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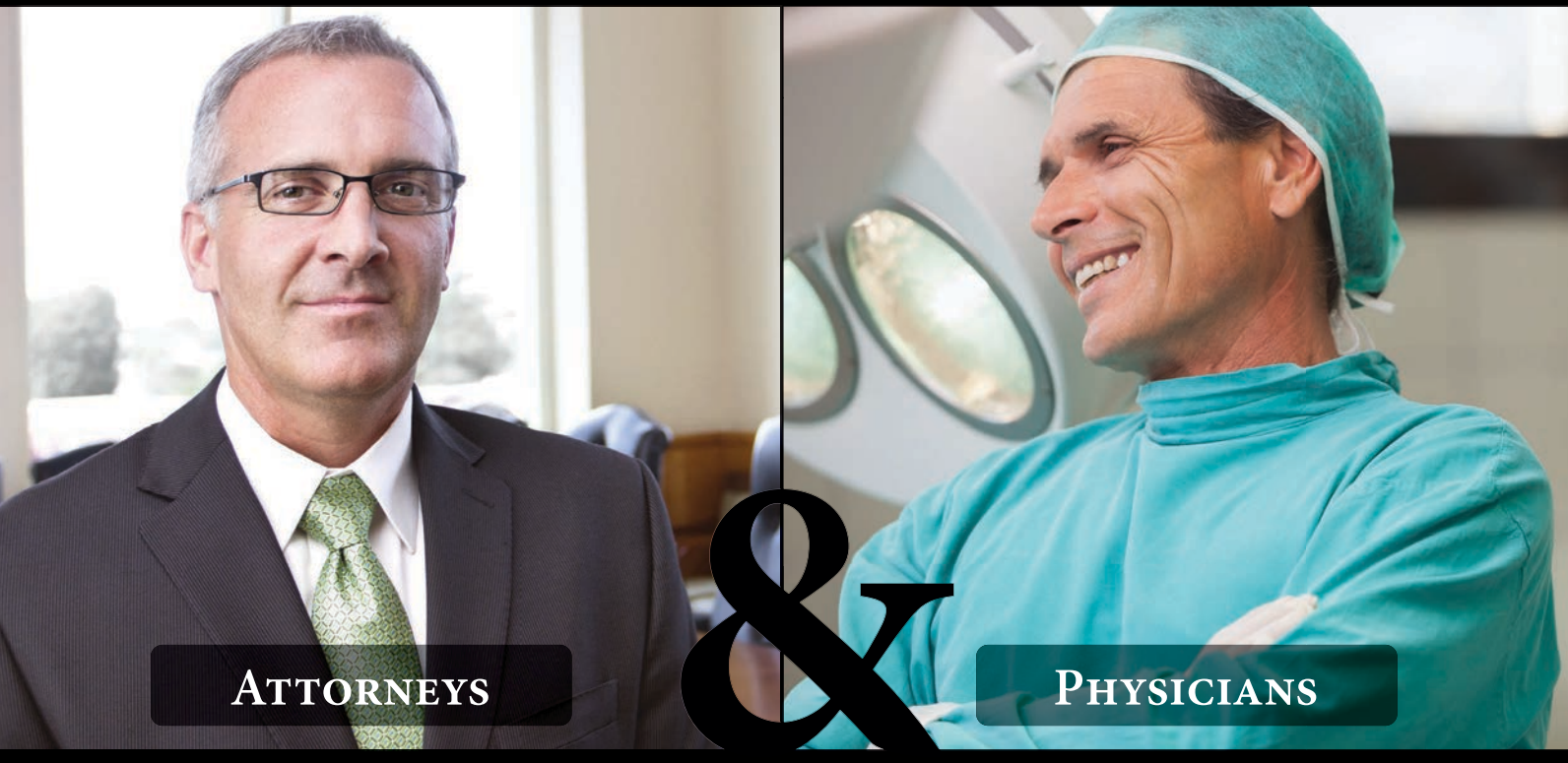

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INDUSTRY/NEWS

Climate Insurance Working Group Releases Recommendations

As a result of the nation's first-ever law to study how to use insurance to protect Californians from climate change, the California Climate Insurance Working Group released 40 state and local policy recommendations focused on reducing damage and improving recovery following a wildfire, extreme heat wave or flood. While benefiting all consumers, the recommendations also focus on low-income communities, seniors and those without insurance who are more vulnerable to the impacts of climate change.

The report, "Protecting Communities, Preserving Nature, and Building Resiliency; How First-of-Its-Kind Climate Insurance Will Help Combat the Costs of Wildfires, Extreme Heat, and Floods" recommends policies to the Insurance Commissioner, the Governor's Administration, the State Legislature, local governments, businesses, and communities across the state.

While many of the recommendations would require action by the Governor, the State Legislature, or local governments, California Insurance Commissioner Ricardo Lara says he'll prioritize several policies under his existing authority, including:

- Creating "climate ready" pilot projects utilizing nature-based solutions, such as a community flood insurance plan for an at-risk area that gives residents some disaster coverage and also invests in wetland preservation, reducing costs of future relief and rebuilding.
- Advocating for ranking of heat waves to better communicate the deadly risks to consumers and help communities prepare, similar to how tropical storms and hurricanes are described by "category" level, as a member of the Extreme Heat Resilience Alliance.
- Increasing pre-disaster mitigation by consumers, business, and local governments, which Commissioner Lara is currently pursuing through a partnership with Governor Newsom's administration to create a list of wildfire mitigation measures.
- Incentivizing safer building and keeping people out of harm's way through proposed regulations to require insurance companies disclose wildfire risk scores to consumers and businesses while incentivizing home- and community-hardening.

Good News for Generics

The Food and Drug Administration recently announced that they are making real gains when it comes to greenlighting generic drugs. In fact, the FDA noted that it has now approved more than 100 drugs under its competitive generic therapy (CGT) designation. CGT is a designation for products that have inadequate generic competition in the market due to low market potential, less profit margin or complexity in manufacturing. There appears to be new generics for GI issues, blood pressure, asthma and more.

Society of Actuaries Contribute $150k to Mentorship for Future Actuaries

The Actuarial Foundation announced the generous sponsorship of the Society of Actuaries (SOA) for the Foundation's STEM STARS Actuarial Scholars Pilot Program. This support will help the Foundation launch the first cohort with its primary goal to break down the barriers to enter the profession for high school students and to support them during their college journey.

The pilot program will consist of a cohort of 20 high school juniors and seniors. Four student support groups formed by the Foundation, including a Corporate Advisory Council, Scholarship Mentors, University Partnerships and Applications Review will create a community of volunteers and partners committed to these students' success. Each of these support groups will provide students with academic tutoring, social rapport, mentoring, career placement and peer encouragement that they need to be successful on their pathway to becoming actuaries.

The STEM STARS Actuarial Scholar Pilot Program will also leverage two of the Foundation's most successful national programs, the Math Motivators Tutoring Program and The Modeling the Future Challenge to engage teachers, students and guidance counselors. Look for more information about the STEM STARS Actuarial Scholars Pilot Program coming soon at www.actuarialfoundation.org.

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Cal Broker Prepping for 2022

We're gearing up for 2022 and we're keen to add new contributors to the mix. Please reach out if you're interested! Email us at editor@calbrokermag.com.

Pandemic Fall Out: Babies Postponed

The U.S. Social Security Administration reported that the COVID-19 pandemic contributed to the total fertility rate declining to its lowest level in U.S. history. Total fertility rate (number of births a woman is projected to have in a lifetime) is 1.54 this year. Research suggests, however, that babies were simply postponed during the pandemic. The fertility rate is expected to rise to about 1.64 next year.

EVENTS

SIIA 41ST ANNUAL NATIONAL EDUCATIONAL CONFERENCE & EXPO, IN-PERSON & VIRTUAL, October 3 - 5, JW Marriott, Austin, TX. Register & secure room NOW! Hotel is nearly sold out. Info at www.siaa.com.

FORECASTING HEALTH PREMIUMS

The American Academy of Actuaries has published an issue brief examining what's driving changes in individual and small group markets health insurance rates for 2022. Key conclusions of the brief, which was developed by the Academy's Individual and Small Group Markets Committee, include:

- As more information is available on how COVID-19 has and could continue to affect healthcare spending, carriers are more likely to include adjustments in their 2022 rates.
- Issues surrounding the pandemic continue to be a consideration for rate setting, including how the pandemic may affect regional variations in hospital utilization, the cost of vaccinations and need for booster shots, how and where members seek or delay medical care, and utilization for mental health services and telemedicine.
- Uncertainties remain regarding how the potential ending of the public health emergency and the enhanced premium subsidies available through the American Rescue Plan Act will affect plan enrollment and spending.

