the goal of enrollment technology is to make life easier for you and your clients. But if you choose the wrong tool, the system intended to simplify the process can end up adding even more difficulty and confusion. By weighing considerations such as the size of your agency, the products you sell, your clients' needs and your other top priorities, you'll be able to choose the enrollment technology solutions that consistently support your success.

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Supporting Employee Health Requires a Focus on Whole-Person Wellness

BY
CHERYL MORRISON DEUTSCH

We have a habit of seeing mental and physical health as two separate conditions. We compartmentalize the way we think and speak about each daily. The articles we read regarding just one or the other, apps we use to manage either, or the professional counsel we seek for support — whether it's a trainer at the gym or a therapist. In reality, the two are very much connected, two halves of a whole that make up our overall health and wellbeing.

Think about the last time you did not get enough sleep and your ability to work the next day was impaired. Or when you experienced muscle tension and an upset stomach due to stress. Or if you've experienced weight gain and suffer from insecurity and anxiety as a result. It is not hard to recognize the impact one has on the other.

Viewing mental health and physical health as connected is not a new concept. The World Health Organization (WHO) has always included mental wellbeing as part of its definition of health:

"[Health is] a state of complete physical, mental and social well being and not merely the absence of disease or infirmity," WHO states. "Neither mental nor physical health can exist alone. Mental, physical, and social functioning are interdependent. Furthermore, health and illness may co-exist."

For many of us, this connection between our mental and physical health was never more apparent this

year, when COVID-19 simultaneously struck a hit to both. Take for instance the 30-year-old woman who started telecommuting, as did her husband, and was suddenly forced to balance her work and home lives in a different way. With limited time for herself, this might have led to increased stress, and maybe she started upping her snack intake as a result. Pair that with less gym time during lockdown, and she is now struggling with numerous areas of her health.

Everyone deals with stress in different ways. This year many of us may have relied on unhealthy coping mechanisms without access to our usual resources. High levels of stress and anxiety can lead to a laundry list of physical repercussions, including sleep trouble, unhealthy cravings, loss of motivation to exercise, chest pains and even a weakened immune system. These negative outcomes can impact businesses as much as individuals. People unable to cope with stress in healthy ways end up being less productive employees and can potentially cost the business if their current stress develops into chronic health conditions over time.

EAPS ARE NOT CUTTING IT

Companies are on the hunt for resources that can help employees adapt to changing conditions. One option is Employee Assistance Programs (EAPs), which are designed to help employees address the mental distress surrounding a variety of crises that arise in life, from family problems and substance abuse to workplace performance issues.

But EAPs have several shortcomings. They can be incredibly complex and confusing to navigate (especially while experiencing mental distress) and are often targeted at very specific scenarios. In fact, little evidence exists to demonstrate that EAPs are effective in serving the goal of employers to maintain productive, healthy and well employees overall.

Failing to provide the level of support employees need when they need it most, many employers have started to lose confidence in EAPs.

To ensure employees are healthy, happy, and ready to take on this new world, employers need to offer solutions that are easy to use — that employees will actually use — and that are specifically designed for general stress and anxiety, including its mental symptoms, as well as their physical implications.

VIRTUAL BEHAVIOURAL CARE TO THE RESCUE

So, what does an effective, easy-to-use, and engaging support program look like in the world we live in today? One consideration — and a particularly important one in our 'new normal' — is that these programs should have the ability to be delivered virtually. Brokers need to be thinking about how remote care and wellbeing support can fill the gaps in existing benefits programs.

Luckily, care providers and consumers alike jumped into telehealth with both feet this year. Recent research reported nearly 80% of varying specialists increased their use of telemedicine technology in response to COVID-19. More good news is that digital support programs serving mental health exclusively are also on the rise, with 10,000 mental health apps now available today. But there's still a gap to fill — what's missing in an all-encompassing program that accounts for both mental and physical health, giving equal weight to both sides of the coin.

The best programs are those that take whole health into account, recognizing how our bodies and mind connect to either help or hurt us. They focus on helping users develop coping skills that can reduce negative mental and physical health symptoms during these challenging times. Ideally, a few factors should come together:

- **Broad scope:** So many applications zero in on one specific goal — whether its weight loss, relaxation or better sleep. And these are great if your goals are hyper-specific. But platforms that account for whole-person wellness, spanning stress management, sleep, nutrition and fitness, can yield a bigger impact on overall wellbeing.

- **Personalization:** Everyone's life situation is different and the way we respond to stressors are different too. Programs need to meet people where they are and be able to adapt to their specific personal needs.

- **Human connection:** We've all used apps with automated "motivation" before. But bots can only get you so far. Live outreach from real-life coaches who come to know us and what motivates us, can help keep employees engaged in their health and wellbeing long-term.

