INSIDE: WHY THE NEW DRUG PIPELINE WILL MAKE YOU RETHINK YOUR PBM STRATEGIES | UNDERSTANDING CALIFORNIA'S UNIQUE MEDIGAP RULES

CALIFORNIA BROKER

VOLUME 39, NUMBER 9

Serving California's Life [illegible] Planner

11 MILLION NEW PET OWNERS!

$99 billion spent on pets!

Pet insurance growth at 700%!

Hey, we're all ears!

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CALIFORNIA BROKER

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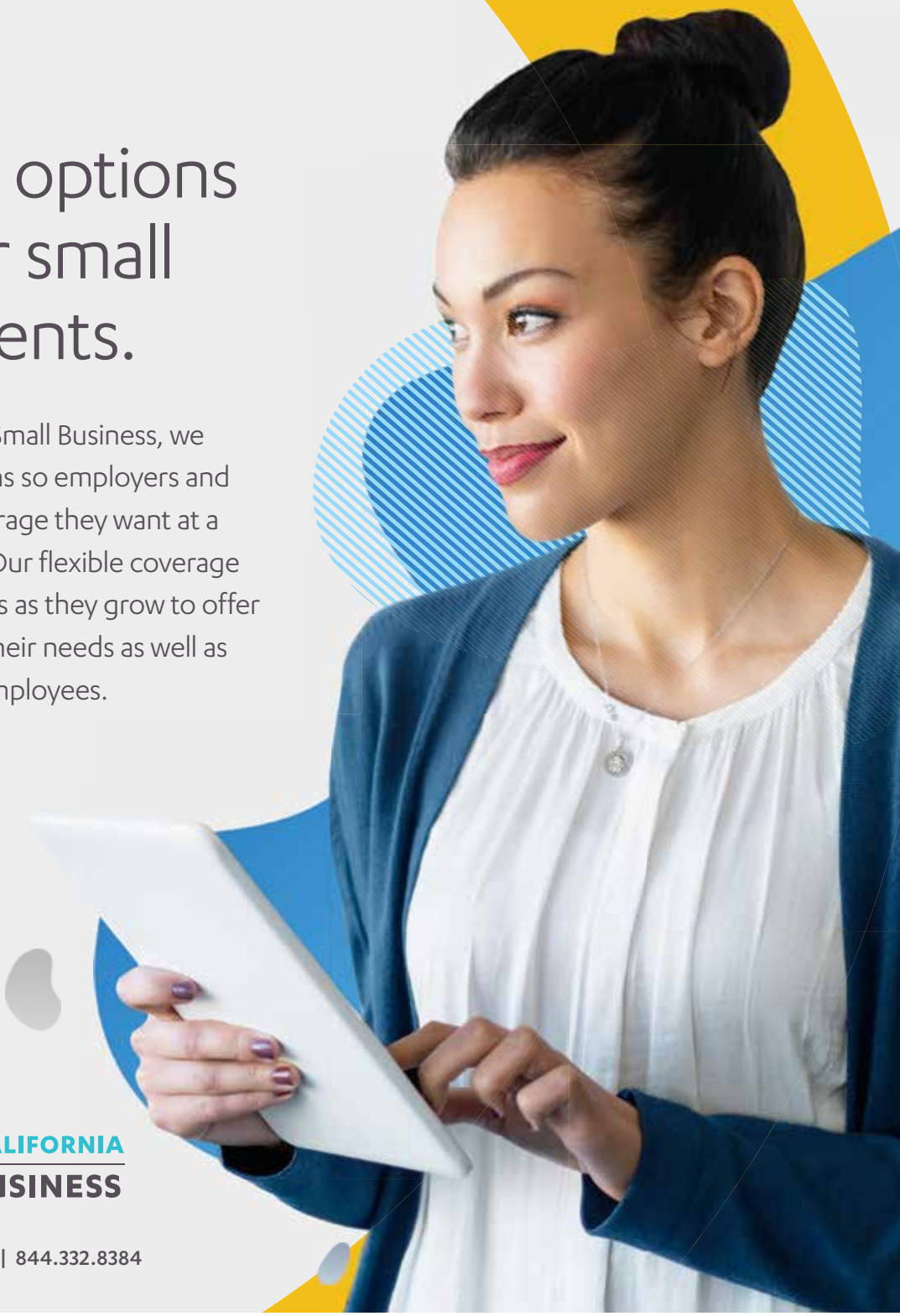
JUNE 2021

Health plan options that fit your small business clients.

With Covered California for Small Business, we help tailor health plan options so employers and employees can get the coverage they want at a price that fits their budget. Our flexible coverage options work with businesses as they grow to offer coverage that will adapt to their needs as well as care for and retain quality employees.



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IN EVERY ISSUE

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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Charlie with Thora Madden at the 2019 Senior Summit at Pechanga.

Goodbye, Charlie

Many readers met — and loved – little Charlie, Associate Editor Thora Madden's constant companion and Cal Broker's conference mascot. Sadly, we said good-bye to Charlie this year. We dedicate this issue with the pet survey compiled by Thora to Charlie's memory. She was a sweet and loyal companion.

RIP Charlie Jan. 30, 2012 - Jan. 2, 2021

Monoclonal Antibodies Bring More $

Have you noticed all the television commercials lately suggesting that COVID-19 patients ask their doctors for monoclonal antibodies? Well, there's a good reason! The Centers for Medicare and Medicaid (CMS) recently boosted the Medicare payment rate for monoclonal antibody infusions to treat COVID-19. Effective May 6, the national payment rate is $450 for most healthcare settings, up from the previous rate of $310. That explain$ that.

Sutter Health | Aetna to Expand Insurance Product Offerings in Northern California Launches COVID-19 Navigator

Sutter Health | Aetna announced its plans to offer fully insured products to employers across Northern California for the 2022 enrollment season. The announcement follows issuance of a Certificate of Authority from the California Department of Insurance (CDI), designating the joint venture healthcare company as an independent insurance carrier in the state.

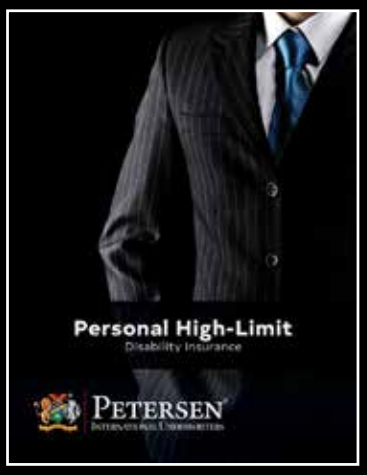
Sutter Health | Aetna currently offers self-insured Exclusive Provider Organization (EPO) and Preferred Provider Organization (PPO) commercial health plans to large employers in its 16-county service area. Today, if an employer wants a fully insured product, it must select an Aetna plan that includes the Sutter Health | Aetna performance network. Upon CDI approval, the joint venture will be able to sell its own fully insured products to employers.

HIGH LIMIT DISABILITY

Individuals annually earning in excess of $500,000 need disability benefits that can keep pace with their affluent lifestyle - they need High Limit Disability. The benefits of a recently-insured surgeon, making $1,100,000 consisted of:

- **$10,000/month Group LTD**
- **$15,000/month Individual DI**
- **$32,000/month High Limit DI**

Call **(800) 345-8816**
or
visit **www.piu.org** for more information.



Occupation: **Surgeon**
Age: **51**
Income: **$1,100,000**
Total Benefit: **$57,000/month**

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UnitedHealthcare Announces Upgrade to Integrated Plans

Enhancements to its integrated health plans include:

• Potential Premium Savings and Net Cost Guarantee.

For employers with self-funded health plans (more than 300 employees) that integrate medical and specialty benefits, UnitedHealth now offers a Net Cost Guarantee. Employers receive an administrative fee credit if actual health care costs exceed projections. Separately, the premium savings program uBundle® enables certain employers with fully insured plans to save up to 4% per year on medical premiums when combining UnitedHealth's medical plan with specialty benefits such as dental, vision, life, disability and supplemental health coverage (accident, critical illness and hospital indemnity plans).

• Launch of UnitedHealthcare Benefit Ally™.

Benefit Ally is designed to simplify payouts for employees whose employers combine three supplemental health plans with medical benefits. Following a qualified accident, critical illness diagnosis or hospital stay, Benefit Ally automatically triggers a payout to the member—all without the plan participant having to submit a claim or additional paperwork.

• Expanded Resources for Employers.

Later this year, vision, dental and financial protection aggregate claims information will be added to Health Plan Manager™, an interactive online tool. The tool enables employers to analyze and understand health data.

COVID-19 Delays REAL ID Enforcement

Did you forget about the new REAL ID requirement for airline travel? Well, that's okay because the U.S. Department of Homeland Security announced an extension of the REAL ID deadline from Oct. 1, 2021, to May 3, 2023.

Oscar Launches +Oscar

Insurtech company Oscar Health announced its launching a new business called +Oscar. The new business will offer providers and third-party payors access to Oscar's tech-enabled insurance platform.

EVENTS

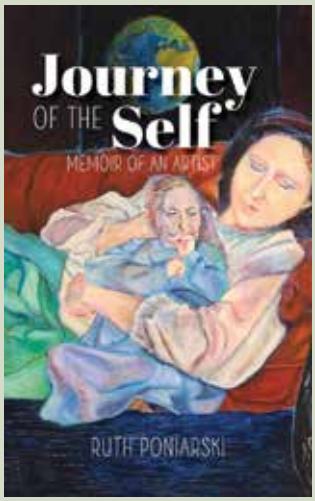
IICF International Inclusion in Insurance Forum
June 15-17. Info at IICF.org.

NAHU Annual Convention & Grow Your Business Expo, theme is "The Path Forward"
Virtual June 27-29, info at nahu.org.

BenefitsPro Broker Expo
in person in San Diego, August 16-18.
Save 15% with promo code RIGHTPLAN. Info at Benefitspro.com.

American Association for Medicare Supplement Insurance
National Medicare Supplement Insurance Industry Summit
Sept 8-10, Schaumburg Convention Center, Chicago area. Info at medicaresupp.org.

GOOD READ: Memoir Details Author's Journey with Mental Illness and Disability



During Mental Health Awareness month in May, much of the talk has been about reducing the stigma of mental illness. We recently received a book that goes a long way toward that. Ruth Poniarski's new book, "Journey of the Self: Memoir of an Artist," is a beautifully honest memoir that's a must-read if you want insight into what it's like to struggle with mental health. The book has received glowing reviews, including a Kirkus Star review. Poniarski, diagnosed with psychosis, schizophrenia, severe anxiety and bipolar disorder, nonetheless has become an accomplished artist. Find out more about Ruth and see her art at ruthponiarski.com. "Journey of the Self" is available on Amazon and at other bookstores.

Golf for the Greatest Cause

The Insurance Industry Charitable Foundation is hosting its annual Insuring The Children Golf Tournament on September 14 at Arroyo Trabuco golf course in Orange County. Proceeds help fight child abuse and neglect. What better reason to golf!? More info at iicf.org.

New Tech Helps Transition from Fully to Self Insured

Advanced Medical Strategies (AMS), a healthcare IT company that provides clinical insights and financial analysis of medical diagnoses, announced the launch of CensusRater. Housed on the AMS Predict Platform, CensusRater uses real-time claims data that empowers brokers to quickly assess a group's total claims cost at varying specific deductibles, based solely on census data. CensusRater solves data gap problems by comparing a group's census data to the actual claims of similar sized groups, in similar states, by age and gender, with similar claims rates.

CB's 2021 survey of PET INS

A Q & A WITH THE TOP DOGS

When we learned that there were 11 million new pet owners in 2020 (who, by the way, spent $99 billion on their pets) and that pet insurance had grown by a whopping 700%, we were all ears! So, **Cal Broker** reached out to the top dogs in the pet industry to find out what's happening and why.
Here's the scoop from the leaders of the pack!

SURERS

COMPILED BY **THORA MADDEN**

Top Dogs

MILES THORSON
CEO & Co-Founder, Odie Pet Insurance

BETH WYMER
Animal Health and Insurance Expert, Pumpkin

DR. SARAH MACHELL
Medical Director, Vetster

CALIFORNIA BROKER: WITH SO MUCH HAPPENING IN THE PET BENEFITS SPACE, WHAT SETS YOUR COMPANY APART?

Miles Thorson, CEO & Co-Founder, Odie Pet Insurance:

Odie is a wellness first, tech-enabled pet health insurance brand that empowers conscientious pet parents. Our aim is to democratize pet wellness and to provide all dog and cat owners access to essential pet care services through a centralized digital hub.

> **Pet ownership has skyrocketed to unseen levels ... accelerating the need for quallty pet insurance. ... Odie provides access to essential pet care services through a digital hub.**
>
> **— Miles Thorson, Odie**

Beth Wymer, Animal Health and Insurance Expert, Pumpkin:

Pumpkin is a direct-to-consumer pet insurance agency and wellness provider founded to help ensure pets live their longest and healthiest lives. Pumpkin insurance plans offer dog and cat owners advanced veterinary care coverage. Our optional Preventive Essentials non-insurance plan add-on offers life-threatening disease prevention through reimbursing vaccines and related annual wellness exams and lab tests.

Dr. Sarah Machell, Medical Director, Vetster:

Vetster is not an insurance plan—we actually connect pet owners to thousands of licensed professionals ready to provide online pet care through video, chat and voice-enabled appointments, 24/7.

Jacinta C. Mathis, VP of Growth, Wagmo:

Wagmo is a tech-first pet insurance company with easy-to-understand plans, super-fast claims processing and community benefits. Wagmo goes beyond what typical pet insurance companies cover and reduces pet expenses while growing a resourceful community and suite of services to empower humans to be their best pet parent selves.

CB: HOW HAS THE PANDEMIC IMPACTED YOUR BUSINESS?