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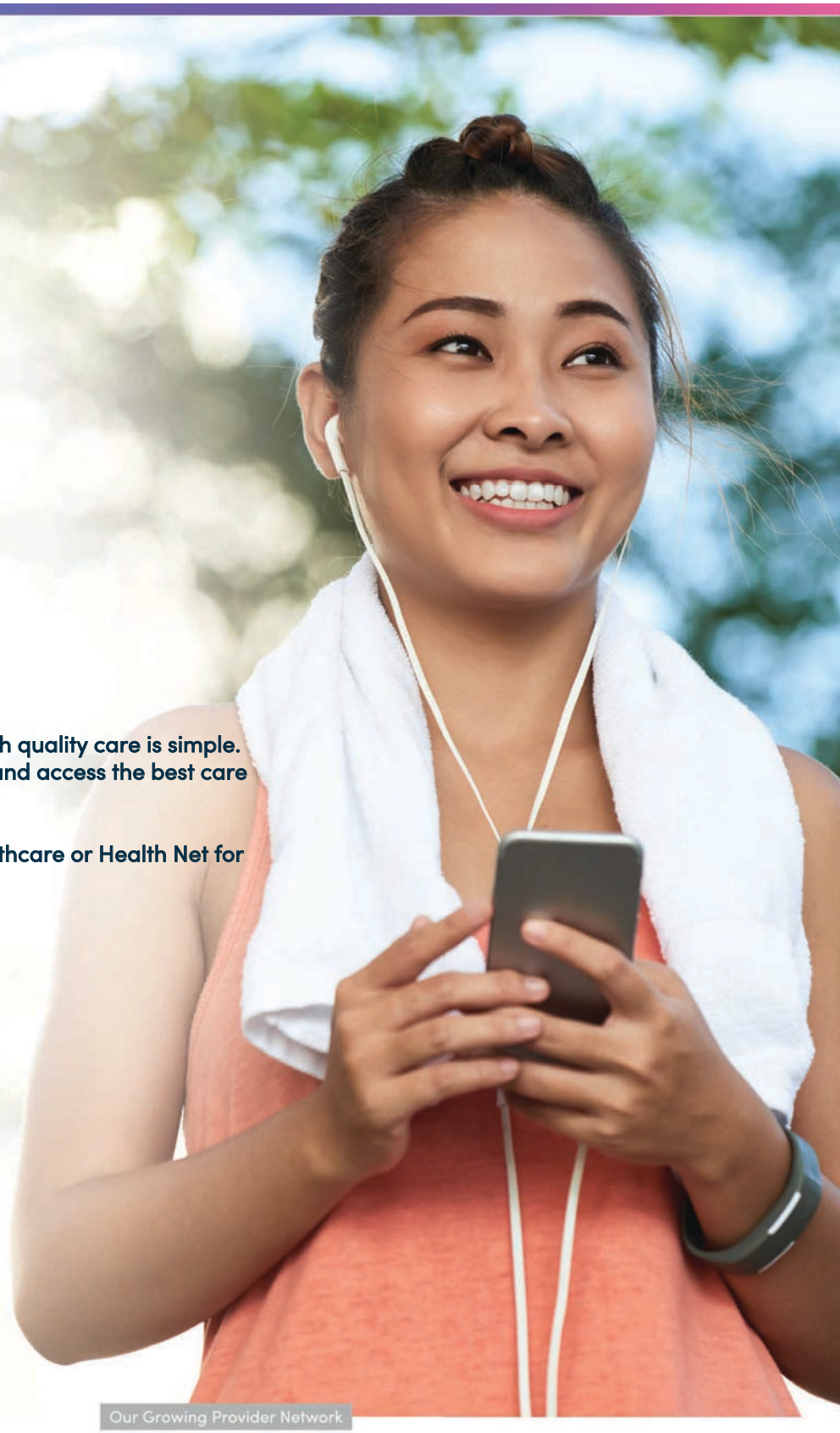

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6 KEY REASONS OFFERING BETTER VISION BENEFITS WILL HELP YOUR ORGANIZATION

Great vision benefits help with employee retention and more

BY ANTONIO MORAES

FOR MOST EMPLOYERS, vision benefits have been a "check the box" offering because there has been little innovation in the last 50 years. Employees typically choose between two fairly standard plans, with limited coverage, and may never take advantage of them at all, despite the fact that premiums typically cost between $96-$144 per year (or over $340 for a family plan). As a result, a small fraction of your client's workforce uses its vision benefits to obtain glasses or contacts each year.

Instead of opting for the status quo and "checking the box" with your benefit plan offerings and failing to see a real return on investment (ROI), here are six reasons why offering better vision benefits will help you boost employee utilization, lower benefits costs for you and your employees, and retain your best people.

1. Employees want better vision benefits

A recent study by Vision Monday magazine showed that 87% of employees surveyed would be more likely to stay at a company that offered high-quality vision benefits, such as coverage of premium lens and frame options. Not only do great vision benefits help with employee retention, but research has repeatedly shown that access to high-quality benefits is a key factor job candidates consider when deciding whether to join a new company. It shouldn't be understated either that most employees would take a pay cut in exchange for better benefits, too.

2. Vision insurance cost gaps affect most employees

Not only do your employees want robust vision plans for themselves, but they also want to rein in costs to cover their families as well. For a family of four with traditional vision insurance, the average price of doctor-recommended glasses exceeds $306 at what is considered a 3,000% markup, even after applying traditional vision benefits. Add in the premiums and a family of four is typically spending over $1,000 with vision care and vision insurance.

When you consider that 60% of Americans don't have $1,000 saved for emergency expenses, it's no wonder why high out-of-pocket costs in the retail environment lead to many employees opting out of utilizing their vision plans each year.

3. Employees are drastically underutilizing vision benefits

As a result of costs and coverage limits employees have with traditional vision plans, just 14% of the workforce uses its vision benefits to obtain glasses and 10% for contacts each year. Even worse, only 35% of employees take advantage of their eye exam coverage per year, even though exams are proven to help prevent growing and costly epidemics like eye strain.

4. Digital eye strain is a productivity killer

As we just mentioned, research shows that increased screen time and fewer breaks are a detriment to employee productivity because of eye problems that form as a result. A jarring 79% of employees report that time spent on their devices is impacting their job performance due to headaches, fatigue and focus issues. This is according to a study by the Society for Human Resource Management (SHRM). Headaches alone result in $17 billion in absenteeism, lost productivity and medical costs for business per year.

5. The productivity loss with uncorrected vision problems is huge…like billions huge

If you're just "checking the box" and offering status quo vision benefits, it's more than likely your people aren't maximizing your coverage. It's been estimated that the cost of uncorrected vision problems is $244 billion. Even though you may be offering premium family plans, it's more than likely your people don't know how to maximize their benefits, or simply aren't satisfied with the breadth of these plan offerings since they can only choose one pair of glasses or contact lenses per year.

6. High-quality vision care actually saves your company money

It is estimated that early detection of eye diseases, such as diabetic retinopathy, saves companies $7 for every $1 invested, according to a special report by Workforce.com. This could mean saving $8 billion from lost productivity.

Conclusion

While employee benefit packages traditionally focus on healthcare packages, there is growing employee demand for more comprehensive vision care, as benefitspro.com explored. As digital eye strain and other issues related to increased screen time are on the rise, employers need robust vision benefits plans that all employees can leverage to stay healthy and productive. CB

ANTONIO MORAES *is the CEO and co-founder of XP Health, a benefits technology company in the vision space. As an international author, speaker, investor and serial entrepreneur, Moraes previously co-founded Vox Capital, a healthcare innovation fund that became a Harvard Business School and Harvard Kennedy School case study. Moraes is the co-author of the movie, "A New Capitalism," available in 190 countries on Netflix, Amazon Prime, and iTunes, and of several articles and publications about healthcare, benefits and innovation.*

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Supporting Employee's Eye Wellness in the Workplace to Improve Quality of Life

BY DR. RICHARD HOM

MYOPIA (an elongation of the eyeball) is a common eye disorder that results in blurred vision, but is relatively easy to fix with prescription lenses or contacts. This disorder affects 150 million people in the U.S. and is the most common of the refractive errors, which also include hyperopia (a shortening of the eyeball) and astigmatism. Among these, myopia has the highest prevalence, affecting nearly 42% of Americans, a figure that has doubled in the last three decades, across all race, ethnic and gender demographics.

There are growing concerns that this number could be even higher post-COVID-19 as screen time increased dramatically for all age groups, and while many were less likely to spend time outside. A new phenomenon has surfaced during this time called 'coronavision,' where many people noticed their eyesight deteriorating during lockdown.

As vision issues and disorders become more common in part due to the pandemic, ensuring access to acceptable vision care has become paramount to help maintain the overall well-being of Americans. The eyes play a vital role in our quality of life, so it's important that employers provide comprehensive vision benefits and encourage employees and their families to pursue regular eye exams. It is clear that if not taken care of, these issues can evolve into more severe conditions that can have life-altering implications.

Vision health was an issue before the pandemic

As previously mentioned, the prolonged period living in quarantine and working remotely has contributed to an increased prevalence of various eye conditions including myopia, dry eye and computer vision syndrome. The uninterrupted stretches of time many are spending staring at a computer screen has led to a sharp rise in symptoms of eye fatigue and strain, which when not addressed can lead to myopia and vision impairment.

This is especially concerning given the incidence of refractive errors increases with age, meaning most of the American workforce was already at risk of developing vision issues before the pandemic. According to JAMA Network, Pre-COVID-19, people between the ages of 20 and 39 had 46% prevalence, those between 40 and 59 years of age saw 50% prevalence and those over the age of 60 had almost 63% prevalence.

Supporting employee vision health should be a consistent priority for employers as persistent vision problems not only cause and worsen eye fatigue, but also lead to discomfort and headaches, all of which can impact one's ability to work and be productive. Beyond offering vision benefits, employers should also make an effort to ensure employees are taking measures to protect their vision while working. For some, this means going further than recommending employees wear blue light blocking glasses,

as there are a number of published studies demonstrating they're ineffective at alleviating eye strain.

However, some effective methods that should be encouraged include improving ergonomics by adjusting the height and angle of the computer screen and correcting posture, and following the 20-20-20 rule: every 20 minutes, look up from the screen and focus on something at least 20 feet away for 20 seconds. Additionally, if an employees' work environment exposes their eyes to chemicals, debris, and/or pollutants, they should always wear safety goggles.