- **Technology integration:** Not everyone wants or can afford to buy the latest and greatest health tech device. Digital programs should be compatible with the devices that employees already use in their day to day lives.

Even in the most difficult of times, staying healthy — physically and mentally — is possible. It just might look a little different and require an added dose of mindfulness. By including mental and physical wellness programs — delivered virtually — in their benefits portfolios, brokers can give employers and their employees what they need, when they need it most.

CHERYL MORRISON DEUTSCH, *President and Chief Experience Officer, Zillion, has been a leader at the intersection of healthcare and technology throughout her career. She has been responsible for the delivery of multiple innovative offerings that connect clinicians and patients. She has over 25 years of experience in translating business and technology requirements into actionable plans to provide a superior user experience. Prior to joining Zillion, Cheryl served as executive director of Customer Experience, Collaboration and Transformation at Kronos.*

Helping Employees Go "Next Level" When It Comes to Financial Wellness

BY DENNIS HEALY

In characterizing 2020, many have said, "We are all in the same storm; we are not all in the same boat." Our experiences and the long-term impact can be tremendously different. Similarly, employees move through varying levels of financial wellness across different stages of their lives, from starting their careers to nearing retirement — and through myriad ups and downs along the way. For employers that want to provide programs and benefits that address employees' personal fiscal needs and goals, there is usually no one-size-fits-all approach.

However, there is a common denominator when it comes to financial wellness, or the lack thereof: more employees than ever admit to being stressed about their financial situation. And according to PwC's 9th annual Employee Financial Wellness Survey, more employees say that financial matters cause them the most stress than any other life stressors combined.

The need for an increased focus on employee financial well-being comes at a time when they may be in a very different place than they were just a year ago. The stress and uncertainty in dealing with the coronavirus pandemic has illustrated that for many Americans, one medical disaster, accident or stock market dive could mean going from financially solvent too deep in debt overnight.

How do your clients define financial wellness, and is it a priority for them? Furthermore, what can you do to ensure they are able to proactively provide the programs and tools, especially during these challenging economic times, to help their employees reach that next level?

FINANCIAL WELLNESS DEFINED

The term "financial wellness" generally refers to an individual's financial health and the process of understanding how to knowledgeably manage their assets. Cautioning that traditional measurements such as income and net worth don't always tell the full story, the U.S. Consumer Financial Protection Bureau (CFPB) expands on the definition of financial well-being, adding such factors as:

- Having an ability to meet financial needs day-to-day and over time
- Having the capacity to absorb a financial shock
- Feeling secure in the financial future, and/or
- Having the financial freedom to make the choices that allow you to enjoy life.

GAUGING THE VARYING LEVELS OF FINANCIAL WELLNESS

As employees come in to work each day, they've got a lot on their minds from a financial perspective. Among the most pressing questions is how they'll pay their bills and

meet their essential financial obligations. In the aftermath of the pandemic, it makes painfully clear for many the importance of fundamental financial planning concepts, like managing cash flow, addressing debt challenges and saving for emergencies. Yet for employers, it's often difficult to determine what employees are going through — as people usually don't enjoy talking about their financial status and struggles.

Here are some illustrations that may help you visualize employees' financial frame of mind – and some of the actions they may be taking (or putting off) – to gauge their different levels of financial well-being:

- **Financial survival:** Struggling with paying bills, credit card debt that can't be paid off each month. Constantly searching for the means to pay for essential items (food, gas, rent/mortgage) and living paycheck to paycheck. No emergency savings started and no financial plan in place. Potentially depleting retirement accounts to cover shortfall.
- **Financial management:** Taking initial steps to analyze spending habits, creating a budget (like 80% of Americans) and starting to save for emergency situations, such as car repairs or medical bills. Also forming an action plan to pay off credit card debt and other bills. Saving more proactively for retirement.
- **Financial direction:** Has met or plans to meet with a financial planner or advisor. Implemented both a short-term and long-range financial plan and is investing regularly in a retirement savings plan. Has more fiscal flexibility to take on new endeavors, like a remodeling project or a family vacation.
- **Financial freedom:** Through disciplined and proactive financial management over time, the employee has minimized debt while maximizing savings potential, can look forward to a comfortable retirement, has created an estate plan as well as arrangements for long-term care, and as the CFPB suggests above, is enjoying life to the fullest without financial worries.

WHAT YOUR CLIENTS CAN OFFER TO HELP EMPLOYEES GO TO THE "NEXT LEVEL"

More and more employers are recognizing the need for employees to take control of their personal finances and the impact on their overall well-being. In response, workplace financial wellness programs are offered by 53% of firms, twice as many as four years ago, according to Bank of America Merrill Lynch. Keeping the above financial categories in mind, what programs or benefits can your clients offer their employees to help them go "next level" when it comes to financial wellness?