Thorson, Odie:

The pandemic has positively impacted our business in several ways. Pet ownership has skyrocketed to unseen levels over the past year. This record increase in pet ownership coupled with pet parents being at home more has greatly accelerated trends around the importance of pets and the overall need for quality pet insurance.

Wymer, Pumpkin:

Pumpkin launched during the pandemic in April 2020. It ended up being an opportune time. While many businesses suffered during this difficult time, the pet care industry was rapidly growing because of a 700% increase in pet adoptions and fosters at the beginning of the pandemic. Eleven million people adopted pets during this time, and the pet care industry reached $99 billion in sales in 2020.

JACINTA C. MATHIS
VP of Growth, Wagmo

Machell, Vetster:
The pandemic catapulted the need for virtual pet care across North America. Currently, vet clinics are so over-booked that animals needing access to prescriptions and treatment plans are having to wait weeks, which has the potential to impact survival rates. Pet owners shouldn't let wait time concerns get in the way of booking a vet appointment for a sick pet. Many appointments and medications can be performed and administered right from home! Vetster is here for all pet parents, whether their regular vet is fully booked or not accepting new patients, we offer accessible pet health care around the clock.

Mathis, Wagmo:
The pandemic has changed our families and communities in a tremendous way. During this time Wagmo has expanded partnerships and offerings to truly support the complete needs of pet parents.

CB: HOW IS YOUR REIMBURSEMENT CALCULATED? IS IT A PERCENTAGE OF THE VETERINARIAN'S BILL (IF SO, WHAT PERCENTAGE), OR AS A PERCENTAGE OF A BENEFIT SCHEDULE?

Thorson, Odie:
Reimbursement is calculated as a percentage of the overall vet bill. This can range between 70%-90% depending on the policyholder's tailored plan.

Wymer, Pumpkin:
We reimburse 90% of eligible vet bills after the annual deductible has been met. Pumpkin's add-on preventive care plan refunds 100% of eligible preventive vet care costs. There is no deductible amount or waiting period for this optional plan that can only be purchased with the insurance plan.

Mathis, Wagmo:
Wagmo offers 100% reimbursement on veterinarian bills for qualifying expenses after the deductible is reached.

CB: CAN A MEMBER CHOOSE ANY VETERINARIAN?

Thorson, Odie:
Absolutely. Odie provides pet parents with maximum flexibility and the freedom to work with their preferred veterinarian.

Wymer, Pumpkin:
Unlike a human health insurance HMO, Pumpkin's pet insurance coverage isn't limited to a "network" of health care providers. Since we pay you back directly, your pet is free to receive treatment from any licensed veterinarian, specialist, emergency clinic or hospital you choose in the U.S. or Canada.

Your pet is free to receive treatment from any licensed vet, specialist, emergency clinic or hospital you choose.

— Beth Wymer, Pumpkin

Machell, Vetster:
Pet parents looking to book an appointment through Vetster have access to search through over 3,000 veterinarians and technicians in our marketplace to find the right fit for their needs. They can browse through our network of veterinary professionals and select a partner that speaks their language, treats their pet's species, and is located within their region to potentially offer a full diagnosis, treatment plan and prescriptions, when needed.

Mathis, Wagmo:
Wagmo Insurance and Wagmo Wellness are reimbursement-based and a member can choose any veterinarian for service. Members can upload images of their receipt to our mobile app or website for claims processing and reimbursement.

CB: DOES YOUR PLAN USE A BENEFIT SCHEDULE?

Thorson, Odie: The Accident & Illness policies do not have a benefit schedule. Our Routine Care plans that can be purchased as an optional add-on do carry set benefit schedules for things like vaccinations, heartworm medications, microchipping and more.

Wymer, Pumpkin:
No, we don't use a benefit schedule.

Mathis, Wagmo:
Wagmo does not follow a benefit schedule for insurance, and covered claims are reimbursed at 100% after the deductible is met.

CB: WHAT PRE-EXISTING CONDITIONS ARE NOT COVERED?

Thorson, Odie:
We define a pre-existing condition as any condition for which a vet provided medical advice, the pet received treatment for, or displayed signs or symptoms of the condition prior to the policies effective dates or during the

waiting periods. Odie has some of the shortest waiting periods including three days for accidents, 14 days for illnesses and six months for cruciate ligament events.

Wymer, Pumpkin:

Illness, disease, injury or change to your pet's health that first occurs or shows symptoms before coverage is effective or during a waiting period are considered pre-existing conditions and are not covered. However, Pumpkin has what's called a "curable conditions clause" in which "pre-existing" conditions that are curable, cured and treatment and symptom-free for 180 days, can be deemed cured and therefore no longer excluded, with the exception of knee and ligament conditions.

Mathis, Wagmo:

Wagmo Insurance does not cover the cost, fees or treatment for preexisting conditions (before coverage is active), but covered claims are reimbursed at 100% after the deductible has been met. Wagmo Wellness plans, which are offered separately from Insurance, reimburse according to a specific list of routine and preventative care expenses and are subject to maximums per expense category.

Wagmo expanded partnerships and offerings to truly support the complete needs of pet parents.
— Jacinta Mathis, Wagmo

Vetster is not an insurance plan. We connect pet owners to licensed professionals.
— Dr Machell, Vetster

CB: HOW MUCH EXPERIENCE DOES YOUR COMPANY HAVE PROVIDING PET INSURANCE?

Thorson, Odie:

Odie is new to the pet insurance market. However, our parent company and founding team have a long and extensive history of building specialty insurance programs for world class providers such as Swiss Re, AIG, Lloyd's of London, and more.

Wymer, Pumpkin:

Pumpkin is a new pet insurance agency that launched in April 2020. While the company is new in the space, it is owned by Fortune 500 global animal health company Zoetis (NYSE:ZTS). Plans are underwritten by United States Fire Insurance Company that has been in the pet insurance space for over 20 years.

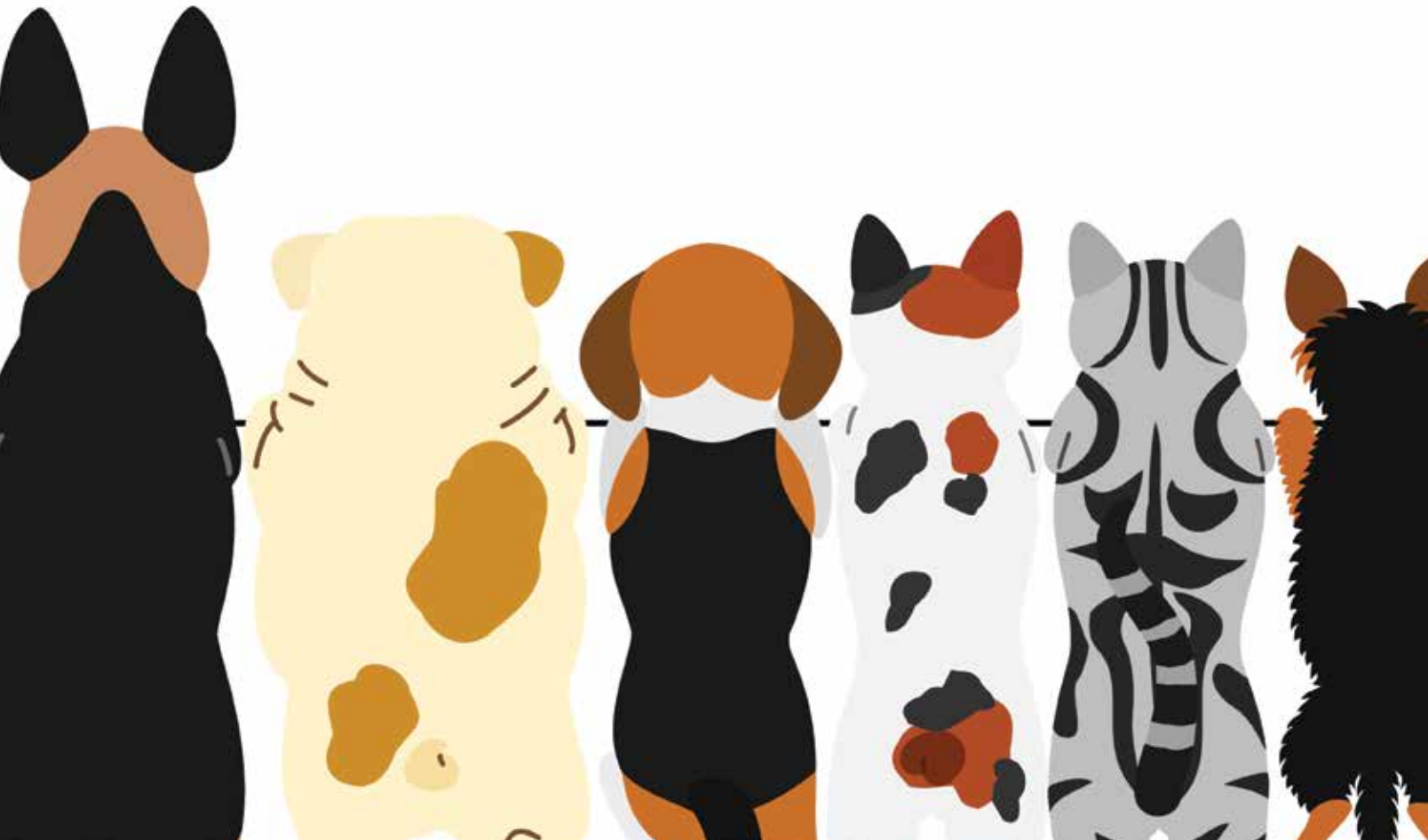
Mathis, Wagmo:

Wagmo has been in business since 2018. Co-founders Christie and Ali have worked in insurance for years and obsess over pets.

CB: DOES THE POLICY PROVIDE LIFETIME COVERAGE?

Thorson, Odie:

Odie policies do not have any upper age limits and are designed to provide coverage throughout the entire pet's life starting at just 7 weeks old.



Wymer, Pumpkin:
Yes we cover all dogs and cats beginning at 8 weeks of age.

Mathis, Wagmo:
As long as your policy is in good standing your pet qualifies for coverage throughout their lifetime.

CB: ARE THERE AGE CUT-OFFS FOR COVERAGE?

Thorson, Odie Pet Insurance:
Coverage can start for pets as young as 7 weeks and can continue for the entirety of the pet's life.

Wymer, Pumpkin:
Pumpkin is proud to offer coverage for all cats and dogs 8 weeks and older. Unlike some other pet insurance programs, Pumpkin does not have an upper age limit or breed restrictions for its policies.

Mathis, Wagmo:
The pet must be older than 8 weeks and younger than 15 years to begin coverage. If a pet has a current insurance policy and ages past 15, coverage will continue for the life of the pet.

CB: DOES YOUR PLAN OFFER DISCOUNTS ON OTHER SERVICES OR SUPPLIES?

Thorson, Odie:
Odie has established several value partnerships to contribute to the overall health, wellness and happiness of the pet and their owner. We provide access to 24/7 tele-vet services, discounts and promotions to leading pet care products including the healthiest foods, supplements and more.

Wymer, Pumpkin:
Pumpkin's optional Preventive Essentials non-insurance pack is one of the few wellness plans that cover 100% of the costs associated with an annual wellness exam, vaccines and a fecal exam. Other wellness plans may pay a certain dollar amount or reimburse for a percentage of the costs. Additionally, Pumpkin Insurance plans cover eligible treatments that some other providers' plans exclude altogether or charge extra for, like hereditary conditions, dental illness, preventable illnesses, behavioral problem treatments, and alternative therapies like acupuncture.

Mathis, Wagmo:
Multi-pet discounts, no claims discounts, and other exclusive discounts for employer groups and companies are available to complement Wagmo's affordable prices.

CB: HOW CAN READERS REACH YOU TO FIND OUT MORE?

Odie Pet Insurance:
www.getodie.com
hello@odiepetinsurance.com
877-327-0471
Live support available M-F between 8am and 5pm Central.

Pumpkin:
www.pumpkin.care
help@pumpkin.care

Vetster:
https://vetster.com/
support@vetster.com.

Wagmo:
partnerships@wagmo.io

Are You Innovating Your Ancillary Benefits Selling Strategy?

It's time to shake things up to meet the needs of a changing workforce

BY ALLEN WU

We've heard it time and time again—everything will change as a result of the COVID-19 pandemic. Every aspect of our lives was, is or will be, altered because of the events of this past year. But has that thought really sunk in and been applied to your business?

As we approach open enrollment in the fall, no longer should brokers simply go through the motions of renewing clients and simply asking if there are any changes that need to be made to a plan. It's time to be innovative, think creatively and reinvigorate your selling strategy—particularly with ancillary benefits.

MEDICAL AND PHYSICAL HEALTH CHANGES

Previously, many employers simply looked at the price of ancillary benefits as a determining factor on whether to offer the product and how much to contribute to it. However, there was not as much an understanding or focus on what exactly they were paying for or the claims process associated with employees using the benefits. Now we are seeing a shift from solely focusing on price to also analyzing those "what if" scenarios, particularly regarding what a COVID-19 hospitalization or death could do to a family if it were to happen.

For example, hospital indemnity plans are supplemental insurance plans designed to pay for the costs of a hospital admission that may not be covered by other insurance. These plans may not have been widely adopted in the past for an employer group, but now we are likely to see an increase in consideration to address the possibility of hospitalization. It's important to work with the client to determine if they should offer it as a voluntary benefit that employees can take advantage of that does not cost anything for the employer.

Additionally, preventive and health maintenance benefits will also be top of mind this year as we see a shift in consumers becoming aware of how preventative care affects the overall body, combined with a general sense of wanting to remain healthy. Due to forced closures, for example, many consumers have not been to the dentist in over a year. As they return for those overdue cleaning services, we can expect to see a significant increase in claims.