Beyond the employee, vision benefits help children

While employee health is an employer's first priority, they should also consider the impact that offering quality vision benefits has on the well-being of the employee's family, since children and in some cases, spouses, will use these benefits as well. This becomes especially important as it relates to children because their vision health has also been negatively impacted by the pandemic, which could have severe implications for their overall development.

While children haven't been exposed to the daily 9 to 5 of looking at a screen, the stretches of virtual learning has been damaging to their vision, leaving them at higher risk of developing vision issues. This is especially true of younger children in elementary school. Myopia is the biggest concern, and often first diagnosed between the ages of 8 and 12 years old. Worse still, myopia may become worse as the body grows during the teenage years.

Uncorrected vision conditions are among the biggest public health problems in the United States, affecting one in every four children, according to the American Optometric Association. Yet, one in every three schoolchildren in America have not had a vision test in the past two years, if ever. Only 39% of students referred for an eye exam through a routine vision screening end up visiting an eye doctor, and the gap is even larger in high-poverty communities — which leads into the most critical aspect of vision benefits for both adults and children: regular eye exams.

Routine eye checkups are key in preventing untreated vision problems in children that may cause developmental delays, hand-eye coordination problems or a potential lag in their literacy skills. When students who need glasses get them, it can help them learn up to twice as much. For adults, regular eye exams are important to monitor and prevent more serious issues. Those with pre-existing refractory errors are at higher risk for certain types of eye diseases like retinal degeneration, glaucoma, cataracts and retinal detachment, all of which can lead to vision impairment or blindness if not addressed.

The best thing anyone can do to maintain eye wellness is to get an annual eye exam, which can assist with identifying and treating issues, as well as helping ensure individuals are wearing the appropriate corrective lenses with the right prescription.

Choosing a comprehensive vision plan

When evaluating vision plans, consider the benefits of integration. In addition to providing coverage for annual eye doctor visits, integrated plans connect employees' medical records with their dental, vision, pharmacy and disability information, enabling their primary physician and eye care specialist to work in tandem. This is an important component to maintaining overall health as a simple eye exam can help detect non-eye related medical conditions.

Additionally, an integrated plan allows eye doctors access to a patient's full medical record, providing them with insights on any chronic conditions that may affect the eyes. Integrated care provides eye doctors and primary care physicians with the tools they need to develop an early intervention plan that minimizes or manages conditions that might lead to vision loss or other serious health problems down the road.

Anthem Blue Cross and Blue Shield's standard integrated vision plan encourages annual check-ups, as well as an eye safety benefit. Anthem provides real-time visibility into a patient's health history including medications, diagnoses, lab results and care alerts to vision providers, so they can better diagnose and treat consumers. For example, in the past year, Anthem's integrated health program helped identify more than 30,000 cases of diabetes through vision exams.

Many don't realize that high blood sugar can lead to blindness, so while some vision problems can be caused by excessive screen time, there could be an underlying issue to blame. Integrated plans can dramatically improve intervention and prevention of not only eye disease and disorders, but other serious chronic conditions affecting whole body health.

Quality vision benefits can make a big difference

Vision impairment is one of the top 10 disabilities among adults 18 years and older, costing our economy $51.4 billion annually. As reported in 2016, it is estimated that the annual cost of failing to correct refractive errors with eyeglasses in the United States was $35.3 billion, $8 billion of which was lost productivity. Eye wellness continues to be a growing public health issue, making it even more important for employers to provide vision benefits that will give employees and their families access to quality vision care to prevent and manage vision conditions, which in turn will keep them healthy and able to work and live comfortably. CB

DR. RICHARD HOM *is currently the Optometric Director at Anthem Blue Cross and Blue Shield. He holds doctorates in Biomedicine and Optometry as well as an MPA degree.*

A retired lieutenant colonel U.S. Army Reserve, Dr. Hom is also a Diplomate in Public Health and Environmental Vision with the American Academy of Optometry and a Trustee of the California Optometric Association. His interests are patient safety, population health, telemedicine and the social determinants of disability.

Contact: **https://www.anthem.com**

Dental Coverage: An Essential Element to Assure Your Client's Good Health

A CalBroker conversation with Humana's Dr. Dean Fry, DDS
and California Market VP Brian Sullivan

Linda Lalande, CalBroker (CB): What is Humana's approach to health coverage?

Dr. Fry: At Humana, we really provide a holistic package that helps move a member along their health journey. This includes medical, dental, vision and companion offerings to enable "lifelong wellbeing." So, dental is critical — taking care of oral health affects your overall health and ensures wellbeing through a continuum of care.

CB: What is the relationship between ORAL HEALTH and overall physical health? What are the different clues found in your mouth that might need intervention, or that can support a person to make sure that other health problems don't develop?

Dr. Fry: On our chart, we show the relationship between Oral Health and Diabetes, Heart Disease, Stroke, Cancer, Pregnancy and Tobacco Use, etc.

Here are a few examples of how the dentist as gatekeeper is so important to our overall health.

Oftentimes people see their dentist more than their doctor. So, as a gatekeeper of care, dentists can see many health conditions that manifest first in the oral cavity. There may be a telltale sign that something is going on with the body that may not have been diagnosed before.

Periodontal disease and the inflammatory process is the real culprit here and can often be an indicator that something is going on that might need a physician's attention.

With regard to expectant moms, there was a study done in Australia a number of years ago where they looked at periodontal disease — bone loss and inflammation in the mouth. They found that pregnant women who had untreated periodontal disease had a 15% increase in low birth weight and premature babies. That certainly seems to point to a direct correlation.

Things like oral cancer can also be seen in the tissues of the mouth. Oftentimes in a dental x-ray, a tumor or cancerous lesion might be detected, indicating there may be cancer somewhere else in the body. If caught early enough, it may be able to be successfully treated.

And, we really need to talk about COVID-19. It is certainly having an impact on oral health — we are seeing things like loss of taste, tissue lesions as indicators of infection, and dry mouth. Dry mouth specifically can make someone more susceptible to periodontal disease and tooth decay. Of critical importance is that the mouth (oral cavity) is an important site for SARS-CoV-2 infection and implicates saliva as a potential route of SARS-CoV-2 transmission.

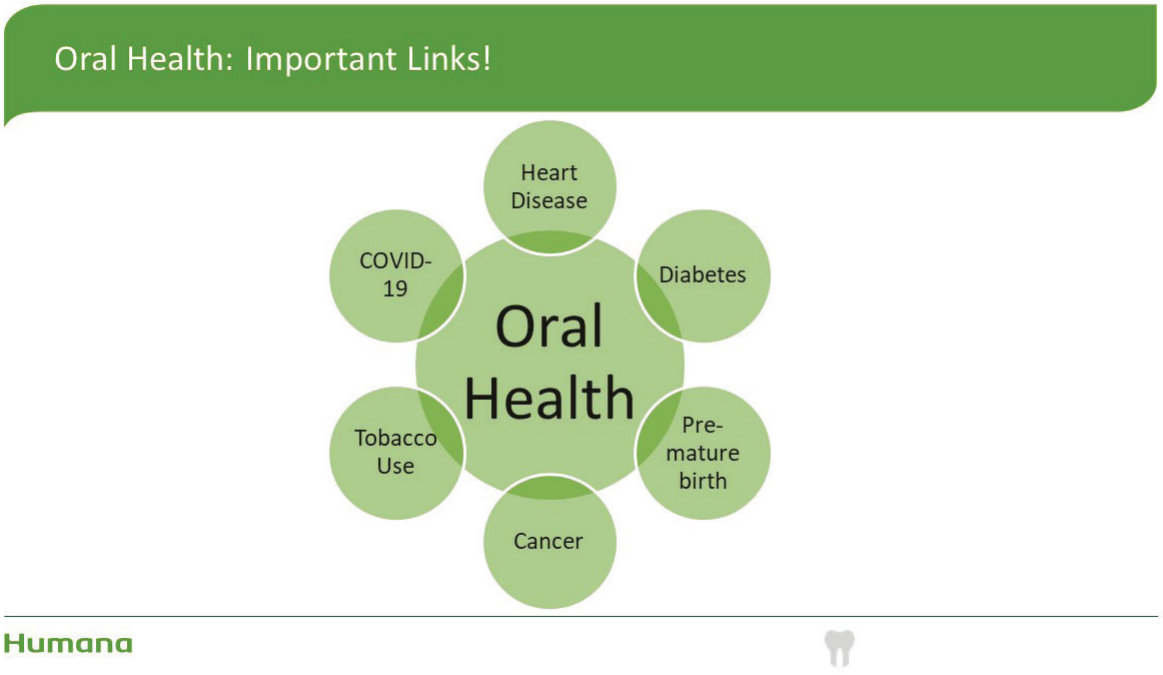
Interestingly, dentists are also reporting seeing more cases than ever before of chipped and cracked teeth due to grinding because of the stress of the pandemic. It affects mental, physical and oral health. Humana has a COVID-19 Long-Hauler team looking at health holistically so we can help members achieve our common goal of lifelong wellbeing.

CB: Are most dentists pretty well trained to recognize signs? Does Humana do something special to help educate them?

Dr. Fry: I would say yes, dentists are well trained overall.

The connection between oral health and overall health has grown closer and closer and it's something that is being taught in dental, and even medical schools, today. That's great because it really is bringing these younger dentists out of school with the mindset that 'hey it's more than just the mouth — it's the total body.' The younger dentist will often go into a clinical practice and have a mentorship with a more experienced dentist — and there is the opportunity for shared learning. It's a very good thing. Things change, we learn new things, technology advances and looking at what's going on in the industry is critical.