A pivotal first step is to find programs that offer the information and assistance employees are actually looking for. Though the vast majority (91%) of workers who have participated in office programs spoke to their overall effectiveness, there can be a disconnect between what employers offer and what people are seeking help with. For instance, employers surveyed believe that budgeting and handling income or expenses are the most important financial skills, while employees prioritize saving and investing for the future.

Consider this: workers would also like to focus on individual items one step at a time, while companies are instead looking more holistically at the impact of employer benefits on overall personal finances. So, start by better understanding your employees' priorities and different levels of financial literacy. This could be done through employee surveys and workplace assessments.

The CFPB offers these additional suggestions for clients to help their employees improve their financial wellness. These considerations include:

- Making your financial wellness program an ongoing education experience proves to be much more effective than a "one-and-done" program. Create multiple touchpoints over an extended period of time to create behavioral changes.
- Connecting employees to "just-in-time" information that is timely, relevant and actionable is important. People are more likely to pay attention if the information is connected to an important life event or their desire to achieve a goal.
- Keeping your presentations and content short. Webinars and seminars should be less than an hour and printed materials should be brief.

Part of your solution to help employees improve their financial wellness may be right in front of you. The CFPB suggests reviewing existing human resources programs and employee benefit resources that can be leveraged as part of your financial wellness program. For example, your organization's financial, banking or life insurance partners may have tools, programs or websites designed for your employees that you may not be fully promoting.

Also consider what benefits could supplement your existing programs – and help employees get a leg up on the financial wellness ladder. This could include offering benefits like a student loan repayment plan that can help employees eventually break free from college loan debt and focus more on savings goals.

Another benefit to consider offering is legal insurance. It helps mitigate financial risk as it often includes a financial education feature that could contribute to employees' financial wellness. Legal insurance plans can provide assistance for employees facing debt issues, needing financial counseling and looking to set or meet financial goals, among other things.

Helping employees get to the next level of their financial wellness is a win-win initiative for both you and them: they achieve more financial goals, which in turn leads to less stress both at work and at home. Plus, you open the door to higher levels of employee well-being and workplace productivity in the process.

DENNIS HEALY *is a passionate advocate for legal insurance because he has seen firsthand how it helps people receive the protection and legal help they need. He has nearly 30 years of insurance industry experience, with a primary focus on the sale of group voluntary benefit products to employer groups of all sizes through the broker and consultant community.*

Disability Claims – From There to Here

BY ART FRIES

Disability claim departments have made great inroads regarding the processing of disability claims over the past 30 years. Prior to then, the disability claim process was simple from both the carrier's end and the claimant's end. There was a simple form for the claimant to complete as well as the attending physician statement. Tax returns were not requested and there was very little support from physicians, C.P.A.s or other consultants within ("in house") or from outside independent consultants.

It was common for larger cities to have local claim managers and a staff of local claim adjusters. Many claims were decided on a local basis with little interference from the home offices. If a claim involved a certain amount of dollar value that was a significant number, usually home office approval was required. Local brokers who sold disability insurance often had relationships with the local claim managers and a broker with a large book of business might have some influence in the decision process. I can even recall a claim whereby the client had just purchased a disability policy and then went on claim several months thereafter. The claim sounded "fishy" to me and I communicated such to the local claim manager — who was appreciative of my feedback and after an investigation of the case denied the claim appropriately.

Sometimes a call to a vice president at the insurance company might have been warranted on behalf of a claimant

In spite of the many improvements made in the claim process on the part of claim departments and third party administrators, there is still a huge lack of conformity in the wording of claim forms...

who appeared to have a legitimate claim. Those were the days when relationships mattered and there was a degree of trust between producers and insurance company claim departments.

Those days, of course, are long gone. Now it is almost impossible to determine who the claim manager is for a particular insurance company. As a member of a group of "heavy hitters'' who sold a substantial amount of disability policies, mostly to professionals, I enjoyed the quarterly meeting of some 8 to 10 of us who were privy to changes that would soon occur in the industry before that information was available to the general producer audience. Having a local marketing manager or local claim manager for a particular insurance company talk in front of our group was indeed a pleasure and most informative. Although there was healthy competition between the various companies as well as those who were selling disability products, there was an unusual camaraderie that enabled us to want to be the most informed and the best at our craft.