Currently, carriers are analyzing and making prevention-related actions, such as covering cleanings up to four times a year for dental or expanding calendar years to adapt and help consumers catch up from 2020. Because we are likely to feel the impacts of 2020 for years to come, consider working with clients to determine how to incent members to be more proactive in their preventative care and then support it through ancillary benefits.

THE GROWING NEED FOR WORKSITE BENEFITS

While many employers are evaluating and addressing medical offerings, there is an entirely other side of an employee's health that should be considered. This year, it is critical to begin conversations with your clients on worksite and non-medical related benefits.

Ancillary benefits that are expected to grow in popularity are income

protection plans as well as long-term and short-term disability coverage. Some carriers do not include COVID-19 as a critical illness or a disability that would be covered under these plans. Others are beginning to evaluate their plans from that perspective and revising the rules around what is included and what is, not related to paying an employee that may not be able to work due to the virus. We need to consider the lingering and long-term effects this virus can have on a person's health and the potential disabilities down line, which will directly impact these ancillary benefits.

THE MOUNTING MENTAL HEALTH CRISIS

Additionally, mental health concerns across the nation are at an all-time high. According to the 2021 State of Mental Health in America report, 19% (47.1 million) of people in the U.S. are now living with a mental health condition, a 1.5 million increase over last year's report. Employers in California have a major advantage in this mental health battle as it is a mandate in the medical insurance offering. However, the question to ask is—is it enough? Do the employees need additional support or are there other voluntary benefits we can provide?

Unfortunately, many employees slip through the cracks and their mental health may be suffering with employers completely unaware of it, particularly over this past year. As an industry, we need to ensure we are offering support for our workforces. While Employee Assistance Programs (EAPs) in the past may have been automatically grouped with disability insurance, consider making these programs more of a conversation starter rather than an afterthought. Employers need to evaluate how these confidential counseling services can benefit employees and determine how many face-to-face conversations their program allows an employee to have. If on average each conversation costs $0.85-$2 per person, the return on investment for the employer is really incomparable.

When opening up the conversation with the client, it is critical to examine how the employer is supporting the overall health of the workforce. Healthy employees tend to perform well, and be more productive and engaged at work. Because mental health is directly correlated to one's overall physical health, when one deteriorates, the other is likely to follow. Employers that support both through proper traditional and ancillary benefits are driving down the overall cost of healthcare for the organization and likely improving the overall company performance.

It's time to be innovative, think creatively and reinvigorate your selling strategy—particularly with ancillary benefits.

HOW TO SHIFT THE CONVERSATION THIS YEAR

The key to selling benefits this year is personalization. It begins with having in-depth conversations with your clients to assess the needs and pain points of the workforce. Consider not only looking at what other companies are doing to ensure the client stays competitive and retains talent, but also ask for feedback from the employees and analyze current participation. These conversations and analysis will illuminate the gaps in coverage and the discrepancies that may exist.

While some employers may not be able to sponsor all benefits, it's important to factor in and discuss the return on investment for the employer. Are the voluntary benefits enough? If the employer invested a bit more and contributed to some ancillary benefits, would that create a more stable workforce? We simply can no longer go through checking the boxes, particularly after this last year. Employees want to feel heard and supported on a personal level, and customized kits based on age, pay schedule and family structure can improve the enrollment experience.

Additionally, incorporate real-world examples when discussing benefits with employee groups. By showing them examples and helping them think through those "what if" scenarios, you will have greater success in enrolling each individual with additional ancillary and voluntary benefits. Remember the key is personalization so spending time on the phone to ensure they feel cared for through their benefits will provide a great return on investment for your efforts.

Finally, with some employers heading back to the office and others remaining remote, a benefit administration system can simplify the process for conducting group presentations, having these one-on-one conversations and enrolling the workforce. Ensure you are arming yourself with the tools you need to be successful and, to that extent, the clients and employees themselves. The simpler the enrollment process can be through a centralized platform, the better to ensure an uncomplicated and less challenging experience.

As we begin to analyze how the pandemic will affect our individual health, our workplace and all aspects of our lives long term, it's critical to ensure this analysis extends to health insurance and benefits. This year, ancillary benefits should be more top of mind as employees reflect on the past year and wonder if the impossible will become possible again. If this past year has taught us anything, it's that we are craving human interaction, a personal touch and the need to feel supported. As brokers, you have the opportunity to provide that care and let them know you are looking out for them and their family this year. CB

ALLEN WU *is a non-medical sales executive at BenefitMall. The company partners with a network of 20,000 brokers and more 120 carriers to deliver employee benefits to more than 140,000 small and medium-sized businesses. For more information about BenefitMall, visit* **www.benefitmall.com.**

The American Rescue Plan Act (ARPA) of 2021 and Related Legislation

A Whirlwind of Funding and Entitlements Throws the Health Insurance Industry into Turmoil!

BY DOROTHY COCIU

So much has happened in Washington since I last updated you! Shortly after I wrote the Washington, D.C. Roundup for the April magazine, two important events took place:

- DOL/EBSA Employee Benefits Security Administration (EBSA) released a Disaster Relief Notice 2020-01 which significantly changed the rules for the COVID-19 Outbreak Period.
- President Biden signed The American Rescue Plan Act (ARPA) of 2021, a $1.9 Trillion relief package/ entitlement program, which, combined, threw the entire health insurance industry into what could have been the most chaotic state of turmoil we've seen in decades.

Although there is a lot of stress and chaos to our industry due to these new statutes, I don't want this article to be a negative one. Quite frankly, we've had enough negativity throughout 2020 and early 2021 with the pandemic. As vaccine distribution widens and people now have more hope than they have in the past 14 months or so, I want to focus on the new requirements. This chaos was dumped on us with little or no notice, but those in our industry stepped up, put on their big-boy (or girl) pants, and dove in to make things happen...

So, this article is dedicated to the Health Insurance industry... To the carriers, the third-party administrators, the general agencies, the benefits attorneys, the benefit consultants, and the related companies that were all, whether we liked it or not, thrown into turmoil. They studied, trained and implemented what was and is needed due to these new laws, and helped the most affected: the insureds, the employers that sponsor health plans, the Medicare recipients, and many more, oftentimes with little or no additional compensation, and with very little sleep these past several months! This is my salute to all of you!

THE OUTBREAK PERIOD CHANGES RESULTING FROM NOTICE 2021-01; HOW DIFFICULT IS THIS TO ADMINISTER?

Let me begin by restating what

I reported in the updated version of the above-referenced article (updated March, 2021, published in April). Prior to the release of EBSA Notice 2021-01, we were expecting the "outbreak period" limitation which resulted from COVID-19 legislation, would expire on Feb. 28, On Feb. 26, the DOL/EBSA released Notice 2021-01, which drastically changed:

- the way we track HIPAA Special Enrollment
- the 60-day period to elect COBRA
- the date for making COBRA premium payments, along with benefit claim determinations.

This Notice allowed the deadlines to be extended based on an individual-by-individual basis—and that each person has their own "tolling period." To the average consumer or insured, this is all great news, but to those who have to administer it, this was anything but. Why is this important and why is this rolling basis difficult to administer? What are the obstacles? I asked a few industry representatives and my own company's benefits attorney, Marilyn Monahan, of Monahan Law Office, to help me explain.

"I suspect the biggest challenges will be implementing the COBRA timeframe extensions, as well as the additional time that participants have to submit health Flexible Spending Account (FSA) claims," stated Monahan. "If FSA claims are submitted late, it may be difficult to track and calculate carryovers and forfeitures. However, employers and TPAs may be able to offset these concerns through communication, such as by encouraging participants to get their claims in as soon as possible so that they are reimbursed as soon as possible. The extensions in connection with COBRA—coupled with the COBRA subsidies—can create some complex administrative issues. I also suspect, however, that with the passage of time, it becomes less likely that a qualified beneficiary will request a COBRA effective date that goes back up to one year."

From an administrator's perspective, this was not an easy task. Mary Ann Wessel of EBA&M Corporation, who administers COBRA as well as claims administration, provided these thoughts: "This is more difficult to administer," she noted. "We have lost some ability to determine if many participants are still qualified beneficiaries, have found other jobs, or have dropped COBRA. It appears to be more difficult to obtain initial information from some employers as to why the participant experienced a termination—probably due to the fact that employers are finding it more difficult to administratively keep good tracking."

Jeffrey Strong of Sterling Administrators had this to say: "It is a challenge primarily due to each person having their own tolling periods. This makes it harder to have uniform answers and support."

Bobbi Kaelin of PayPro Administrators said: "Well, where can I start with this one? I should first indicate that our involvement in this area is the administration of COBRA—so our responsibilities under the notice may be different than other TPAs. With that said, the individual tolling periods are somewhat challenging. However we've been working with our technology partner to utilize the data we already have within our system. This certainly minimizes much of the workload, however, it does not eliminate it." Related to the tolling periods, Bobbi continued: "From our perspective, the major obstacle is obtaining/updating/uploading the information on those individuals. We need accurate Information. Maybe as far back as 2019. If we have accurate and full information, it's then a matter of tracking the tolling period based on the individual's 'event' date."

Is the outbreak period's individual tolling period something that can be solved with IT programming? Or since it's for such a short-term period, is a programming solution even feasible? What are the options here? Once again, I asked industry experts for their perspective.

MaryAnn Wessel stated: "Wex COBRA System to which we migrated in 2020 does a great job of tracking. We are fortunate in that we chose and implemented this new system in 2020 ahead of this tracking requirement. Our prior system would have required much more manual tracking."

Jeffrey Strong felt that this would be handled differently by most administrators. "Due to the short time period, most will handle this manually."

From the perspective of Pay Pro Administrators, Bobbi provided these thoughts: "The individual tolling periods should be able to be tracked and managed by updating/programming the administration system/platforms—utilizing accurate and complete data. I know we've been working with our technology partner on every aspect of ARPA and COBRA, as well as our Flex plan administration, preparing and planning for the requirements. If you're an employer trying to administer and implement these requirements on your own—sheesh, you've got your workload cut out for you."

All in all, the clear message is that this will NOT be easy. Administrators and employers alike have their hands full with this legislation!

The American Rescue Plan Act of 2021 – Summary Overview

The ARPA was a $1.9 Trillion relief package that:

- extends unemployment insurance benefits
- provides $1,400 stimulus payments to qualifying Americans
- makes several important health-policy-related changes
- provides for vaccine distribution and testing to combat COVID-19 pandemic
- makes policy adjustments to the Medicaid program
- facilitates health insurance coverage and provides more money for healthcare providers
- makes two technical Medicare payment changes.

That, of course, if a very brief summary of a massive entitlement package. I will attempt to break them down for you, focusing on what affects the health insurance industry.

Public health funding

In general, ARPA provides for:

- COVID-19 vaccine distribution, testing and contact tracing
- support for healthcare workforce expansion and public health initiatives
- $7.5 Billion directed to Centers for Disease Control and Prevention

to pay for, prepare for, promote, distribute, administer, monitor and track COVID-19 vaccines (see section 2301)
- $7.66 Billion to state, local and territorial public health departments to hire staff and procure equipment, technology and other supplies to support public health efforts
- $100 Million for Medical Reserve Corps
- $800 Million for National Health Service Corps
- $200 Million for Nurse Corps
- $330 Million for teaching health centers that operate graduate medical education
- $47.8 Billion to continue the implementation of an evidence-based national COVID-19 testing strategy (HHS funding for COVID-19 testing, contract tracing and mitigation activities) (see section 2401)
- $1.75 Billion to support genomic sequencing and surveillance initiatives

EMERGENCY RURAL DEVELOPMENT GRANTS FOR RURAL HEALTH CARE

Section 1002 provides for a provider relief fund for rural providers (some have called it a provider relief look-a-like fund for rural providers). These grants are provided through Sept. 30, 2023, and includes $500 Million for Emergency Development Grants for Rural Healthcare, as well as vaccine distribution, medical supplies, reimbursement for revenue loss, telehealth investments, COVID-19 and other testing in rural settings.

ADDITIONAL FUNDING

Section 2101 provides for $500 Million in funding for Department of Labor Worker Protection Activities, including OSHA enforcement of high-risk facilities, including meat plants, agriculture, correctional facilities, and others.

In addition, Section 2302 provides for $1 Billion for Vaccine Confidence Activities (ads, importance, etc.), section 2303 provides for $6.05 Billion for enhancements to the supply chain for COVID-19 vaccines, therapeutics and medical supplies, section 2304 provides for $500 Million for COVID-19 vaccine, therapeutic and device activities at the FDA (current and future treatment, approved and licensed), and section 2501 provides $7.6 Billion For public health workforce activities (including cost-wage benefits, recruiting, hiring, training for contact tracing, case support, nurses, etc.).

Funding for Mental Health and Substance Use Disorders (Public Safety and First Responders) and Behavioral Health Provisions at the Local Level Included in ARPA are:

- $1.5 Billion in block grants for Community Health Services (section 2701)
- $1.5 Billion for block grants for prevention and treatment of substance abuse (section 2702)
- $80 Million for mental health and substance abuse disorder training for healthcare professionals, paraprofessionals and public safety officers (section 2703)
- $20 Million for an education and awareness campaign encouraging healthy work conditions and use of mental health and substance abuse disorder services by health care professionals (section 2704)
- $40 Million for grants for health care providers to promote mental health among their health professional workforce (section 2705)
- $30 Million for community-based funding for local substance abuse disorder services (section 2706)

ARPA includes considerable funding at the local level for the behavioral health industry as well. This includes $30 million for community-based funding for local behavioral health needs (section 2707), grants to state, local, tribal, and territorial governments, tribal organizations, nonprofit community organizations and primary and behavioral health organizations to address community behavioral needs worsened by COVID-19. Additional grants funded are to be used for promoting care coordination among local entities; training the mental and behavioral health workforce, relevant stakeholders, and community members; expanding evidence-based integrated models of care, etc.