From a Humana perspective we look at what kind of initiatives can really support a more holistic view — things like social determinants of health in the dental practice. How do we



do that within the standard dental practice so that we really are looking at everything that affects the patient?

We do have a provider portal that offers educational pieces on our website. We work very closely with many of our dental service organizations that include our dentists. Oftentimes we'll do webinars and sit on panels to help with education. Our clinicians participate locally and nationally in CE learning events.

CB: Looking at the social determinants of health is definitely a trend of late. It seems like COVID-19 has revealed and emphasized how important that is — whether it's a wealthy patient or a less advantaged one.

Dr. Fry: That's exactly right. Social determinants of health really don't have boundaries and limits on who it affects. Whether that's food insecurity or loneliness — those types of things can really affect anyone regardless of who they are. It's very important that when somebody touches the healthcare system, we are looking out for all of that. In dental, we need to make sure we're not just focused on the mouth, looking for cavities, or periodontal disease. Yes, these things are very important to your physical health, but we need to be looking holistically at the whole person.

CB: What percentage of your members have dental coverage? And are you able to measure health improvements as a result?

Dr. Fry: Humana has 7.3 million members with dental coverage nationally. That gives us lots of 'observational data' to work with. So, how do we determine what certain outcomes mean? Our observational stats show us evidence, but we don't have the scientific studies yet that show us WHY. Science is still working on causation and correlation. The dental industry is working diligently on how to measure better health outcomes scientifically, but we have a ways to go on true measures of health.

For example:

- If we see that the overall costs for a member with diabetes is less if they go see the dentist, how does that correlate? Does that mean their A1C level remains stable because they are getting that more holistic care? Does it mean that because they are seeing their dentist as another touchpoint on their health care journey, they are more in tune with their health? We don't know yet, but we're watching and tracking.

- One thing that we do see is a 27% lower medical spend from our members who see the dentist versus those that don't.

- For those who only see their doctor, inpatient admits are 1.8 times higher and ER visits are 1.4 times higher, versus those who also see their dentist. While this is strictly observational, those are significant differences and worth our attention to find out why.

Brian Sullivan: Studies show that 75% of heart attack victims suffer from periodontal disease. Is it causational or correlational? It doesn't really matter.

The point is that it's important to deal with periodontal disease, especially if it helps prevent heart attack or heart disease from occurring or worsening. Then it's worth it to have good dental benefits particularly for employers that have larger populations where their claims have a direct correlation to the cost of their premiums.

Dr. Fry: Good point, Brian. Periodontal disease is really a driver behind the whole inflammatory process in the oral cavity. That's really where problems begin. Some studies say people with untreated periodontal disease are twice as likely to have a heart attack, or stroke. Untreated expectant moms show low

birthweight and/or premature birth. When you look at things like diabetes, inpatient admits and ER visits, heart conditions, etc. we know that the inflammatory process is really where the problem lies.

Diabetes is one of those conditions which make people more susceptible to periodontal disease, and periodontal disease makes diabetes harder to control, so it is a vicious cycle. There are some studies showing that following periodontal treatment we see the A1C level staying more static. I certainly hope we see more good studies and data coming out about this important correlation.

Osteoporosis can be also detected through dental x-rays and patients can be alerted to get treatment for this. We know that brittle bones can be a challenge as we age. Oftentimes the dentist is the first line of defense.

CB: This is great logic. This can help agents with some data points and conceptual thinking that can bridge the gap for clients about the importance of providing dental coverage with medical.

Brian: Yes, agents need to go beyond their common spreadsheets that list benefits like Perio/Endo lumped together as if they are the same thing. The reality is they are VERY different. Agents need to understand this to make sure the benefits reflect the reality of the treatment needed.

Dr. Fry: Agreed. They are two very different categories that often get lumped together to the detriment of the patient.

> **Endodontics**, such as root canals, are episodic, not chronic.

> **Periodontics** is the diagnosis and treatment of diseases and disorders of the gums, like periodontal disease, which is chronic.

When you have healthy teeth and gums, the gums and bone are at a certain level. As the inflammatory process begins, bacteria begin to increase, this, in turn, burdens the immune system. Bone loss causes the gums to recede, creating pockets around the teeth that can get deeper and deeper. So, treatment with long term maintenance is critical. You want to eliminate the inflammation, arrest the bone loss, and lower the bacterial activity, and maintain that.

At Humana, we recommend four periodontal cleanings a year to keep your mouth healthy. Home care is critically important as well, in the maintenance of periodontal disease.

Visiting your dentist regularly is key to helping discover early signs of conditions like periodontal disease and maintaining good oral health.

It's really true, an ounce of prevention is worth a pound of cure.

Understanding the difference will help agents recommend the right benefits.

Brian: Our standard plans offer 3 regular dental cleanings and 4 periodontal cleanings a year for those who have the disease. Only rare custom plans don't offer this. The four deeper periodontal cleanings take the place of the three regular cleanings for those with the disease. That's standard for Humana because we believe that it's critically important — **we don't want to create any kind of barrier to people receiving the kind of care and treatment that they need.**

Most plans from our competitors on the market offer at most two cleanings. Unfortunately, people just do what the insurance pays for. You go to the dentist, they see coverage for two cleanings and even if the patient needs more, they only do the two. Ultimately patients don't get the care and treatment they need.

Dr. Fry: It's not just access to care, it's access to health. Because, it really is promoting and maintaining the good health of that member. That's ever so important.

We have a protected, secure provider portal where there is a holistic view of patient records, where the physician, dentist, eye doctor and any other specialists can log in to see a member's health summary. Health alerts are also generated, calling specific attention to certain conditions and treatment.

Humana also has great case manager nurses for members with chronic conditions. The nurses get alerts about conditions that develop and they in turn contact members to help remind the members to get dental or other care, helping them along their health journey. We have fantastic nurses — I have the utmost respect for these professionals.

CB: Any closing comments for our readers?

Dr. Fry: When you think about selling dental coverage, it's more than just benefits — it really is about HEALTH. Oral health is part of and affects overall health. When we talk about holistic care and lifelong wellbeing, the dental benefit is part of that and really reflects our mindset and what we are trying to accomplish for the health of our members.

Brian: We sell individual dental plans, but more often it's offered as part of employer sponsored programs. And we offer plans for groups of 2+. They can buy dental only, or a package with life and vision — it's really their choice.

On the Medicare Advantage side, people can add on dental. And there are plans that have dental embedded in them. Humana puts on their Medicare card, "Did you know that you have DENTAL?" as a reminder.

The important consideration is not why Humana over the others, it's WHY DENTAL?

As independent brokers and agents we have an obligation to make sure that we're protecting the whole health of the people we serve. And including dental is part of that responsibility. It's more than just fresh minty breath and pearly white teeth. It is a link and passageway for the entire whole-body health. That's really the key consideration.

This is particularly true in the small business marketplace. Oftentimes because medical is such a huge expense, they don't want to add dental, but it's critical for them to understand it's necessary to keep people healthy.

Agent communications are available online, along with in depth training and an annual Agent Experience in August that can be accessed in replay by request.

Go to: www.humana.com/agent/

Dental coverage should be more than a pretty smile

Human care means providing everything you'd expect from a dental plan, plus more

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No Surprises Act Sparks Questions and Industry Concerns While Awaiting Further Guidance

PART 1

BY DOROTHY COCIU

Author's Note:
Due to space constraints, this article is being split into Part 1 and Part 2. **This is Part 1.**
Part 2 will be printed in an upcoming issue of California Broker, and will include updates from recently released rules and guidance.

We've all been there, or know someone close to us that has, or for health agents, you've seen this from the clients we all serve. You need healthcare, you see a doctor or go to an emergency room. You may even be hospitalized. If it's an emergency, you go to the nearest emergency room, which may or may not be part of your health plan's network. Even if the ER is part of the network, you are seen by an ER doctor, who it turns out is not part of the network. Or you have surgery, and although the surgery center may be a network facility, the surgeon or assistant surgeon, or more commonly, the anesthesiologist or radiologist, is not. You go about your life, you pay your copays or coinsurance, and think everything will be fine because, after all, you have insurance!

One day, you come home from work, check your mail, and there is an envelope with a medical provider's address on it. You open it, thinking it's only a confirmation of the insurance payment, or a copy of the plan's EOB or something. And then, as you're staring at the black and white in front of you, the text becomes blurred, you start to feel tunnel-vision coming on, because you're staring at a bill from the provider that says you owe $800+ dollars, even though your most recent EOB that you received says that the bill was paid by your health plan. After the initial shock, you think it's a mistake, so you wait until the next day and call your health plan, and you discover that the health plan has paid everything it was supposed to pay, so the provider has "balanced billed" you the difference between the billed charge and the amount paid by your health plan.

Imagine now (or recall from personal experience if it's happened to you) a similar situation after you were hospitalized for a major surgery. There was only one hospital near you, or perhaps they had to move you to a hospital that specializes in the type of care you need. You thought you did all of the right things. You had the surgery or procedure pre-authorized, and again, you thought everything would be fine after you pay your copays or coinsurance, because once again, you have insurance!

And then it arrives in the mail…that "surprise" bill that says that you owe $47,500 for your recent hospitalization or surgery expenses. This time, it's not just tunnel-vision; it is panic. Your body is drenched in sweat and you are visibly starting to shake, because you don't have $47,500 right now (or ever!) to pay for this! As someone who in my past ran a third party administrator and have seen many, many balance bills, I will tell you that I've seen balance bills of over $125,000 for hospitals and over $75,000 for air ambulance charges. And I've heard of them billing for far more than even this!