In spite of the many improvements made in the claim process on the part of claim departments and third party administrators, there is still a huge lack of conformity in the wording of claim forms. Many forms have archaic and confusing wording. Some of the questions hope to confuse the claimant as well as the attending physician and at best are ambiguous in nature. The result is confusion on the part of the claimant as well as the attending physician. In turn, a confusing question receives a confusing answer. Some questions are repeated over and over again on the forms, hoping the respondent will provide inconsistency in their answers. And some questions require a "rephrasing of the question" by the claimant in order to give an intelligible answer.

Sometimes I see independent medical evaluation (I.M.E.) reports that smell of "boilerplate language" with very little effort put forth by the physician hired to be "independent" but are often influenced by the insurance carrier so as to be hired on other future claims.

I see physician questionnaires sent to dentists and chiropractors that have nothing to do with their duties. Or an attending physician statement (APS) sent to the claimant with the expectation that their physician/medical provider will complete the same with a degree of accuracy. And the APS might be completed by a physician's assistant or "insurance person." And none of these individuals has any clue as to how to complete these forms since they never received any training or completed a course (there are none) on how to complete this type of form. And they do not know the difference between the contractual wording of an individual policy, group or association, State disability, Social Security disability, or Workers' Compensation.

There are "medical review people" — often physicians (employees of the insurance company or outsourced) — who provide medical opinions on claimants that they have never seen or spoken with.

For those claims that appear to be solidified and of a long-term nature, it seems that having the claimant complete a monthly "progress report" (or claimant's continuation statement) is a waste of time and money and just an additional hassle for a claimant. Often with my own clients for whom I provide disability advice, I can provide guidance on how to submit forms less frequently; however, they should not have to ask me for this type of advice.

Sometimes "common sense" seems to be lacking on the part of the claim person. It is typical to see a change in claim personnel handling a claim over a period of years. Most of the time, they do not have the time to read the claimant's file from the beginning, so they merely glance at it. Then they "lean" on the claimant with requests for more frequent forms or exams and field investigations when a proper read of the file would have shown that they were just "spinning wheels" with no opportunity to terminate a solid claim.

These are just some of the obstacles that have been set up to prevent disability claimants from receiving claim approval or termination of benefits. Advice is clearly required in order for a disability claim to be presented to the insurance company in a clear, concise fashion. And continuing advice is needed to make sure the claimant is prepared for the battle that lies ahead. Although far and few between, there are those who can provide advice, for a fee of course, to claimants in a consult capacity.

ART FRIES *is a disability claim consultant providing advice on a national basis in the U.S. He is located in Nipomo, Calif. He can be reached at 800-567-1911, e-mail:* **friesart@hotmail.com***; website:* **www.afries.com.**

Inside Versus Outside Buyers

BY PHIL CALHOUN

Transferring commissions to employees, inside buyers, often seems the easiest way to exit as the owner. In all cases inside buyers cannot pay you out with a one-time payment and will need to pay over time. So, it is critical that commissions continue as projected. With an inside sale it is vital to have a Plan B ready if something happens to key employees. I suggest consulting with an objective business advisor to assess your employee's abilities and gain an objective analysis of their potential. Performance must be tied to the purchase.

I have found the focus when considering an inside sale turns to address the payout and how the following impact the payout: new revenues added via group client growth, cross selling of plans to existing clients, commission rate increases for any reason, new client referrals from long term clients, or loss of clients for various reasons.

Be careful when putting a deal together that you avoid going too informal. Avoid verbal statements which can come back and haunt you and your deal. Trust only goes so far and can blow up a deal when losing sight of any balance. Get the agreement in writing and have employees seek legal counsel and other advice.

Outside buyers are totally business and facts based. What is written is negotiated and then backed with a legally signed agreement. While inside buyers know all of the secrets, they may not give as much credit to the numbers, financial trends, and relationships built over time. The bottom line is you want to get paid and avoid any subjective issues which can significantly impact the value of a deal.

Contact me for ideas on preparing to "sell" commissions through a planning process.

Go to www.commission.solutions for more information or call 800-500-9799 or email phil@integrity-advisors.com

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You'd really be helping out OCAHU member Phil Calhoun if you'd answer his three-question survey about commissions. Phil is writing about protecting, growing and selling commissions for Cal Broker this year and he's planning to offer CE courses and boot camps for brokers. You can remain anonymous with the survey or you can share your email and receive a link for a free e-book. You may also be included in a drawing to receive a copy of "The Health Brokers Guide to: Protect, Grow and Sell Commissions" by Phil Calhoun. Go here for the survey: https://forms.gle/Yd9fEyTBKLqdm8jh9

PHIL CALHOUN *is president of Integrity Advisors. Phil and his team provide personal coaching on business planning for brokers. Phil's team includes legal and accounting professionals with experience working with brokers and health agencies. For ideas on growing commissions go to www.commission.solutions. You can also call Phil at (800) 500-9799 or email* **phil@integrity-advisors.com.**

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