There are also provisions for those that work with telehealth, including activities that support, enhance, or expand mental and behavioral health preventive and crisis intervention services. In addition, there was an additional $10 Million provided for creating/enhancing a national child traumatic stress network (section 2708), and $30 Million for COVID-19 emergency medical supplies enhancements (section 3101).

I am only touching on some of the provisions in ARPA. There are many more. I want to cover the most important provisions affecting our industry.

COBRA PREMIUM ASSISTANCE (SUBSIDIES) – SECTION 9501

Before I begin this section, I want to provide a shout-out to my benefits attorney, Marilyn Monahan, of Monahan Law Office, because she and I did a joint webinar for my own clients on all of these provisions in March. Quite honestly, when I was confused on some of the provisions, she was there to assist me in understanding them, so Marilyn, you are much appreciated! You are, indeed, a benefits industry rock star! By the time we did our webinar, I was confident I was up to speed on most of the provisions (although I must admit, I still ask her for her assistance from time to time with client questions!).

Under ARPA, "assistance eligible individuals" (AEIs) are entitled to free COBRA continuation coverage, including the 2% administrative fee, for up to 6 months. The subsidy begins on April 1, 2021 and ends on Sept. 30, 2021. We are at this time awaiting additional guidance from the federal Departments of Labor (DOL) and Treasury (IRS), but we were provided Model Notices and some FAQs on April 7, 2021. These FAQs and Model notices can be found at: https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/cobra/premium-subsidy.

While we await additional guidance, it's important to note that some of ARPA's COBRA subsidy provisions are very similar to the COBRA subsidy provisions included in the American

Recovery and Reinvestment Act of 2009 (ARRA). Although ARRA did not provide a 100% subsidy, many of the steps and processes appear to be similar. This has helped industry representatives, particularly carriers and COBRA administrators, in getting a jump on the new but temporary provisions.

"Yes," stated Monahan, "for those provisions in the two bills that are very similar, it is helpful to be able to refer to the 2009 IRS guidance to get an inkling of the direction in which the IRS might go when they issue further guidance on ARPA."

Jeffrey Strong also felt the steps were similar, and that seems to help the situation. "Yes it has," he said. "Before it [the subsidy] was 65% and this time it is 100%, but we have something to compare to and an idea on how to manage. The 'second bite of the apple' portion of the law is more of the challenge."

Bobbi Kaelin responded: "Absolutely! With ARPA the framework and general understanding of government subsidies is already in place. Although the subsidies now and multiple notices are different, most systems were updated at the time so it's a matter of adjusting the dates/details for ARPA. Whereas in 2009, we were challenged as everything involved was new: modified platforms, new tracking premium requirements, new notices, education internally and externally, and much more. In addition to our internal operations, we worked closely with our brokers and employer-clients, explaining the subsidy itself, and the new process we implemented to track and/or collect premiums from two sources, provide notices for the tax credit to the employer, and how to reconcile premiums already paid as the subsidy was enacted."

So, the previous ARRA legislation does seem to take the sting out of the process.

WHO IS ELIGIBLE?

Under ARPA, "assistance eligible individuals" (AEI) are entitled to free COBRA continuation coverage, including the 2% administration fee, for up to 6 months beginning April 1, 2021 (through Sept. 30, 2021). AEIs are those whose eligibility for continuation coverage is due to either an involuntary termination of employment (other than gross misconduct), or a reduction in hours that results in the loss of coverage. It does not need to be COVID-19 related. This can include individuals who experience a qualifying event (QE) during the subsidy period, prior to the subsidy period currently on COBRA, and who have not exhausted their maximum 18 month of continuation coverage. Or individuals who experienced a QE prior to the subsidy period, who did NOT elect COBRA, or allowed their COBRA coverage to lapse, and have not exhausted their maximum 18 months of continuation coverage—meaning they have a new opportunity to enroll and take advantage of the subsidy. I can imagine that this new enrollment opportunity will cause administrative nightmares for COBRA administrators.

While we await additional guidance, it's important to note that some of ARPA's COBRA subsidy provisions are very similar to the COBRA subsidy provisions included in the American Recovery and Reinvestment Act of 2009 (ARRA). Although ARRA did not provide a 100% subsidy, many of the steps and processes appear to be similar. This has helped industry representatives, particularly carriers and COBRA administrators, in getting a jump on the new but temporary provisions.

WHAT KIND OF INTERNAL TRAINING, TRACKING, AND COST WILL THIS REQUIRE FOR COBRA ADMINISTRATORS? IS THIS SOMETHING THAT AN ADMINISTRATOR CAN ABSORB, OR WILL IT REQUIRE AN INCREASE IN COBRA ADMINISTRATION COSTS IN GENERAL?

Jeffrey Strong replied, "Yes, very much so! There are a lot of moving parts here now and the COBRA administrator market is working to figure this all out. There is training that is going on as we speak. As we get more information from the DOL, we are able to refine the tracking and cost needs more. The big question in the market right now is cost and who is going to absorb it. I suspect it will cause an increase in costs in general across the administrator realm."

Bobbi Kaelin provided her perspective as well: "We have benefitted by our experience under ARRA, so at least we're not 'starting from scratch' in many ways. However, there is certainly an increase in the workload itself in a variety of areas. Internally we've spent additional time training and educating our teams; reconciling information that may have been inaccurately reported or not reported at all; updating the system for each client for new/multiple notices for each scenario; and updated our premium payment processes. In all, our workload has increased tremendously. In addition, there are 'hard costs' involved such as the preparation, printing, tracking and mailing/remailing costs for every single individual it pertains to."

Bobbi continued: "I do not believe that this is something any administrator can absorb. At PayPro Administrators, we're not increasing our general COBRA admin fees. Instead, we will implement temporary and nominal fees in place for the new/modified notices that need to be re-sent/provided. For any 'new events' that occur after April, the newest notices are already in place and there are no additional fees. Phew!

"For new clients," she says, "there will be a temporary fee for those new notices that need to be re-sent and we will require more detailed and accurate information than they are likely used to. For those brand-new COBRA events and their associated notices, we do not anticipate any additional fees. "

MaryAnn Wessel stated: "We have no plans right now to increase our fees, but we always monitor costs by department." So, we'll see how all of this plays out over time.

It's important to note, however, that someone who terminates employment VOLUNTARILY is not a qualified AEI under the ARPA COBRA Premium Assistance provisions.

EXTENDED ELECTION PERIOD

It's important to understand that individuals who experienced a QE prior to the subsidy period, whose maximum period of COBRA coverage has not yet ended, and who either did not elect COBRA or allowed their COBRA coverage to lapse, have a NEW OPPORTUNITY to elect COBRA and take advantage of the subsidy. In these situations, the COBRA coverage is prospective; it does not begin before April 1, 2021, and it will not extend beyond the length of their maximum coverage period had they elected COBRA when originally eligible. Under these circumstances, the administrator must provide a revised COBRA election notice within 60 days of April 1 (or by May 31) and AEIs will have 60 days to elect COBRA after they receive the notice.

Under ARPA, "assistance eligible individuals" (AEI) are entitled to free COBRA continuation coverage, including the 2% administration fee, for up to 6 months beginning April 1, 2021 (through Sept. 30, 2021). AEIs are those whose eligibility for continuation coverage is due to either an involuntary termination of employment (other than gross misconduct), or a reduction in hours that results in the loss of coverage. It does not need to be COVID-19 related.

This is much easier to understand with examples, so I will provide some. These examples were taken from the statute, and modified for easier understanding by Marilyn Monahan (thanks again, Marilyn!).

COBRA SUBSIDIES – SCENARIOS

Let's assume that Alpha Corp is located in Pasadena, Calif. In 2020, Alpha had 50 employees, so therefore they are subject to Federal COBRA (over 20 employees). Alpha Corp offers full-time employees a fully insured health plan. During 2020, Taylor works full-time for Alpha as a bookkeeper. Taylor elected her company's health plan and was covered by that plan. In November, 2020, let's look at some sample scenarios:

1) Taylor quits. She is offered COBRA, elects COBRA, and is currently on COBRA. Is she eligible for the COBRA Premium Subsidy provided by ARPA? No, because she is not an AEI as she voluntarily terminated.

2) Taylor is terminated for cause. Taylor is offered COBRA, elects COBRA, and is currently on COBRA. In this scenario, Taylor is considered an AEI, and eligible for a subsidy beginning April 1, 2021, through Sept. 30, 2021.

3) Taylor is terminated for cause. She is offered COBRA, elected COBRA, and then let her COBRA coverage lapse at the end of Jan. 2021. Taylor must be provided a new COBRA Election Form, and be given the opportunity to elect COBRA again. If she elects COBRA again, effective April 1, 2021, COBRA premiums will be subsidized, through Sept. 2021.

4) Taylor is laid off because Alpha's business is down due to COVID-19. Taylor is offered COBRA but did not elect COBRA. She will now be given a new opportunity to enroll prospectively. Effective April 1, 2021, the premiums will be subsidized through Sept. 2021.

WHO IS NOT ELIGIBLE FOR THE SUBSIDY?

An AEI is not eligible for the subsidy as of the first date that the individual is eligible for coverage under any other group health plan (other than coverage consisting only of excepted benefits, coverage under a health FSA, or coverage under a QSEHRA) or Medicare. If an AEI becomes ineligible for the subsidy because the AEI becomes eligible for other coverage or Medicare, the AEI must notify the group health plan. Failure to provide the notice to the group health plan could subject the AEI to an IRS penalty.

TYPES OF COVERAGE ELIGIBLE FOR PREMIUM SUBSIDY

All group health plans subject to COBRA (under ERISA, IRC, or Public Health Service Act (PHSA)), or coverage "under a State program that provides comparable continuation coverage" (in other words, "comparable" state mini-COBRA laws), are eligible for the premium subsidy. This includes (we assume at this point, but are awaiting guidance) state and local government plans subject to the Public Health Services Act (PHSA). We assume at this time that this will include dental, vision, and HRAs, as these were allowed during the ARRA subsidy starting in 2009. Premium subsidy eligible plans do not include a health flexible spending arrangement. This was spelled out in the statute.

One question that will likely come up is—does the subsidy apply to Cal-COBRA or other state mini-COBRA laws? At this time, we assume that it applies to employers with 2-19 employees, but we are awaiting further guidance.

ARPA, simply stated, says that continuation coverage provided "under a State program that provides comparable continuation coverage" to COBRA will also be eligible for the subsidy, although we need a definition of "comparable," which we assume will be covered in guidance. Given what has been provided to us to date, we assume that certain state mini-COBRA laws (such as Cal-COBRA for those working for employers with 2-19 employees) should be eligible for the premium subsidy. Similar language was included in ARRA in 2009 regarding subsidies, but again, we are awaiting guidance.

When can the subsidy end early? Under the ARPA, coverage is generally good for up to 6 months, April 1, 2021 through Sept. 30, 2021. However, the subsidy can end early if the AEI's 18-month continuation coverage period ends prior to that date, or if the AEI becomes eligible for coverage under another group health plan (other than coverage that is only excepted benefits, a health FSA, or a QSEHRA) or Medicare.

PREMIUM PAYMENT RESPONSIBILITY AND TAX CREDITS

If the AEI does not pay the COBRA premium, who is responsible for payment? In a multiemployer plan, the plan is responsible. The employer is responsible for a plan that is either

subject to COBRA under ERISA, the IRC, or the PHSA, or is self-funded. If one of these circumstances does not apply, such as a fully insured group plan that is subject to state continuation coverage laws, the insurer is responsible. We assume this will be the case with mini-COBRA participants as well as church plans, but again, we are awaiting further guidance.

Basically, in a fully insured arrangement, the employer cuts the premium check to the insurance carrier (the same as they would an active employee and dependents), but later gets a tax credit. In a self-funded plan, the employer will not receive the check from the COBRA participant, but will continue to pay the COBRA premiums. Self-funded employers, too, will receive a tax credit to reimburse them for the cost of COBRA coverage.

The employer, insurer, or plan is entitled to reimbursement of the premium in the form of a federal tax credit against certain quarterly payroll taxes for the reimbursement of the COBRA premiums. These payroll tax credits are generally in the form of Medicare taxes. If the credit, however, exceeds the payroll tax liability, a refund will be available. You should be aware, however, that there are restrictions on "double-dipping"; i.e., if the employer is receiving a tax credit for qualified health plan expenses because the employer is providing paid leave under the FFCRA (which is of course voluntary, as the FFCRA mandates ended on December 31, 2020, but the CAA allowed for an employer to voluntarily continue providing paid leave into 2021), the employer cannot also take this tax credit. It is advisable that you advise your employer clients to seek the advice of their tax and/or legal counsel regarding these circumstances before they take tax credits, to be sure they are complying with the provisions of each of these laws. The "how to'' do this "mechanics'' should be forthcoming in guidance.

REIMBURSEMENT TO AEIS IF PAID DURING SUBSIDY PERIOD

Let's say that the AEI goes ahead and pays the premium during this 6-month subsidy period, even though it should have been subsidized. The statute states that the employer, insurer or plan must reimburse the AEI within 60 days. Is this tracking of who pays or does not pay a responsibility of the employer/plan sponsor or the contracted COBRA administrator? I felt this would be best answered by an attorney, so I asked Marilyn to explain: "When the employer sends out the revised COBRA notices, the employer should attach another model form issued by the DOL—the 'Summary of the COBRA Premium Assistance Provisions under the American Rescue Plan Act of 2021.' The Summary includes a form an AEI can fill out to notify the employer that the individual believes they are eligible for the subsidy. According to the DOL's FAQs, 'Accordingly, plans and issuers should not collect premium payments from Assistance Eligible Individuals and subsequently require them to seek reimbursement of the premiums for periods of coverage beginning on or after April 1, 2021, and preceding the date on which an employer sends an election notice, if an individual has made an appropriate request for such treatment.' It would also be appropriate for the employer to identify—and track—those who are eligible for the subsidy and refund payments when appropriate."