Some people actually ended 2020 and began 2021 in a positive financial position, because they were able to keep their jobs during the pandemic. Because you were stuck at home, you didn't spend much, so your bank account balance is higher than normal. But for many, it's been a tough financial 18+ months. COVID-19 has impacted our lives in so many ways, including, in many cases, our income. We may feel lucky that we didn't lose our jobs. But basic expenses, like the cost of buying a home, the cost of fuel for your vehicle, and the cost of groceries we need have all increased. And our pay has decreased or stayed the same. Or perhaps you were laid off, and you're now just starting to get back on your feet, but it seems like everything you do or need to buy is now more expensive. Your savings account has decreased, or perhaps been depleted.

Whatever your financial position may look like right now, none of us wants a surprise medical bill. **The good news on that front is that recent federal actions, it is hoped, will stop these sorts of provider practices from happening in the future.**

For some time, many in the health insurance industry have asked for two important pieces of legislation:

1. Transparency in health care costs and control of providers that "balance bill" their patients after insurance payments and

2. normal plan copayments and coinsurance have been paid.

This is an amount in excess of the expected or "usual and customary" or "reasonable" amount. This "Surprise Billing" practice is so common that it has become almost the norm. It's definitely one of the most important issues in the healthcare industry in the minds of consumers, and therefore, the legislators. Recent legislation on both of these items will soon be in effect. New legislation, as we all know, often brings confusion and misunderstanding.

I will attempt now to break these rules down for you in understandable terms.

On July 1, 2021, federal departments — HHS, DOL and Treasury, as well as the Office of Personnel Management (OPM) — released an interim final rule (IFR) with a comment period on the No Surprises Act. This is part of the Consolidated Appropriations Act (CAA), and it goes into effect on January 1, 2022. This rule is entitled "Requirements Related to Surprise Billing: Part 1." This was followed by Frequently Asked Questions (FAQs) in late August, which dove into many provisions of the No Surprises Act and Transparency in Coverage rules.

Background

Most health plans, whether they are group plans, individual plans, a Marketplace plan or Medicare plans, offer a network of providers and facilities (your PPO or EPO network – or "in-network" providers) that agree to accept payment at an established, contracted rate. Non-network providers generally charge higher amounts as there is no contract rate pre-established for that service or stay. In many cases, the out-of-network provider may balance-bill the patient for the difference between the billed charge and the amount that the health plan or insurance has paid, unless it's prohibited by state law. Balance bills can happen in both emergency and non-emergency care.

In the case of an emergency, as briefly described above, the patient usually goes to the nearest emergency room. In many cases, although the ER is a network-contracted facility, many of the providers that work inside of that facility may not be part of those networks. Often emergency rooms are staffed by independent contractors or doctors not belonging to many networks; they are often non-negotiated third parties, providing services such as anesthesiology, pathology, radiology, rehabilitative care, physical therapy, or neonatology. In many cases, the patient has no control over the physician or other provider inside those facilities. When I was managing a TPA some years ago, we called these "forced providers." It's unfortunate, but common, and even more so because most consumers do not routinely ask their providers inside of an emergency room or hospital if they are contracted. The result is often a balance bill.

We also see this commonly in the event that you need an air ambulance. You generally do not have the ability to select an air ambulance from a network provider directory. Air ambulance companies have notoriously over-charged in many circumstances.

It's important to note that in most cases, **surprise bills usually do not count toward your deductibles or out-of-pocket maximums,** which many people do not understand.

According to CMS:

- A recent study found that payments made to providers by people who got a surprise bill for emergency care were more than 10 times higher than those made by other individuals for the same care.
- 9% of individuals who got surprise bills paid more than $400 to providers, which may result in financial distress for consumers, given recent findings that show 40% of Americans struggle to find $400 to pay for an unexpected bill.
- Studies have shown that in the period from 2010-2016, more than 39% of emergency department visits to in-network hospitals resulted in an out-of-network bill, increasing to 42.8% in 2016. During the same time, the average amount of a surprise medical bill also increased from $220 to $628.
- Although some states have enacted laws to reduce or eliminate balance billing, these efforts have created a patchwork of consumer protections. Even in a state that has enacted protections, they typically only apply to individuals enrolled in insured health insurance coverage, as federal law generally preempts state laws that regulate self-insured group health plans sponsored by private employers. In addition, states have limited power to address surprise bills that involve an out-of-state provider.

It is important to understand that the provisions of the No Surprises Act relate back to former ACA requirements, such as the requirement of plans to reimburse emergency services at a rate at least the amount that would have been paid in-network, regardless of whether or not there was a network in place. The ACA did not, however, prevent the out-of-network emergency room from any sort of balance billing.

The interim final rules (IFR) generally apply to group health plans and health insurance issuers offering group or individual coverage, including grandfathered health plans, effective January 1, 2022. The No Surprises Act does not apply to retiree-only plans, excepted benefits, short-term limited-duration plans, Health Reimbursement Accounts (HRAs), flexible spending accounts (FSAs) or health savings accounts (HSAs).

What is the intention of the No Surprises Act?

The No Surprises Act was passed in December, 2020, as part of the Consolidated Appropriations Act of 2021. **The intention of the law is to protect consumers from the types of balance-billing or surprise billing practices described above.** The No Surprises Act focuses on billing practices in certain non-network situations by **limiting the amount of the bill to the amount that would have been payable under an in-network arrangement.**

This piece of legislation was bipartisan, which is not exactly common in Washington, D.C. in recent years. That tells you that everyone seems to agree on the intent: To protect consumers from these horrendous and detestable provider practices. However, I do want to mention up front that although this legislation, as it stands now, protects consumers from these practices in non-network situations, **it may not fully protect self-funded health plans when they use financing methods such as reference-based pricing,** which I will address later in this article.

Summary of The No Surprises Act's Interim Final Rules (IFR)

Protections addressed in the No Surprises Act apply primarily to emergency services, non-emergency services delivered by out-of-network providers at an in-network facility, and out-of-network air ambulance services.

If a plan or health insurance coverage provides for any benefits for emergency services, this rule requires emergency services to be covered without any prior authorization, regardless of whether the provider is an in-network or out-of-network emergency facility. In addition, plans must cover emergency services regardless of other terms or conditions of the plan or health coverage, other than exclusions due to coordination of benefits or any waiting period.

The interim final rule limits cost sharing for out-of-network services to be limited to the amount paid in-network, and requires such cost sharing to count toward any in-network deductibles and out-of-pocket maximums. Most importantly, it prohibits balance billing.

The IFR states that these limitations apply to out-of-network emergency services, air ambulance services furnished by out-of-network providers, and certain non-emergency services furnished by out-of-network providers at certain in-network facilities, including hospitals and ambulatory surgical centers.

Specific provisions of the No Surprises Act limit out-of-network services to billing amounts without cost-sharing requirements that are greater than those applied in-network, and limits cost-sharing as if the total amount billed for services are equal to the "recognized amount." Commonly, in an out-of-network scenario, this has been limited to the Usual, Customary & Reasonable (UCR) amount. Under the No Surprises Act IFR, the amount must be calculated based on one of the following amounts:

- An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act.
- If there is no such applicable All-Payer Model Agreement, an amount determined under a specific state law.
- If neither of the above apply, the lesser amount of either the billed charge or the "qualifying payment amount," (or QPA), which is generally the plan or issuer's median contracted rate. (We now have a new industry acronym – QPA – for qualifying payment amount, just in case you are confused).

According to the IFR, the All-Payer Model Agreement is an agreement between the Centers for Medicare & Medicaid Services (CMS) and a state to test and operate systems of the all-payer payment reform for the medical care of residents of the state under the authority of Section 1115 A of the Social Security Act. It may be voluntary or mandatory for a given payer.

Emergency services also include any post-stabilization services, unless all of the following conditions are met:

- The treating provider determines the patient is able to travel using non-medical transportation to an available provider or facility
- The provider or facility provides notice and obtains consent
- The patient is in a condition to receive the information and provide informed consent
- The provider or facility satisfies any additional requirements or prohibitions under state law.

Employer/Plan Sponsor Concerns

Employers are just now starting to realize that all of the provisions of the No Surprises Act will impact them. I asked our attorney, Marilyn Monahan of Monahan Law Offices, what she thinks are the most important/impactful sections that affect employers and their insured participants. Marilyn responded as follows:

a. **The restrictions on surprise billing for out-of-network emergency and non-emergency services** will be good news to many participants who have experienced—or who are worried about experiencing—surprise medical bills. During open enrollment, employers should consider the most effective way to explain these new rules, so that participants understand when and how they apply.

b. **The new restrictions on ancillary services** provided in conjunction with a non-emergency visit to an in-network facility (such as anesthesiology, pathology, radiology, and diagnostics) will also be good news, since the definition of 'ancillary services' encompasses a broad range of services that have often been the basis for surprise bills in the past.

Many plans and claims administrative practices will automatically deny an emergency claim, for example, based on a predetermined list of final diagnosis codes without regards to the actual symptoms being presented to them at the time of care. It is often only following claim denial that a plan or claims administrator will review all of the facts, and generally upon a formal (but sometimes informal) appeal.

c. **Employers with self-funded plans should review their plan documents** to ensure that the terms are consistent with the IFR. These employers should also communicate with their TPA to ensure that the TPA will be prepared to administer benefits according to the new rules as of the applicable effective date and make any amendments to their services agreement that may be necessary. In fact, a detailed conversation with the TPA about the implementation process for the many provisions in the CAA that impact health and welfare plans is essential.

Administrative Concerns and Confusion Over the No Surprises Act

The No Surprises Act throws confusion into the claims payment industry by requiring that coverage be provided without limiting what constitutes an emergency medical condition, solely on the basis of diagnosis codes, such as the ICD-10 codes, which are common in claims adjudication use.

Many plans and claims administrative practices will automatically deny an emergency claim, for example, based on a predetermined list of final diagnosis codes without regards to the actual symptoms being presented to them at the time of care. It is often only following claim denial that a plan or claims administrator will review all of the facts, and generally upon a formal (but sometimes informal) appeal.

If you review the term "emergency medical condition," it refers to a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect to either:

1) place their health in serious jeopardy

2) seriously impair bodily functions

3) cause serious dysfunction to a bodily organ or part.

In general, it **requires a plan to consider anything a prudent layperson should consider**, given all documentation and all symptoms, without relying solely on an ICD-10 code. This includes mental health and substance abuse disorders.

Plans must ultimately determine whether the standard was met by reviewing presenting symptoms, without imposing any type of time limit between onset and presentation for emergency care.

I asked Marilyn what she thinks plan sponsors and administrators need to focus on to apply this prudent layperson standard in an emergency situation.

Marilyn responded: "If the plan documents apply a different standard to claims for emergency services, amendments will have to be made. The TPA's claims procedure manual and processes must also be updated. The TPA should also consider this guidance from the preamble: 'the determination of whether the prudent layperson standard has been met must be based on all pertinent documentation and **be focused on the presenting symptoms** (and not solely on the final diagnosis).' Based on this reminder, the revised claims procedures should also include, as necessary, updated record keeping requirements that will enable the plan to prove that it has satisfied the new legal standard in each case. The emphasis placed on the prudent layperson standard in the preamble to the regulations implies that this issue may be a priority for the Departments. (86 Fed. Reg. 36872, 36879-36880.)"

In relation to the administrative and legal process for plans, including plan documents and plan communications, Marilyn continued: "The Surprise Billing IFR — along with the other provisions of the CAA applicable to health and welfare plans — place many new obligations on plans and issuers:

- Employers with fully insured plans should communicate with their carriers to ensure the carriers intent to comply on time.
- Employers with self-funded plans have more work to do.

The changes created by the CAA will probably require changes to plan documents, ID cards, provider directories, and more. They may also require changes to the terms of TPA contracts and claims processing manuals.

Employers should be prepared to discuss with their TPA **who will be responsible for implementing each relevant section** of the CAA, and the timeframe for implementation. Employers should also consider whether any changes need to be made to the written contract with the TPA, including adjustments in cost, scope of services, indemnification, and other key clauses."

Some plans and administrators may be concerned that if you can't control costs by using strict ICD-10 codes, what can plans and administrators do to control the cost of health care, particularly in a self-funded health plan? Plans may have to find alternate ways of reducing or maintaining costs, such as higher ER copays or coinsurance, raising

deductibles, or having additional deductibles for ER services. Other ways of keeping ER costs down in a health plan is to educate your employees on more cost-effective steps prior to walking into an emergency room. This would include things like using Urgent Care Centers instead of high-cost emergency rooms, or for many services that are not life-threatening, implementing new or encouraging plan participants to use telehealth options.

Qualifying Payment Amount – QPA – Applications to Self-Funded Health Plans

The definition of a qualifying payment amount and applications to the marketplace are a bit confusing — particularly in the self-funded market. The QPA is defined as the median of the in-network (or contracted) rate in a geographic area, and applies in other portions of the law, including the base-line factor that an arbiter may consider when they determine the final amount to be paid under the new federally-established independent dispute resolution process (IDR – yes, another new acronym).

Another important self-funded consideration is that ERISA must always preempt state surprise billing laws when applied to self-funded plans. The IFR allows the option for self-funded plans to voluntarily opt-in to a state law.

Under the No Surprises Act, when a self-funded plan and an out-of-network provider cannot agree on a rate, they must go through an independent dispute resolution process.

- The IFR stated that a median contract rate should be determined by taking into account every group health plan offered by the self-insured plan sponsor.
- The IFR allows for administrative simplicity for self-funded plans to permit the TPA who processes their claims to determine the QPA for the plan sponsor by calculating the median contract rate based on all of the plans that it processes and administers claims for.
- The IFR states that the contracted rates between providers and the network provider for the health plan would be treated as the self-insured plan's contracted rates for purposes of calculating the QPA.

Third Party Administrators will find the No Surprises Act quite complicated, and frankly, quite expensive to administer. TPAs will need to set up their claims payment systems to administer the QPA. Most self-funded health plan sponsors will rely on their TPAs to assist them with all of the No Surprises Act requirements. It will likely be the norm for TPAs to assist self-insured plans with the Model Notice that is required. Ultimately, the No Surprises Act will be costly to administer for TPAs. They will need to determine the QPA, which will not be easy and will not be cheap in most cases. In addition, changes will need to be made in understanding the implications of the ER services determination. **Extra steps will need to be taken up front to examine more documentation and understand symptoms, rather than initially denying a claim up front.** All of that will cost more — in claims adjudication training, in system adjustments, and more. Not to mention the QPA's independent dispute resolution process.

What this means to self-funded employers is that they should expect their claims fees to increase due to the No Surprises Act. The independent dispute resolution will be discussed next month in Part 2 of this article.

The geographic regions used to determine the contracted rates will follow the metropolitan statistical areas (MSA) used by both Medicare and the U.S. Census. The IFR includes the "rule of three" expansion, meaning that if a plan cannot identify three rates to determine a median rate within an MSA, then the plan is permitted to increase the size of the MSA to include the state as a single region.

The IFR issued clear guidelines for steps to be taken in order to determine the appropriate rate, using primarily databases. This piece ties in directly with the Transparency rules, which were in part also addressed in the IFRs. One important provision that was included in the IFR addressed self-insurance industry concerns related to the possibility of conflicts of interest while using databases. The IFR states that the organization maintaining the database cannot be affiliated with, controlled by, or owned by any health insurance issuer, provider or healthcare facility.

Although the IFR did not address all self-funded concerns, the rules did for the most part, follow comments made from industry associations such as the Self-Insurance Institute of America (I am a member of this association). Overall, the self-funded industry seems pleased with the initial set of rules, and are anxiously awaiting additional guidance.

From an administrative perspective, many of the requirements were not addressed in Part 1, but we're hoping those will follow soon in expected fall rules and guidance. We are also expecting more guidance on the arbitration/IDR process to be released in September.

We will continue this article in Part 2, which will include updates from additional rules, which are expected to be released in the coming days or weeks!

Author's Note: I'd like to thank Marilyn Monahan, Ryan Day and Larry Thompson for their assistance with this article. I'd also like to thank NAHU for the informative webinar in July, which started me on the path to fully research this topic. CB

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Classes can also be found on her educational platform, the Empowered Education Center, at **https://advancedbenefitconsulting.com/empowered-education-center/.**

CAHU Membership Helps Grow Your Business

BY CRAIG GUSSIN

I AM A HEALTH INSURANCE agent and have been a member of the California Association of Health Underwriters (CAHU) for many years. State membership also includes membership in a local chapter and in the National Association of Health Underwriters (NAHU). You may be thinking, "Why should I be a member? What will it do to help me, my business, and my clients?"

There are so many reasons to be a member.

Because I belong to both CAHU and NAHU and participate enthusiastically, my business has grown tremendously. For example, I get calls from members across the country looking for a local California agent to help their clients. I also refer business to agents in other states where I am not licensed and don't know their local plans.

Keeping up on legislation

Do you like being a health insurance or Medicare agent? Have you looked at what the Sacramento and Washington, D.C. legislators are considering doing to our industry? In case you don't know (or have tuned out), they are considering getting rid of our health insurance system and us, as they think we are not needed. They believe the government can do a better job. The DMV of health insurance, consider that thought! Oh my, what would health insurance look like?? No options? Rationed benefits? No agents to help clients get the coverage and services they need?

As I began writing this article I was listening online to the Healthy California for All Commission Meeting. They talked about a unified financing system for California, AKA a new way of saying Single Payer. They discussed how bad our current healthcare system is and what can be done better as a unified system. Which means they propose replacing our current health insurance

plans and our jobs because they think they can put together a better health care plan for California with almost all medical care being free. How feasible is this?

By being a member you will know what is going on in Sacramento and Washington, D.C. from the inside. You will be kept informed by NAHU about what you need to be aware of in Washington, D.C. and across the country.

NAHU and CAHU have lobbyists in Sacramento and Washington, D.C. that advocate for the interests of health insurance and Medicare agents all year. They meet with our legislators and educate them on the essential role we play. We agent members also go to Sacramento and Washington, D.C. yearly to meet our legislators and share with them what we do for their constituents and lobby for needed reforms. Without this advocacy, legislators and their staff would have no idea what a health insurance or Medicare agents' role is and how we help their constituents find the right plan for their particular needs. Also, we show how we are there for our clients and their constituents 12 months a year. We don't just sell them a plan and never see them again.

If you sell Medicare plans, just by selling one a year, the commission will pay for your NAHU/CAHU membership for the whole year. That is a very small price to pay to keep your job, your livelihood, your employees employed, and your clients serviced!

You may be thinking, "Why do we need lobbyists? Why should I contribute to a Political Action Committee (PAC)?"

To start, the opposition has lobbyists, so we should too. Their lobbyists are trying to get their point across to the legislators about why health insurance has to change to a Single Payer type plan and casts agents as "unnecessary overhead." **Our lobbyists know the legislators and meet with them to elucidate the critical role of the agent.** They counteract the inaccuracies of the opposition, along with sharing stories of how agents helped their constituents with buying the right plan for their needs, handling their claims, etc.