Bobbi Kaelin provided her perspective. "Ultimately, it's the responsibility of the employer/plan sponsor. However, here at PayPro Administrators, we will work with the plan sponsor to track/report premiums that we have received and remitted to either the carriers directly, or to the plan sponsor. The responsibility for reimbursing the AEI, at this point, will be determined between the carrier, plan sponsor, and the Administrator (if the administrator collects the entire premiums and remits it directly to the carrier under a separate COBRA invoice)."

NEW NOTICE REQUIREMENTS

There are several new notice requirements for COBRA under the ARPA. In general, new notice requirements include the following:

- Modify existing COBRA election notice to send to those who have a qualifying event on or after April 1, 2021 to inform them that they are eligible for a premium subsidy
- Modify existing COBRA election notice to send to those who already have ha a qualifying event but are now entitled to an extended election period (this must be sent by May 31, 2021)
- Modify existing COBRA election notice to notify AEIs of the Plan Enrollment Option, if the employer offers this (more information on this to follow)
- Create a new notice to inform those whose subsidy is ending between 45 and 15 days of the end of the subsidy (so approximately between Aug. 15 – Sept. 15 , 2021 if the subsidy is ending on Sept. 30, 2021)

New Model Notices were released on April 7, 2021 and can be found at: **https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/cobra/premium-subsidy.** They are available in pdf or word formats. The FAQs can be found at: **https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/cobra-premium-assistance-under-arp.pdf.**

What must employer plan sponsors and/or COBRA administrators be prepared to do before these notices can go out?

"They will need to figure out a delivery mechanism, electronic, mail, etc. Then they need to figure out who needs to get the notices," stated Jeffrey Strong.

Bobbi Kaelin also commented. "First communicate with your TPA. You'll want to make sure your TPA is responsible for sending on the notices on behalf of the plan sponsor. The TPA may request that you review or update information in order to provide the notices to applicable individuals. Additional information may be requested by the TPA as well. Confirm or inform your TPA if you wish to allow eligible individuals to enroll in a less expensive plan.

"Additionally," stated Bobbi, "for both plan sponsors and TPAs, be prepared to receive questions from sponsors, employees, beneficiaries and those that question why they are not receiving a notice of COBRA coverage

Continued on page 42

Buckle Up

It's STILL a wild ride

BY DAWN McFARLAND

Have you heard that saying that "God laughs at us when we make plans"? Pretty sure 2020 and 2021 are perfect pictures of that. This column is the "Agent's Voice" and from my agent perspective and the observation of my colleagues around me, there is no longer a calm time in our industry. Fourth quarter began spilling into January—with the ACA and now the SEP extensions, subsidy increases and COBRA subsidy navigation from American Rescue Plan Act (ARPA)—holy moly!

You know what is great about all of this? It is just in time to show how valuable agents are and why we need to be kept around whatever reformation of healthcare comes about. It's so interesting how legislation creates the impetus of change, but we're the "boots on the ground" who have to figure out how to make it work.

Oh and let's not forget that there are some new broker commission transparency rules coming down the pike from the Consolidated Appropriations Act of 2021. Did someone say Mental Health Parity NQTL Analyses? Mental Health is not just a little issue these days, right? If you haven't heard how these could impact you (group agent, Medicare agent AND IFP agent) be sure to watch one of the NAHU Compliance Corners, or read one of my favorite blogs by MZQ Consulting. Sometimes it feels like we are a spaceship constantly dodging meteors because we are the implementers!

We are the ones our clients call when the Department of Labor comes knocking. We are the ones our clients call when they get the email that they may now be eligible for a new subsidy. We are the ones they call when they receive a large medical bill.

All of this work we do is best shown by our voice in Washington, D.C. and Sacramento. And it matters. I am sure you have heard of the single payer and public option proposals in multiple states, including California.

By the time you read this, we will have completed our annual Sacramento visits with CAHU up and down the state. One of the big discussions related to this event, called Capitol Summit, was "can we have the summit in person?" (at that time California was not in a tier where that was possible) or "do we go forward virtually?" especially since we cannot walk the halls of the capitol in person. Virtual won after a survey of membership showed that while many were in favor of in-person events, slightly more were in favor of waiting just a little bit longer.

As with everything these days there are many differing opinions and that can make our environments hard to navigate. Add the forums of public opinion (especially social media) and well, it sometimes feels like a harsh and judgmental world. How about we support each other and accept that when someone else has a different perspective, we can still be kind to each other? We have a great big platform to set the example of spreading positivity over negativity.

We've seen a lot of talk around mental health these days too—well, no wonder, right? It's been a tough year no matter what side of the aisle you sit on and we are all eager to GET OUT! As we start re-entering public places with less social distancing and more people vaccinated, let's take it easy on one another while we re-acclimate. There is a thing called "reentry anxiety" and it is real. A shocking 50% of us are experiencing it. If that's you, Google it and you can find lots of great tips on how to deal with it.

I know I am sure excited to get back to seeing people (and concerts!) again, though I am grateful for the ways I have efficiency that I did not use before. Change creates opportunity. I am curious to see what we humans come up with for the next hybrid work environment and what we will do with all of our empty commercial space.

Every time I write here, I will ask that if you are employed in the health insurance industry that you **join your local chapter of the Association of Health Underwriters** (which then makes you a part of your state chapter and NAHU (National Association of Health Underwriters). If you are already a member, thank you! If you want to hear more about the value it adds, give me a call. And if you want to get involved in the work we do for industry, even better!

Here's to seeing you, in the flesh, very soon! And to HUGS! CB

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 (LAAHU). Contact: dawn@mnmbenefitsolutions.com or visit* **www.mnmbenefitsolutions.com.**

New Insurance Industry Study Underscores Marketing's Powerful Impact on Key Growth Metrics

BY PATTY NEWCOMER

The insurance industry has been slow to adopt new technology. But in 2020, driven in part by the pandemic, professionals accelerated their use of modern marketing strategies. As a result, growth increased in key areas. Marketing made the difference between revenue growth and lackluster performance.

In a recent survey designed to gauge independent insurance agencies' perception of marketing's value, respondents reported that enhanced marketing strategies delivered many business benefits, such as:

- stronger client retention
- improved client acquisition
- revenue growth

Virtually all respondents (98%) agreed that successful marketing strategies create a competitive advantage, and 96% reported that more effective marketing would grow their business.

THE SURVEY ALSO FOUND THAT:

- nearly 40% of respondents said that marketing increased their income by at least 25%
- more than half of these said that marketing has helped increase revenue by more than 50%

Studies show that videos can dramatically increase time on site and landing page conversion rates by 80%.

The survey revealed that the majority of independent agencies (98%) see the revenue-building value in marketing, but only 37% are "very comfortable" using modern marketing tools. This shows a major disconnect between the value agents see in digital marketing tools and their comfort level using them.

Also worth noting is that decision-makers stated they are willing to switch to different insurance networks to gain better technology platforms. Among those who responded, half expect their industry networks to provide modern systems. Clearly, agents want access to modern marketing tools, but need training to help them use these tools and systems effectively.

Adding new marketing activities can seem overwhelming to time-crunched insurance agents and brokers. The same survey revealed a distinct preference for marketing technology and software that supports day-to-day agency functions while streamlining operations. Agents are most interested in finding technology that can automate many marketing and operational tasks. This would allow agents to concentrate on those areas where they can add their own creative touch to servicing clients and attracting new prospects.

Pre-written content can be a key part of an automated marketing strategy. The majority of agents rated pre-written content "valuable," including the 41% who consider it "very valuable." Marketing platforms that let agents communicate across many channels are also essential when it comes to reducing the work for agents.

Must-have modern marketing channels include an interactive, mobile-friendly website, email, social media platforms and online events. Using professionally prepared content in automated, pre-designed campaigns to convert prospects to clients or to grow the average number of policies per client can effectively expand an agent's book of business.

While the survey found that email is still a key part of any successful communication strategy, social media is now essential to agents' strategies for attracting new business. *Nearly half of all respondents acquired new clients from social media.*

Not surprisingly, younger insurance professionals see more business value in social media than do their older counterparts. More than two-thirds rely on social media to build their brands, share special insights, and generate new business. A strong social media presence amplifies a broker's personal brand and sharing relevant content demonstrates expertise. Some insurance brokers are still resistant to using social media for business, but those who do find that it increases client engagement, helps attract and convert leads, and drives agency growth and revenue. Whether an agent uses email or social media, the key is that consistently valuable communication helps to build and deepen client relationships.

One more piece to consider when looking at modern marketing options is the value videos can bring for brand enhancement. Some of the most effective videos made by insurance agents offer insights on market conditions, comment on industry trends, and show their fun personalities. Studies show that videos can dramatically increase time on site and landing page conversion rates by 80%.

Insurance professionals who add marketing strategies and tools are reporting higher customer retention and client growth rates. The industry can no longer rely on in-person meetings, lunches and webinars to build relationships. A digital footprint that's authentic will resonate with current and future clients, and smart agents who embrace marketing will enhance their unique value in 2021. These will be the agents that grow their businesses, revenue and personal brand for years to come. CB

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Pharmacy Benefit Management Best Practices:

Clinical programs and value-based decision-making

BY GREGORY O. CALLAHAN, MARC GUIEB AND DUSTIN K.POLLASTRO

Pharmacy benefit managers offer a wide range of clinical programs designed to improve health outcomes for members while reducing overall healthcare costs. Plan sponsors may find it challenging to develop a process that effectively evaluates these programs. How should plan sponsors evaluate which programs to implement, maintain, or discontinue? This article explores industry best practices plan sponsors can use to consistently assess the value of both new and existing clinical programs.

THE ROLE OF CLINICAL PROGRAMS IN PHARMACY BENEFITS

Pharmacy benefit managers (PBMs) offer numerous clinical programs focused on disease management, utilization management and medication adherence. These programs are designed to improve health outcomes through patient-focused education, provider intervention and other clinical services. One of the advantages of PBM-offered clinical programs is they are tailored specifically for a plan sponsor's drug coverage and benefit design. This enables programs to maximize their potential clinical benefits for enrolled members through continuous, personalized care.

However, PBMs may unintentionally complicate the decision-making process as they have an interest in achieving their own internal financial targets.

Think of this common scenario: March or April comes around and your PBM account services team is ready to present last year's plan performance review. They walk you through a PowerPoint presentation aimed at covering all aspects of plan performance using plan metrics and statistics. Within the meeting, the PBM's account executive takes a few minutes to review a portfolio of new clinical programs aimed at plan savings and/or improved member healthcare experience.

The dilemma in this scenario is how to vet these program offerings constructively, eliminating the less meaningful programs and electing the programs with higher likelihoods of success.

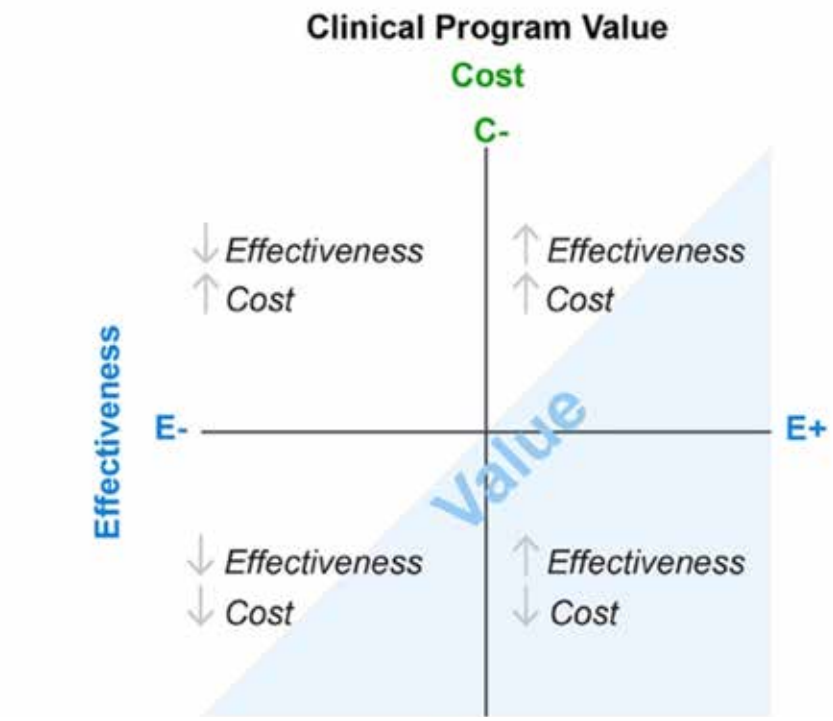
A VALUE-BASED APPROACH TO EVALUATING CLINICAL PROGRAMS

The selection of clinical programs can be a difficult decision due to the complexity from a health economics perspective, especially for plan sponsors that are uncomfortable making decisions requiring expert clinical knowledge. Plan sponsors employing a pharmacy director can leverage that person's

expertise, but not all have extensive experience with clinical program evaluation. We will outline a value-based approach to assist plan sponsors in determining which programs are most meaningful to their members and what the short-term and long-term financial impacts might be.

Figure 1 is a visual tool plan sponsors can use to decide whether a prospective clinical program is appropriate for a pharmacy program. Figure 1 defines value as the relationship between effectiveness and cost.

FIGURE 1: COST-EFFECTIVENESS QUADRANTS



Any program that falls into the bottom right quadrant (i.e., highly effective and low-cost) should be considered, whereas programs falling into the top left quadrant (i.e., low effectiveness and high cost) should not be implemented. Programs falling in the remaining quadrants may require a more detailed analysis and the decision often depends on member demographics, culture, utilization patterns, plan design, and other individualized plan nuances.

THREE PILLARS OF VALUE-BASED DECISION-MAKING

To determine which quadrant a prospective clinical program might fall into, plan sponsors can focus on three major pillars: clinical effectiveness, financial impact, and member engagement. The first two pillars align with the axes of the coordinate plane in Figure 1 whereas member engagement is a key factor for success of the program over both dimensions. It is important to note that each pillar does not necessarily carry equal weight, that is, the relative importance of each may vary by plan sponsor.