Isn't that a good reason to give to the PAC, to protect your job and your commissions?

Additionally, I share pertinent information with my clients such as the Biden administration's American Rescue Plan Act of 2021 (ARPA). Most agents don't do that, so it gives you a way to be different than others. I also develop relationships with my local media, so when they need to know anything relating to health insurance, they know I'm someone they can contact.

Other reasons we need our lobbyists

A few years ago the Centers for Medicare & Medicaid Services (CMS) wanted to reduce the commission they pay Medicare agents by 50% because they did not understand and appreciate our value. They also were only going to pay us renewal commissions for five years. CMS also did not understand what a field marketing organization (FMO) did and saw no need to pay them.

NAHU sent our lobbyist to meet with CMS. They educated CMS on the value of using a Medicare agent when a consumer is going to turn 65 and in future years. After CMS learned the value of a Medicare agent, instead of a reduction in commissions, they raised commissions and renewals, kept lifetime renewals, and continued paying FMO's too. This is just one more reason to be a member: NAHU is an association that protects your job and your income.

The NAHU/CAHU membership advantages go on

If you sell Medicare plans, just by selling one a year, the commission will pay for your NAHU/CAHU membership for the whole year. That is a very small price to pay to keep your job, your livelihood, your employees employed, and your clients serviced!

Also consider: one day you will want to retire and have someone take over your book of business. If you don't have a family member or an employee who is licensed and could step in and take over the day-to-day work for you, what do you do?

By being a member, you can network with other agents at your local chapter meetings. With time they become friends (I have made many friends all over the country as a member). One of those members you meet may be a perfect fit when you decide to grow your business or retire.

Free continuing education credits

By being a member you will also receive continuing education credit (CE) for participating in certain events. I have not had to buy CEs the last 10 years because of all the free CE classes I attended.

You also learn from chapter meeting speakers about many topics to help you grow and protect your business and your income. Helpful topics include:

- Why you need to be incorporated to protect your commissions
- What you need to do to protect your business and income in case of death, disability or upon retirement
- Review of new plans, new ideas on selling that have been successful for other agents

All while getting continuing education credits to boot!

If you are not a member, please consider becoming one. It will be the best investment you ever make in yourself and your business. CB

CRAIG GUSSIN, *CLU, LPRT, DIF is president of RWR Insurance Services, LLC. He serves as PAC chair for CAHU. Contact:* **craig@rwragency.com**

Want to Sell Pet Insurance But Don't Know Who Uses Brokers?

Follow up to our June 2021 survey of pet insurance providers

Several readers wanted to know which pet insurers use brokers to sell. We don't want you barking up the wrong tree, so we've compiled a short list for your reference, followed by a more in depth exploration of one insurer.

DIRECTORY OF BROKER FRIENDLY PET INSURANCE COMPANIES

This is not a complete list of pet insurance companies. It's a resource for brokers and agents to sell pet insurance directly to consumers and/or to employers offering voluntary benefits. A Property & Casualty license is required.

- ASPA ~ www.aspapetinsurance.com.
Click on "For Brokers" Programs offered to employees as a voluntary benefit

- Embrace Pet Insurance ~ www.embracepetinsurance.com. Contact: Kelly Coffey, Director of Business Development kcoffey@embracepetinsurance.com

- Felix Cat Insurance Just for Cats
www.felixcatinsurance.com ~ Pet insurance just for cats
Contact: Tim O'Hare hello@totopetinsurance.com

- FIGO Pet Insurance ~ www.figopetinsurance.com
Programs offered to employees as voluntary benefit
Contact: 888-223-0596 Employer plans/discounts

- Odie Pet Insurance ~ www.getodie.com
Contact: zabrina@odiepetinsurance.com for agent inquiries
877-327-0471

- PAWP ~ www.pawp.com
PAWP works through HR Benefit Consultants (not agents)
Contact: Julia, Head of Employer Benefits
Julia@pawp.com 901-568-4349

- Pet Benefit Solutions ~ www.petbenefits.com
Employee benefit programs: click on "Brokers" to request info

- Pets Best Insurance ~ www.petsbest.com
"We're here because we're family "
Contact: Kerry Sutherland, PR at kerry@ksutherlandpr.com
Nicole May at benefits@petsbest.com 515-473-8709

- Toto Pet Insurance ~ www.totopetinsurance.com
Pet Insurance with a Heart
Contact: Tim O'Hare tim@myconnectedpet.com or
hello@totopetinsurance.com

- Trupanion ~ www.trupanion.com
Employee benefits and Affiliate program
Contact: 855-355-6243 info@trupanion.com

- Wagmo Pet Insurance ~ www.wagmo.io
Employers & Brokers: scroll down to click on Wagmo at Work
Contact: 646-470-2856
Susan Halvorsen, Brokers & Agents Manager susan.halvorsen@wagmo.io
Jacinta.mathis@wagmo.io

Editor's Note:

Remember that this NOT insurance to cover for a dog bite or property damage under a homeowner's policy. Pet insurance covers health expenses for the animals.

Cal Broker does not endorse any particular pet insurance companies. We are providing information here to help interested brokers find resources.

More to Consider

Cal Broker's newest advertising exec Cindie Klima, who is also an insurance agent, researched this article for the magazine. "Pet insurance is an evolving product," says Klima. Of note, Klima says on the horizon is a North American Pet Health Insurance Association (NAPHIA) 'model law' on the way pet insurance is sold. "Pet insurance and how it's sold is not standardized yet," says Klima. Some brokers are predicting that there will even be a "limited license" in the future so that agents won't have to get a Property & Casualty license to sell pet insurance.

Klima also recommends interested brokers check out this site to see how pet insurance can be offered to employers as a voluntary benefit:

https://www.petbenefits.com/brokers.

Q&A Spotlight on Pets Best Insurance

The following information was provided to Cal Broker's Cindie Klima by Kerry Sutherland of Pets Best.

Pets Best offers pet insurance and wellness plans for dogs and cats in every state. Founded in 2005 with a mission to provide access to comprehensive animal healthcare at an affordable price, Pets Best delivers flexible coverage, an easy claims process and excellent customer service.

Cal Broker (CB): How long have you sold through agents/ brokers and what kind of commission you pay?

Pets Best: We've been working with agents and brokers since our inception and have a dedicated broker support team to ensure best in class service and communication for their agency and clients. We offer various commission structures with our standard being 10% the first year and 5% renewal.

CB: How much of your business is sold through agents/ brokers?

Pets Best: About 90% of our business is through brokers directly.

CB: Do you have special packages brokers can offer to companies who would make your coverage available to their employees?

Pets Best: Pets Best is leading the pet insurance industry with HR integrations and billing platforms. Having been in the market for over 16 years, Pets Best knows the industry well and has identified the opportunity to offer comprehensive pet insurance and wellness plans as a voluntary benefit.

Companies and brokers can choose to work with Pets Best directly or collaborate with one of their chosen technical integration companies. Our unique technical ability allows for an easy set-up with your company or clients. Pets Best can quickly create a custom code and web link for your company or tailor the enrollment process for employees by offering a full stack integration using our API. With either option, you will be given dedicated account management support throughout the process. And, Pets Best has begun filing an increased discount for groups of more than 1,000, offering payroll deduction. This discount will be made available as we gain approval in each state.

Pet Insurance is administered by Pets Best Insurance Services, LLC and is underwritten by American Pet Insurance Company, a New York insurance company.

Please visit www. **americanpetinsurance.com** to review all available pet health insurance.

ARPA COBRA Subsidy Expires. Now What?

BY BOBBI KAELIN

As I'm writing this, the American Rescue Plan Act of 2021 (ARPA) COBRA "Subsidy Expiration" letters are being generated. After checking in with LAAHU and NAHU, there currently are no discussions in Washington, D.C. about extending the subsidies.
It appears that this is the end, my friend.

EDITOR's Note: The industry has been focused on implementing the American Rescue Plan Act of 2021 (ARPA). Now, employers and plan administrators must turn their attention to preparing the necessary notice to some Assistance Eligible Individuals (AEIs) concerning the expiration of any COBRA subsidies they have received. To ensure compliance, plan administrators must provide a timely notice to those AEIs who wish to maintain their COBRA continuation coverage after the subsidy has ended.

Plan administrators must notify AEIs at least 15 days (but no more than 45 days) before they will lose the subsidy. For most employers, this will be between August 17 and September 30, 2021.

The subsidy Expiration Notice must only be provided to AEIs who are eligible to continue COBRA beyond the coverage period ending September 30, 2021. Plan administrators are not required to provide the Expiration Notice to any individual who voluntarily drops COBRA coverage, enrolls in other group health plan coverage or Medicare, or whose maximum COBRA coverage period ends before September 30, 2021.

So, back to the topic of this article: **Now what!?**

Ha! We all know the busiest time of the year is upon us and there are lots of details we need to be aware of so we can best serve our clients. But how about we just try to relax a couple of minutes, or just long enough for you to read this page? We're not going to do meditation here, instead, I'll give a couple of quick reminders and mix in some fun and sometimes silly questions I've received from agents, employers and plan participants over the years. Because I'm with PayPro Administrators, the topics will include Premium Only Plans, COBRA, Account-Based Plans, etc. Don't take anything the wrong way — this is intended to provide a little laughter and levity — not upset anyone.

But, on a serious note: The questions and answers should not be construed as legal advice as they are general in nature and I'm not an attorney.