Clinical effectiveness. Evaluate the clinical effectiveness of a program by considering which outcomes are measured and the potential of the program to achieve those outcomes.

When evaluating the outcomes being measured, it is important to identify outcomes having direct clinical significance as opposed to outcomes only functioning as surrogate markers. For example, one PBM might offer a diabetes clinical program with a measurable outcome of increasing diabetic drug adherence within one year. This metric is not ideal because, although this program can measure whether patients are filling their prescriptions, claims utilization is an oversimplified metric that does not measure:

- Actual and proper usage of medication
- Long-term blood glucose control
- Effects on medical outcomes

A better outcomes measurement is monitoring hemoglobin A1c, a patient-specific marker, which is the gold standard for measuring blood sugar levels in diabetics and is a more accurate long-term representation of blood glucose control. Most importantly, studies have identified this marker as strongly correlated with lower hospitalizations and overall diabetes-related spend.

Once outcomes measures are evaluated, plans should consider the likelihood a program will achieve positive outcomes. A PBM should be able to provide information describing the number of other clients that adopted the program, as well as real-world examples of successful results. It is vital to understand how successful the program is across the PBM's book of business and for plan sponsors of comparable size and structure. Review return on investment (ROI) studies and other cost-benefit analyses from the PBM carefully to ensure they are relevant and broadly applicable to your organization. Ask the PBM if the studies were conducted by an outside third party. Outcomes and studies from other PBMs can also be applicable to this effort.

Financial impact. Evaluate the financial impact of a program by considering several financial components: up-front costs, ongoing fees, and potential member and/or plan sponsor savings. The up-front costs comprise both the PBM implementation fees and the costs associated with the variable full-time employee (FTE) hours increase allocated to manage the program, as plan sponsors often do not consider the extra man-hours needed to implement, run, and report program results back to their organizations. This makes the potential program savings variable and more difficult to determine, but a necessary part of properly understanding the financial impact of any value-based program.

The calculation of up-front costs can differ not only across PBMs, but among programs within the same PBM. Some PBMs will charge a per member per month (PMPM) or per enrolled member fee. An up-front cost often overlooked is the additional amount of time a plan sponsor will need to evaluate, internalize, and digest the program's outcomes.

Understanding how well the program is performing is important to evaluate performance over time and adapt when necessary.

Plan sponsors may need to either hire additional personnel or reallocate workloads to accommodate an increase in FTE hours associated with evaluating and overseeing clinical programs.

The potential savings can be a challenging task to quantify over a brief period. ROI for clinical programs is typically low in a first year but may improve in subsequent years and, in some cases, return to lower levels, following a bell curve path of ROI when looking over many years of a program's performance. Initially, members may need time to adjust their lifestyles and treatment habits. Ideally, over time, these adjustments may become permanent and lead to improved member health and well-being. A plan sponsor may expect short-term cost increases for any program related to drug adherence because increases in adherence may drive higher drug utilization. These types of treatment-related cost increases can be viewed as an investment because they can drive long-term cost savings in the form of medical cost savings and improved clinical outcomes for certain conditions. If possible, evaluate financial impacts across both pharmacy and medical benefits to understand the total impact to a plan sponsor, especially with certain medications covered through the medical benefit.

Member engagement. The plan sponsor should evaluate member engagement by monitoring initial member disruption, program enrollment, program retention, and overall satisfaction. When PBMs present a program to a plan sponsor, it is important to understand enrollment by considering the following items:

- How does the PBM identify qualifying members?
- What percentage of qualifying members enroll in
- the program?
- How does the PBM define an enrolled member within
- the program?
- What is the member enrollment process?
- Is there an enrollment period and, if so, what does this period look like?
- Monitoring and maintaining high member retention
- are also important to the program's success. Some
- considerations include:
- How the program measures member retention and
- attrition rates
- The frequency with which these rates are measured
- The current retention and attrition rates of the program
- Understanding common reasons for member abandonment

Answers to these detailed questions can provide the plan sponsor with an understanding of how the program will attract, enroll, and retain members. Plan sponsors must ensure all these considerations are included in either the master agreement or a contract amendment so terms and conditions can be referenced and enforceable.

Member satisfaction is another key aspect to member engagement. Plan sponsors should understand how PBMs are evaluating member satisfaction, often done through a voluntary survey. Plan sponsors should evaluate not only the results of these surveys, but the effectiveness of the questions asked, the scaling of the metrics for the evaluation, and where and how the surveys are conducted.

For each clinical program, measurements for member engagement should be clearly defined and results should be presented to plan sponsors frequently, i.e., quarterly. The success of a clinical program often hinges on active monitoring and follow-up.

NEXT STEPS FOR PLAN SPONSORS

Plan sponsors should implement an objective and consistent decision-making process to select clinical programs and regularly evaluate their effectiveness over time.

Establish a consistent program and services evaluation plan. Plan sponsors should set consistent evaluation parameters across all clinical programs, including proposals for new programs. Some examples may include the following:

- Require PBMs to use the plan sponsor's own utilization and data in all analyses. "Book of business" data or aggregate program results can skew projections and may not be applicable to a plan sponsor's individual member characteristics or plan design.
- If possible, require the use of the most recent plan sponsor data to reflect the current member population. If full-year data is not available, then only the most recent quarterly data should be used and adjusted for factors like seasonality. This enables a fair comparison because outdated data can misrepresent potential program results.
- Set the expectation with the PBM account team that plan performance reviews may not be the most appropriate setting to present clinical programs. These clinical program presentations are better conducted separately from financial reviews to ensure adequate time and focus is devoted toward evaluating the program.
- Require PBMs to clearly define (e.g., outline in the agreement) how patient outcomes or program outcomes are measured and, when reporting, provide the detailed calculations to support the measurements. This helps plan sponsors accurately evaluate program ROI and limits the potential for ambiguous measurements and calculations.
- Some clinical programs charge a fee per PBM intervention. Plan sponsors should require PBMs to

explicitly define what classifies as an intervention. For example, an intervention could be defined as a telephone call, a 20-minute period of counseling, or another outreach method defined by the PBM.

• Plan sponsors should explicitly identify the member population, including the demographics of those enrolled in a clinical program, to budget costs and calculate ROI.

Let's say you decided to implement a clinical program. Fast forward three to five years—by then the conversations about the program utility or relevance have fallen out of focus and what was once a major decision has been forgotten. But the program and fees continue. How does a plan sponsor ensure the continued success of a clinical program if it is not reviewed year over year?

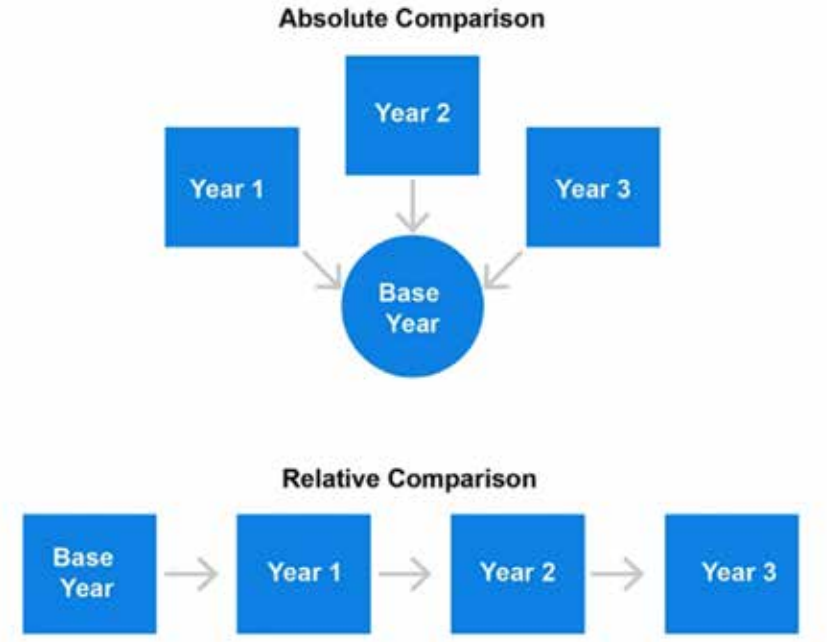
Develop a multiyear reporting plan. Always evaluate program performance in two separate measurements over time, as depicted in Figure 2. The first measurement is the absolute difference, comparing the year prior to program implementation, the base year, to each individual year that follows. The second measurement is the relative difference, comparing consecutive year-over-year differences. Using this combination of comparisons will comprehensively demonstrate how well the program is actually performing.

Understanding how well the program is performing is important to evaluate performance over time and adapt when necessary. Some PBM clinical programs come with an ROI performance guarantee, so a plan sponsor must keep track of all performance year-over-year (note: understand how ROI is being calculated!)

Finally, it is important to know when a program no longer has value and has moved to quadrant I in Figure 1 (i.e., low effectiveness, high cost). The goal of clinical programs is to achieve long-lasting effects without requiring indefinite, high-touch patient outreach. As member behaviors become ingrained habits or markets change, programs can become obsolete or less effective over time. Knowing when to turn off a program is as important as knowing when to implement a new one. Again, continuous monitoring is essential to success, as not all clinical programs are appropriate for every plan sponsor and they can become less effective over time.

Clinical programs can be effective strategies for improving members' health outcomes while also reducing long-term overall healthcare costs for a plan sponsor. Plan sponsors can turn the clinical program decision-making process into a simple and productive exercise delivering value through a consistent process following best practices. CB

FIGURE 2: THREE-YEAR PROGRAM EVALUATION



GREGORY O. CALLAHAN, MBA

Greg spends much of his time preparing and speaking at industry conferences while helping his clients manage the pharmacy/payer/PBM landscape. Greg has held high profile account management positions within the PBM industry spanning more than 13 years over multiple lines of business including Managed Healthcare (Medicare), Coalition / GPO, Taft-Hartley, Commercial, Third Party Administrators, 340B, and fully insured Managed Care Organizations. His consulting specialty is the prescription drug benefit market with experience in prescription benefit operations, PBM contracting and pharmacy program development.

MARC GUIEB, PHARMD, RPH

As a consultant for Milliman, Marc has worked in Medicaid, Medicare and commercial pharmacy benefits contracting and in claims auditing. Marc supports clients through his knowledge of pharmacy operations, regulations, formulary management, clinical trial evaluation, drug utilization review, and pipeline forecasting.

DUSTIN K. POLLASTRO, PHARMD, MBA

Dustin was a pharmacy management consultant at Milliman at the time he contributed to this article. He is now Director, Medical Outcomes Science Liaison, EMD Serono, Inc.

Medicare Advantage Versus

Medicare Supplement Plan

Helping the New Medicare Beneficiary Decide

BY MARGARET STEDT

Agents play a key role in helping the new Medicare Beneficiary in deciding what type of coverage and then the plan that best fits their needs. Many of the Medicare Beneficiaries are confused and frustrated as Medicare Coverage is brand new to them with different names, coverages and plan types than what they experienced on either group insurance plans or individual plans (On or Off Exchange).

When meeting with the Medicare beneficiary you should start by asking what their questions and concerns are. Ask what type of coverage they are on now and how it is working for them. Who are their doctors and do they have relationships with specialists in several Medical Groups? Are they comfortable with the idea of a referral process? Do they travel both inside and out of the country? Is prescription drug coverage important to them and have there been any challenges? These questions will help you in explaining the options and to determine which plans to consider.

Many times, the beneficiary insists that they want a PPO plan like their current coverage. This needs to be addressed carefully as you explain the difference between a Medicare Supplement Plan and the various types of Medicare Advantage Plans. Never say a Medicare Supplement Plan is a type of PPO plan. In the senior products arena, a PPO is a type of Medicare Advantage Plan.

Agents need to be able to explain the difference between the Medicare Supplement Plans (Med Supps) and the Medicare Advantage (MAPD) Plans. I begin by using Section 1 of the CMS booklet "2021 Choosing a MediGap Plan "(CMS Product No. 02110) that is typically provided with the Medicare Supplement Sales Kit. I find the chart on page 7 helpful for the beneficiary to take notes on.

The first step is to explain about Part A and B of Medicare by reviewing the different parts of Medicare. Note that there is no maximum out-of-pocket for the copayments, deductible and coinsurance amounts of Medicare. Agents should review the monthly cost for Part B and IRMAA and note that it typically changes each year. The IRMAA (Income Monthly Adjusted Income Amount) for Part B and D may be found on the www.medicare.gov website.

The next step is to review the two main ways to get Medicare coverage

(1) by remaining on Original Medicare and enrolling in a Medicare Supplement (MediGap) Plan

(2) enrolling in a Medicare Advantage Plan (also known as a Part C of Medicare.

I use the chart provided on page 7 of the CMS MediGap Booklet to review the differences in the plans. Once the client understands Medicare Part A and B then it is time to review the difference between Med Supps and MAPD plans.

REVIEWING THE MEDICARE SUPPLEMENT PLANS

These plans are designed to cover the out-of-pocket costs such as coinsurance and copays of Medicare Parts A and B. The Original Medicare Part A and B is the primary coverage (pays first) and the Med Supp is secondary. The plans will only pay if it

Medicare Supplements and the Medicare Advantage Plans offer great coverage options to the Medicare beneficiary. One is not better than the other. It is a matter of which type and which plan best fits their needs both medically and financially. You as the agent need to understand the differences and plans and present them clearly for the beneficiary's understanding.

is a Medicare approved service and Medicare pays first.

There is a monthly premium for the plans. The rates for the most of the plans in California are based on the covered person's age and residence zip code or county. The rates will change from year to year based on age and a rating action by the company. If they move to another state, they may keep their plan but will pay the rates for the highest premium rate area.

Medicare Supplement Plans are subject to underwriting and pre-existing clauses apply unless the beneficiary meets a Guaranteed Issue (GI) situation. Agents should review the underwriting guidelines for each company they are representing. While the GI situations follow the CMS and state requirements, there are variations between the companies in the plans that can be offered and some the situations such as voluntary or involuntary termination from a group insurance. Also, if and what plans can be offered to the age 65 Medicare Beneficiary.

In California we have the advantage of the California Birthday Rule that allows the covered person to change to an equal or lower plan (e.g., G to another company's G or Innovative G or G to an N). The Guaranteed Issue period is on and 60 days following their birthday.

As the plans are designed to cover the copayments and coinsurance amounts of Medicare, they do NOT cover additional services such as dental, Part D prescription drugs, hearing (hearing aids, exams and screenings), transportation, routine eye care and most glasses and contacts and most health care outside the United States. However, in CA some companies are now offering the Innovative Plans (one company calls theirs Extra) that offer vision and hearing Benefits.

The advantages of a Medicare Supplement are:

1) Choice of any doctor who accepts Medicare anywhere in the U.S. This means if the beneficiary wants to see a Johns Hopkins doctor on the East Coast or a doctor at UCLA, they have that option. Of course, they are responsible for all transportation, but at least they have the option.

2) Med Supp's are portable, meaning if the covered person moves, the policy moves with them without any underwriting.

3) The policy is guaranteed renewable. This means the company cannot cancel the policy for anything other than non-payment. So regardless of the use, the covered person can rest assured that they will always have coverage.

4) A MediGap Plan may reduce out-of-pocket costs. Medical costs are fixed and do not vary month to month.

The main disadvantages to Medicare Supplement plans are the premium costs that typically increase each year and no additional benefits. Some companies may offer ancillary benefits such as gym membership, over the counter items, chiropractic and acupuncture and limited overseas travel (depending on the plan). Remember the plans are designed to cover the copays and coinsurances of Medicare. (Plan C & F cover the Part B deductible.) The Medicare beneficiary must enroll in a stand-alone prescription drug plan for coverage for their Part D prescriptions drugs.

In addition, there is an issue regarding skilled nursing coverage. If the Med Supp covered person was not admitted to the hospital as they were on observation status and did not meet the three-day hospital stay requirement prior to being admitted into skilled nursing, Medicare will not pay, so the Med Supp will not as well.

If a covered person disagrees with a decision by Medicare for a denial of coverage, there is an appeals and grievance process to request that Medicare revisits the decision.

REVIEWING THE MEDICARE ADVANTAGE PRESCRIPTION DRUG (ALSO MEDICARE ADVANTAGE ONLY)

Part C of Medicare are Medicare Advantage plans. Medicare Advantage plans are approved by Medicare and administered by private insurance companies, taking the place of Medicare. This does not mean the member loses Medicare, as they can revert back to Original Medicare under Medicare guidelines, it just means the health plan will pay out Part A and Part B benefits instead of Medicare.

The main benefit to a Medicare Advantage plan is these plans include both Parts A and B and cover most, if not all the deductibles and out of pocket costs associated with Original Medicare. Many Medicare Advantage plans also include Part D coverage (prescription drugs), at no additional premium. Members will still be responsible to pay Part B premiums.

There are several types of Medicare Advantage plans such as Health Maintenance Organization (HMO) Plans, Preferred Provider (PPO) and Special Needs Plans. The plan offerings vary by company and by county. Note the benefits can be no less than those offered by Original Medicare. Depending on the company's plan there may be a monthly premium. There are plans in some areas also offering a giveback of some or all of the Part B premium.

Medicare Advantage plans may also include additional benefits not offered by Original Medicare, such as, dental, vision and transportation to doctor visits! And many are covering the stay in a skilled nursing facility although the individual was on observation status and did not meet the 3-day prior hospitalization Medicare requirement.

The main disadvantage to Medicare Advantage plans is members typically must use an established network for medical care unless it is an emergency or urgent care. Networks may limit which doctors a member may visit. For most services a referral is required from the Primary Care physician to a specialist or for treatment. (Types of services waiving the referral requirement vary by plan.)

Lastly, a beneficiary must be in an enrollment period to be eligible to join a Medicare Advantage plan in addition to the other eligibility requirements.

With any HMO plan, members can change to a primary care physician by contacting the plan and requesting the change. Usually if made before the 15th of the month, they can begin seeing their new primary doctor the first of the next month.

Disenrollment is also simple. If the member changes their mind prior to the plan's effective date they can cancel the application and enroll in a new plan. If they disenroll after the plan's effective date, one needs to submit a request in writing. The agent should discuss the options and consequences of the disenrollment as there are rules as to new plan eligibility and Part D.

If a member disagrees with a decision of their health plan, say on a drug exception or a denial of coverage for a C-pap machine for instance there is an appeals and grievance process to make the health plan revisit the decision.

Once you have determined which type of coverage the Medicare Beneficiary would like to consider you then can go into the plan details, the prescription drug coverages and other benefits. Remember to always secure a Scope of Appointment prior to discussing the Medicare Advantage or Stand-Alone Part D plans.

Medicare Supplements and the Medicare Advantage Plans offer great coverage options to the Medicare beneficiary. One is not better than the other. It is a matter of which type and which plan best fits their needs both medically and financially. You as the agent need to understand the differences and plans and present them clearly for the beneficiary's understanding. And, it is important to note that you will be reviewing the plans with your client yearly to continue to determine the plans that best fit their needs! CB

MAGGIE STEDT *is an independent agent that has specialized in the Medicare market for the past 21 years. She is currently president of California Association Health Underwriters (CAHU) and is a past president of her local Orange County Health Underwriters Association (OCAHU) chapter. Reach her at* **maggiestedt@gmail.com.**

LAAHU's Mentor and Allyship Program Aims to Attract Young Talent

Consider sponsoring an intern for your benefit and theirs

CAL BROKER approached LAAHU's Diversity, Equity, and Inclusion (DEI) committee members to learn more about their Mentor and Allyship Program Adopt-A-Community College effort, and how this can be an important recruitment strategy for your agency.

DEI Committee Chair June Taylor: This month we are excited to put a spotlight on LAAHU's new Mentor and Allyship Adopt-A-Community College Program championed by Elizabeth Underhill. Elizabeth is one of our lead committee members who serves as the enthusiastic team captain of our Mentor and Allyship Program. Through this initiative, we hope to foster awareness and "diversify" the talent entering our profession.

Elizabeth has asked Dr. Jezabel Urbina to be her co-chair, in part for her "enthusiasm in the subject, support, and unique insight," says Elizabeth. "Plus, even though I haven't known her long I can tell she's an incredible person and will be an amazing asset with her experience."

Elizabeth is laser-focused on breaking barriers within our industry and association. We are looking forward to her contributions in this space.

In addition, Dr. Urbina LAAHU Communication Chair shares insights here on the value of entering the insurance industry. A millennial with extensive personal experience navigating the education system, she is using that knowledge to attract young talent.

Dr. Jezabel Urbina: I joined the insurance industry at age 21 by coincidence. I was working for a Medicaid HMO in my hometown doing clerical work while I attended college to be an engineer. I don't think anyone really graduates from high school and says, "I want to be an insurance agent someday."

What I experienced is a very flawed education system which typically perpetuates the idea that undergraduate and graduate degrees are the best (and sometimes ONLY) strategy for future success. Apart from the 'option' to join the military, I don't think we ever had anyone in my community college days sit us young people down and tell us: "Hey, there are other options. You can still be successful without a college degree." Many young adults do not have the money to go to college and don't want to take out student loans.

I was really surprised to find in my research that the average insurance agent is 59 years old. This is not saying that is the average age when they first start. However, the fact that 59 is so close to retirement age lets us know that we are missing attracting that younger age group. Somewhere out there is a large group of millennials or Generation Z's who may be naturally skilled sales agents.

There is definitely a lack of advocacy from the insurance industry to that younger population. If they knew how prosperous they could be in this industry they could make different choices. Why would someone in college take a job selling shoes for a department store if they knew they could make exponentially more selling insurance?

Truth is, building and developing that young talent is going to lead to higher agent retention within your agency and bring on more technologically savvy agents to keep up with today's changing insurance industry. We at LAAHU wanted to spearhead the Mentor and Allyship Program to show the added value sponsoring interns can bring to agencies. The Adopt-A-Community College aspect of the program gives us a chance to go into the community colleges and present our industry's possibilities.

Elizabeth Underhill: I wanted to establish the Adopt-A-Community College program for many reasons. One being that so many young adults have absolutely no idea of the opportunities that lie within the insurance industry. I was certainly guilty of this; I spent my life vowing I would never be in insurance like my family. (Let's face it—insurance isn't exactly "sexy" to the majority of young individuals). Instead I obtained a B.A. in political science and set my path toward politics.

Then after "temporarily" working at my family's agency and a trip to Sacramento with my dad, Chuck Underhill, just weeks into this "temporary" position to attend CAHU's Capitol Summit (then Day at the Capitol), I was hooked. I told him on the flight home that we better get me signed up for classes so I could become licensed. Thankfully, I took an alternative path than the one I originally intended!

Insurance as a career isn't attractive

to young people until they dip their toe in it. Then they will have their mind blown by how wrong they were once they learn about just how amazing this industry is. If we show them the multitude of opportunities, I think they'll get excited. We really need to focus on turning young adults on with an internship/mentorship program that rocks so we can actually attract new agents. Whether they are right out of high school, community college or university—it doesn't matter. There's a place for their talent.

That is why when June K. Taylor, Wayne Guzman and Ross Pendergraft asked me if I would be interested in being a part of their committee and if so, what area I would like to captain, I chose the Mentorship and Allyship program. I developed the Adopt-A-Community College program, which I do not think would be possible without the support of Jezabel. She has already helped me clear my mind of all the noise from others and provided me with supportive suggestions to create the blueprint for the committee—and I will be relying on her heavily to finalize the committee's "architectural plans" so to speak.

I would emphasize that this program is especially important in underserved communities. In communities primarily made up of ethnic minority groups, children and young adults tend to feel "stuck" in their situation. Many may feel like they have been dealt the "two of hearts" and there's nothing they can do to trade it in for the "ace of spades."

Through this program I hope we will attract more youth, show them opportunities waiting for them, and provide a path to success. Ideally, they would enter the insurance industry professionally after their internship. If they decide a different profession is best for them, they have at least gained experience working in a professional setting. They acquire confidence to aim higher, and have a solid network of established and respected professionals as references and mentors to help guide them along the way.

"Building and developing young talent is going to lead to a higher agent retention within your agency and bring on more technologically savvy agents to keep up with today's changing insurance industry."

For those who do choose the path of insurance, they may one day end up working for the agency they interned with. Heck, they may even be the future owner of or partner in your agency—all because of the confidence you instilled and the encouragement and support that inspired them.

Our members will also benefit greatly from this program. An intern can be a huge benefit to our member agents. Having another person on hand to help with various tasks while learning about insurance allows agents more time to focus on what is urgent rather than distractions of time-consuming tasks that cou ld be handled perfectly well by an intern.

Most agents also don't have a succession plan and often find themselves wondering what in the world to do when it comes time to retire. An intern may very well end up becoming a part of an agent's succession plan. Most people feel better about selling their agency to someone they groomed and has worked for them for years. The program can really be a win-win for everyone involved.

Dr. Urbina: Exactly, Elizabeth. It is a win-win. I also believe it benefits agencies to have a diverse agent workforce, not just in terms of language capabilities, but also age groups. Many caregivers handling their parent's or grandparent's insurance may better connect with agents in their age group.

Honestly, I feel a sense of urgency in piloting this program. We have to remember that the retail industry tends to be most teenagers' or young adults' first job. That industry is changing. Many retailers are switching to self-checkouts or closing their doors to the in-person shopping experience and going directly online.

That "first job" experience we all grew up with is changing. Why not be part of that change in a good way? I always tell students I mentor that obtaining my doctorate was a personal goal since I was young, but definitely not something essential to be successful. Young adults need that guidance to let them know that there are other options. The insurance industry can be so rewarding in many different ways besides financially. It can build your social skills, confidence and professionalism early on.

Elizabeth and I are very excited to help LAAHU bring this program to fruition and I hope that many agencies will consider participating.

Elizabeth: See, that right there is exactly why we need Jezabel! She can take the words right out of my mind (albeit much more eloquently) and has the strength and experience to be a key role in such an important initiative. CB

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The American Rescue Plan Act (ARPA) of 2021 and Related Legislation

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at no cost. Plan sponsors and TPAs need to be patient—this is new and quite cumbersome. And eventually more notices will need to be sent out indicating the subsidy has expired. But before those notices are even prepared—everything may change again! Under the ARRA in 2009, the original subsidy period was extended from 9 months to 18 months—without much advance notice. The same could occur with ARPA." Of course, we are all very familiar with that possibility, as it seems to be happening a lot lately!

Is this an additional cost for administrators to absorb and is this something that you feel most COBRA administrators will have to charge additional fees for? "This is the $10,000 question, and currently we do not have much information here; we are getting information updates about every couple of days," commented Jeffrey. "As well as for costs, the COBRA administrator market is reviewing the capital needs to meet the notice requirements and is figuring out what it is, and who will pay. So more to come here."

"Certain tasks, functions or services might be absorbed. However there are certain costs that most TPAs shouldn't be expected to absorb," replied Bobbi. "I would assume that most TPAs would absorb the costs for system upgrades and IT programming. However, hard costs such as re-mailing notices and then additional notices, will likely be passed on to the plan sponsor. At PayPro Administrators, we do not intend to have any additional fees beyond the newly required temporary notice mailings."

These are important questions to ask your administrators now, not later... Inquire about costs and budget appropriately.

Employers should start working with their internal HR departments and COBRA administrators to start preparing for the distribution of the new notices, etc. There will also be tracking to do for anyone on COBRA since November, 2019 (going back 18 months), to give another opportunity to enroll, add back on, receive subsidies, etc. So, the work is far from over!

Employers should start working with their internal HR departments and COBRA administrators to start preparing for the distribution of the new notices, etc. There will also be tracking to do for anyone on COBRA since Nov. 2019 (going back 18 months), to give another opportunity to enroll, add back on, receive subsidies. So, the work is far from over!

Notice scenarios

I'll provide a couple of scenarios, taken from the statute, but again modified slightly and expanded upon by our benefits attorney, Marilyn Monahan, to try to simplify the notice requirements, as it's often easier to understand with examples.

EXAMPLE ONE:

Anna was terminated for cause and her COBRA coverage would have started on November 1, 2019, but Anna did not elect COBRA. Because Anna has not yet exhausted her 18 months of COBRA coverage, she must be offered the opportunity to enroll effective April 1, 2021, and receive one month of subsidized COBRA coverage (as the 18 months would expire on April 30, 2021, with an effective date of Nov. 1, 2019), assuming she is not eligible for other group coverage or Medicare. Anna would receive an updated COBRA election (general) notice, and she would also receive a notice that the subsidy will end on April 30, 2021.

So, in essence, again, the latest you have to go back is to Nov. 2019, to cover the 18-month COBRA period for anyone. So, employers need to look at all terminations from Nov. 2019 to present, to offer new opportunities to enroll, etc.

EXAMPLE TWO:

Andy was terminated for cause and his COBRA coverage would have started on Jan. 1, 2020, but Andy did not elect COBRA. Because Andy has not yet exhausted his 18 months of COBRA coverage, he must be offered the opportunity to enroll effective April 1, 2021, and receive 3 months of subsidized COBRA coverage (as the 18 months would expire on June 30, 2021, with an effective date of Jan. 1, 2020), assuming he is not eligible for other group coverage or Medicare. Andy would receive an updated COBRA election general notice, and he would also receive a notice that the subsidy will end on June 30, 2021.

EXAMPLE THREE:

Derek reduced hours worked starting on Jan. 1, 2021, for personal reasons. This results in a loss of coverage effective Jan. 1, 2021, which is a COBRA qualifying event. Derek elects COBRA. Effective April 1, 2021, Derek is entitled to 6 months of subsidized coverage as long as he's not eligible for another group health plan or Medicare. Derek will receive an updated COBRA election notice explaining the subsidy.

In this example, it's important to note that a reduction in hours does not have to be involuntary. Even voluntary reduction in hours could be subsidy-eligible, unless further guidance disallows that.

Now, if you assume instead that Derek's COBRA Qualifying Event takes effect April 1, 2021, the same result will occur as above; 6 months of subsidized COBRA premiums.

Let's say however that before receiving a new COBRA notice, Derek pays for the April premium for fully insured coverage. If this is the case, the employer would be required to reimburse the COBRA premium back to Derek within 60 days.

Now let's assume that Derek's open enrollment date was Jan. 1, 2021. Derek pays the January premium, then stops paying premiums. Under ARPA, Derek will be given an updated COBRA election notice, and he can re-start COBRA with an effective date of April 1, 2021, and it will be subsidized for 6 months. Under the Outbreak Period rules (covered earlier in this article), Derek has up to one year to pay for February and March, 2021 premiums, if Derek wants coverage in those months. But let's say he had no claims. He elects COBRA coverage effective April 1, so there is a gap in coverage.

Starting on April 1 he gets a subsidy for 6 months, so if he had no claims in February or March, he could simply not pay those back premiums, and let the effective date be April 1, 2021. So, I'm sure you picked up on this right away.

The outbreak period changes plus the subsidy rules under ARPA allows for adverse selection, so that COBRA beneficiaries can elect to have coverage in the months in which they have claims and/or have subsidized coverage, and skip payment in the months of February and March, in this scenario, if there were no claims during those months (assuming new guidance doesn't change that).

Indeed, the Registered Health Underwriter (RHU) and former TPA executive in me gets a bit cross-eyed when I work through these scenarios!

Scenario: time frame extensions and COBRA subsidies

Here is another example to help you to understand the timeframe extensions and COBRA subsidies.

Tim was involuntarily terminated effective Nov. 30, 2020. His health coverage also ended that day. He was offered COBRA and under typical COBRA rules, Tim has 60 days to elect COBRA. Tim did not elect COBRA. Tim is not currently eligible for another group plan or Medicare. Under the timeframe extensions, Tim will have until Jan. 30, 2022 to elect COBRA. Under the ARPA COBRA subsidies, Tim must be provided a new COBRA election notice explaining the COBRA subsidies and the extended election period. He will have 60 days from that notice to elect COBRA, effective April 1, 2021. Tim's maximum period of COBRA coverage is 18 months, or through May 31, 2022.

This means that there will be a gap in coverage unless Tim goes back and pays the COBRA premiums, which he has one year to do. He will still be eligible for subsidized coverage for the period April 1, 2021 through Sept. 30, 2021.

Confused yet?

PLAN ENROLLMENT OPTION: OPTIONAL!

Employers may, but are not required, to offer the AEIs the opportunity to change their coverage from the plan they are currently enrolled in to another one offered by the employer. In such a case, the cost of the coverage in the alternative plan cannot exceed the cost of the current plan the AEI is enrolled in, and the coverage must be offered to similarly-situated, active employees.

The alternative coverage cannot be only excepted benefits, a QSEHRA, or a health FSA. The employer must provide the notice, and the information about the option should be included in the updated COBRA election notices. AEIs then have 90 days to elect the coverage change.

This option would work in scenarios where for example, someone wants to change from a PPO to an HMO if there are better benefits, for example, within the HMO. To do this, the plans must cost the same or less than the one they are covered in.

MARKETPLACE ADVANCED PREMIUM TAX CREDIT (SECTION 9661)

Another important change under the ARPA is additional funding for marketplace advanced premium tax credits, or APTC. Under the ACA, if you purchase an individual health policy from a Marketplace (such as Covered California or the federal marketplace), you may be eligible for a premium tax credit to help pay for the cost of that coverage, depending on your household income.

For 2021 and 2022, ARPA is expanding eligibility for those tax credits. CMS announced additional credits available in the federal marketplace starting April 1, 2021 (check with your state's marketplace to determine effective dates).

In general, the additional subsidies in the Marketplace will be based on the percentage of the Federal Poverty Level (FPL).

Premiums for consumers after these new savings will decrease, on average, by $50 per person per month, or $85 per policy per month. It is reported that four out of five enrollees will be able to find a plan for $10 or less per month after premium tax credits, and over 50% will be able to find a Silver Plan for $10 or less per month. No one will pay more than 8.5% of their household income towards the cost of a benchmark plan, or a less expensive plan.

It's important to understand that individuals who experienced a (QE) prior to the subsidy period, whose maximum period of COBRA coverage has not yet ended, and who either did not elect COBRA or allowed their COBRA coverage to lapse, have a NEW OPPORTUNITY to elect COBRA and take advantage of the subsidy. In these situations, the COBRA coverage is prospective; it does not begin before April 1, 2021, and it will not extend beyond the length of their maximum coverage period had they elected COBRA when originally eligible.

Covered California, for example, in a press release dated March 18, 2021, stated that an estimated 3 million Californians are among the 25 million Americans who stand to benefit from the new and expanded subsidies, which will lower premium costs and make health care coverage more affordable than ever. According to this press release, Covered California will open a new special enrollment period on April 12, for May 1 coverage for the estimated 1.2 million uninsured Californians who are eligible, as well as the 430,000 people currently insured off-exchange who will qualify

for the new financial help. In addition, says the press release, most of Covered California's currently enrolled consumers will see an average of $119 per household in monthly premium savings that will automatically start in May.

Covered California, as well as other Marketplaces, have a major marketing campaign to get more people covered during this special period.

According to Covered California, consumers who earn less than $32,000 a year for an individual will be able to either get a benchmark Silver plan for between $50 and $60 per month and virtually would be able to get a Bronze plan for $1 per month. People currently insured off-exchange will now be eligible for subsidies within the exchange. No one will pay more than 8.5% of their income on health premiums. An individual with income $51k+ per year currently pays (on Covered California plans) an average of $1,100/month for coverage. Under expanded subsidies with ARPA, their monthly premium drops to an average of $508—a savings of nearly $600/month, and a total of nearly $12,000 between this May and the end of 2022.

DEPENDENT FSAS (SECTION 9632)

For the 2021 tax year, the amount that can be contributed to an employer-sponsored dependent care assistance program (aka a DCAP or dependent care FSA) is increased from $5,000 to $10,500, or $5,250 if married and filing separately. This provision may be adopted retroactively to 1/1/2021, so long as a written cafeteria plan amendment is adopted no later than the last day of the plan year, and the plan is administered according to the change in the interim.

"An employer that wishes to increase the contribution limits for its DCAP will undoubtedly have to amend the terms of its written cafeteria plan document," stated Marilyn Monahan. "The amendment must be adopted no later than the last day of the plan year to which the amendment is effective and, in the interim, the employer must administer the plan consistent with the amendment. Any such changes should also be communicated to employees."

TAX CREDIT FOR PAID SICK LEAVE (SECTION 3131)

Under ARPA provisions, employers may be eligible for a 100% credit for qualified sick leave wages. Employers are NOT required to provide the leave, but if they do, they can continue to receive tax credits for the period April 1, 2021 through Sept. 30, 2021. Paid leave benefits of up to $200 are available for reasons (from prior FFCRA class and article) 4, 5, 6 or newly added reasons for leaves, and up to $511 for reasons 1, 2 or 3 of the FFCRA provisions. There is, however, a limit of 10 days for the leaves.

Remember that there was a hard stop for FFCRA benefits on Dec. 31, 2020, but a voluntary extension was then available through March 31, 2021. If employers elected this voluntary extension, they are now entitled to these additional tax credits.

Tax Credit for Paid Family Leave (Section 3132)

For paid family leave, credit is now available under the ARPA for 100% credit, for time period April 1, 2021 through Sept. 30, 2021, for up to $200 with no more than $12,000 across all quarters (up from $10,000). These tax credits apply to all eligible reasons under FFCRA.

LEAVE RULES

Under these leave rules, credit can be claimed on the employer's quarterly taxes, and excesses are refundable, or employers may claim advance credit and can include qualified health plan expenses. All of the same administrative rules from FFCRA apply as to eligible employees and available hours under these provisions. Governmental entities, however, are not eligible to claim this credit.

Credits cannot be applied if an employer is claiming under the PPP Loans, Restaurant Revitalization Grants or Economic Aid to Hard-Hit Small Businesses, Non-Profit Organizations, and Venues Act Grants. As stated above, there is no double-dipping allowed....

In conclusion, I'm pretty sure that your heads are spinning right now and that you probably had to set this article down a few times before you continued. So, I ask you... How do you think this has been for the administrators and industry personnel dealing with all of this? So, for all of you, again, this article is dedicated to you, and to all of the hard work you put into all of these new laws.

Our hats are off to you! THANK YOU!!!! CB

DOROTHY COCIU, *RHU, REBC, GBA, RPA; vice president, Communications, CAHU; president, Advanced Benefit Consulting*

A Salute to Those That Made It All Happen

Author's Note: I'd like to once again thank Marilyn Monahan of Monahan Law Office for her assistance with this article and my previous client webinars on this topic. I'd also like to thank MaryAnn Wessel, Jeffrey Strong and Bobbi Kaelin for their assistance and cooperation with this article.

Disclaimer: The information provided in this article does not constitute legal or tax advice. This article only provides a summary of certain complex and always evolving laws and regulations. Readers should consult their legal counsel for guidance on the application and implementation of the many federal and state laws that impact employee benefit plans and the workplace, including the topics discussed in this article.

Reference Sources: Bill Text, HR 1319, Webinar Materials, The American Rescue Plan Act of 2021 and Outbreak Period Updates, March 30, 2021, by Dorothy Cociu and Marilyn Monahan (Monahan Law Office).

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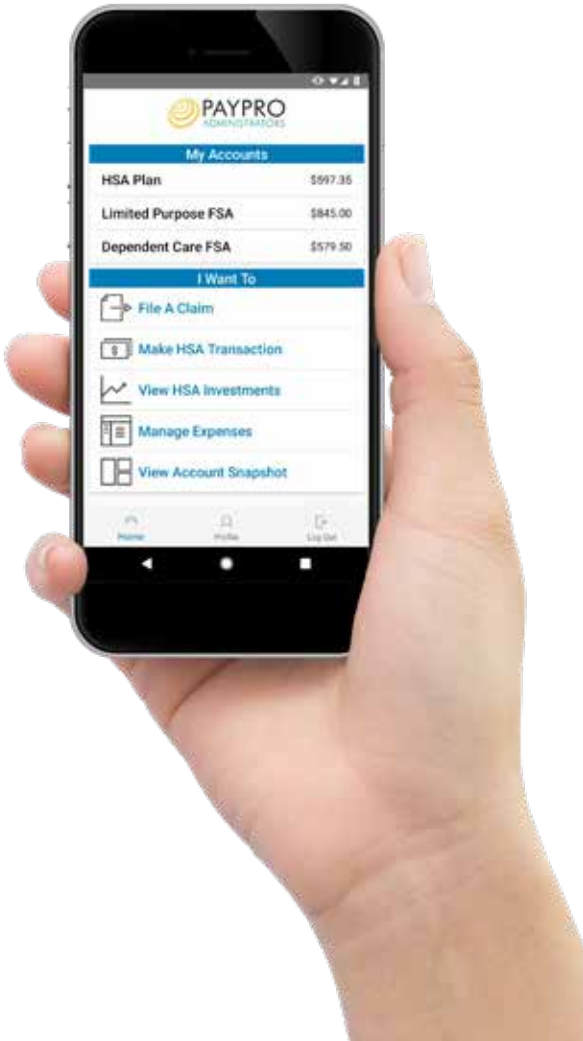

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