ARPA/COBRA conversations

Agent: "I'm so glad this whole ARPA thing is over. My client had three people receiving the subsidies and it was a hassle. I've told the client there is nothing else to do as it expires at the end of September."

Me: "Don't forget the 'End of Subsidy' notices! They are still required to be mailed. Don't forget that step."

Agent: "Damn, I thought everything was done."

Me: (in my head, I wished that months ago - LOL)

Pro Tip: This is an important reminder that the requirements are/were very specific and missing a single step of the process can make a big difference. This applies to every aspect of serving your clients.

Me: "Hi! Joe XXX from XX Insurance Agency asked me to give you a call and talk to you about COBRA Administration. Joe said you have about 39 employees, and 11 are enrolled in your medical insurance plan."

EMPLOYER: "Yes, but I told my agent we don't need a COBRA Third Party Administrator (TPA) because no one ever wants COBRA. I don't know why he wanted you to call me!"

Me: "Oh, well it's a little more involved than that. I'll go over that in a moment, but first a quick question: Have you sent out the ARPA COBRA subsidy notices?"

EMPLOYER: "What's ARPA?"

Me: (Crickets)

Pro Tip: If you're not sharing this type of information with your client, they likely aren't aware. Help protect and educate your groups.

Me: (I received a call from an employer group, telling me they had a new agent working with them; a friend of the owner. I called to introduce myself and PayPro Administrators and asked how the enrollment went.)

Agent: "I enrolled the employees last week and it was easy! Now all I have to do is wait for the commissions to start coming in. This is my first group. Anyways, why are you calling me? What do you do with my client?"

Me: "Congratulations on your first group. How long have you been in the industry?"

Agent: "I got my license a month ago; before that, I was in real estate. That was hard compared to this."

Me: "Hmmm. Are you working for an agency? On your own? If you're on your own, are you working with a GA (general agent)?"

Agent: "What's a GA?"

Me: Sigh.

Pro Tip: If you're new in this business, you have many resources available to you! Utilize the knowledge and services of those within this industry. Consider working with a GA, joining a professional association, such as NAHU, and take continuing education (CE) courses for the information, not just the credit.

Section 125 Stuff - Premium Only Plans (POP)

Agent: "My employer group has a premium-only plan (POP) and we're adding an Health Savings Accounts (HSA) compatible health plan, and an HSA as a part of their benefits. Is there anything I need to do?"

Me: "Yes, if the HSA contributions are going to be made pretax through payroll, you'll need to modify your POP document to include specific HSA language."

Agent: "So the POP document needs to be redone? I didn't know that. What do I have to do?"

Me: "Call your TPA, an ERISA expert or your GA. They can likely assist you

Pro Tip: If you're new in this business, you have many resources available to you! Utilize the knowledge and services of those within this industry. Consider working with a GA, joining a professional association, such as NAHU, and take continuing education courses for the information, not just the credit.

or point you in the right direction. Tell them just what you told me and make sure you have it prepared/adopted before the HSA pre-tax contributions are made. If you also have Flexible Spending Accounts (FSA) in place, you'll also need to modify the documents and add a Limited Purpose and/or Post Deductible FSA. The LPFSA/Post Deductible FSA can be used for dental and vision, as well as post deductible expenses for those contributing to an HSA on a tax-advantaged basis."

Agent: "Is this really required?"

Me: (Radio silence)

Pro Tip: Have a conversation with your TPA if your client has a POP or section 125 plan, including Flexible Spending Accounts when or if any new plans or details are changing.

POP Doc conversations

Agent: "Do we need a new POP document every year? XXXX Payroll Company requires it for my client."

Me: "There are two things you should know: First, the payroll provider is a payroll provider, not the employer. They provide payroll services for the employer. There isn't a rule or law that indicates the payroll service company needs to have the documents in hand to allow for pretax deductions. "Requiring" the documents may be a way to obtain additional business, as the payroll service provider will then likely offer to create those documents for the client, at a fee. A good payroll provider may ask if the employer has a current document in place, just as a reminder or to make sure the client is aware of the requirement.

"And second: No — you don't necessarily need a new plan document every year, but you do need a current document! When in doubt, get a new document or better yet, provide an annual plan document service for your clients. Document language consistently changes and you'll definitely sleep better at night knowing that your client has a current plan document. Agents and brokers have multiple sources where documents can be obtained. Reach out to your GA, your Compliance Team, an ERISA attorney, or your TPA Service Provider."

Pro Tip: Consistently communi- cate with and educate your clients. Remind them of the services you perform, required compliance information, and how you can assist them every step of the way. Protect your clients and your business.

POP - Non-Discrimination Testing

Agent: "Do we need to test a Premium Only Plan (POP) or non-discrimination testing? I heard that wasn't required. I don't want to waste time or spend that money if it's not necessary."

Me: "The IRS regulations include a special safe harbor for standalone premium-only plans. That is important to note — it's only for POP.

Under this safe harbor, a POP is deemed to satisfy the cafeteria plan nondiscrimination requirements if it passes the eligibility test. In other words, the plan will automatically satisfy the contributions and benefits test and the key employee concentration test if it passes the eligibility test.

The eligibility test can be summarized: If the same benefits are offered and available at the same rate and time to all eligible employees, it likely passes the eligibility tests. BUT - if HSAs or Flexible Benefits/Spending Accounts are in place, this safe harbor does not apply."

Pro Tip: Talk to your ERISA expert or document service/TPA.

Flexible Spending Accounts Conversations

Participant: "Can my vet bills be reimbursed under the Health FSA?"

Me: "I'd need more information: Is the animal a service animal, such as a guide dog that could aid/assist you if you were visually impaired?"

Participant: "No, but when I took her to the vet last week it was $350 for some dental work. Way too expensive — and I want to use my FSA for it. She's my baby, a cute little chihuahua that I love."

Me: "Sorry, that's probably not going to be an eligible expense under the Health Care Flex Spending Account."

Participant: "So, can I use my Dependent Care FSA instead?"

Me: (visualize hand slapped on forehead)

Pro Tip: Provide materials that communicate eligible expenses, guidelines and specifics about the Flexible Spending Accounts before enrollment and each year.

Plan Participant: (Angry and upset because we didn't approve an expense for reimbursement under their FSA). "You HAVE to reimburse me for Botox because I'm the "face" of XXX Company. My father is the owner..."

Me: "Oh, I understand what you're saying, but that isn't an eligible expense for reimbursement, in this circumstance. I'm sorry I wish I could change the rules." (This was said seriously.)

Participant: "That doesn't make sense! It is necessary and expensive... Wait, maybe it could qualify as an employment expense?"

Me: "Oh, I have never thought about that. Perhaps you should talk with your CPA."

Participant: "I'm having a laser peel done in a month, I'll ask that, too!"

Pro Tip: Work with or recommend a qualified and professional TPA. Ask your industry colleagues for a referral. And interview the TPA(s) before you introduce them to your clients.

Pro Tip: Same as previous.

Participant: "I didn't use all my money in the Health Care FSA and my employer said we have a use-it-or-lose it plan. It's my money! You have to give me MY money!"

Me: (after reviewing their plan documents) "Gosh, I understand your frustration, but these types of plans have very specific guidelines and rules. (When you signed up - the use it or lose it rule was on your enrollment form). But you still have 90 days after the plan year ends to submit expenses that you incurred during this last plan year. Do you have any expenses you've not yet submitted?"

Participant: "I'm calling an attorney. You are stealing my money."

Pro Tip: Again, same as above. Providing the plan documents to employees is also a requirement. It specifies eligibility information, year-end options, irrevocable elections, and more.

Participant: "My husband wants his mother to live with us, but I don't want her to. Can you give me something in writing that says there is not a tax benefit in doing so?"

Me: (I'm staying out of that one.)

Pro Tip: You stay out of that too!

Employer: "Our other TPA didn't ask for any receipts or documentation if the expense was under $100. Why do you? It seems nitpicky. Or perhaps you don't trust me and my employees?!"

Me: "Uhm, we follow the rules." (I didn't say it exactly like that, lol)

Pro Tip: Work with or recommend a qualified and professional TPA. Ask your industry colleagues for a referral. And interview the TPA(s) before you introduce them to your clients. CB

BOBBI KAELIN *is the vice president of Sales and Marketing at PayPro Administrators. PayPro was established in 1989 and provides payroll, ACA filing, ERISA plan docs and Form 5500 prep, COBRA, §125 and more. We're a broker-driven company, and as such we do not sell or offer insurance products to your clients. We are part of your team!*

Bobbi is a member of and has served on the boards for the Los Angeles Association of Health Underwriters (LAAHU) and the Employee Benefit Planning Association (EBPA) of Southern California. She is also a Continuing Education Provider and will happily provide education within her areas of expertise.

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Mobile: 951-897-6085
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Understanding the Three Medicare Part A and Part B Enrollment Periods and the Hierarchy

BY MARGARET STEDT

THE MEDICARE focused agent should have a clear understanding of the enrollment periods of Medicare A and B and the hierarchy of the periods that apply. This is especially important as more and more individuals are working well past their 65th birthdays. Another group to consider is the younger disabled individuals who qualify after 24 months on Social Security benefits. Also, many agents have had to address the challenges in assisting a number of Medicare eligible individuals that stayed on their COBRA plans or individual plans and had waived their Medicare coverage to save money or to continue on those plans while not realizing the later issues and enrollment delays, not to mention possible penalties and costs.

If enrolling in the month of Initial Enrollment Period	Coverage begins:
The month turning 65	1 month after enrollment
1 month after turning 65	2 months after enrollment
2 months after turning 65	3 months after enrollment
3 months after turning 65	3 months after enrollment

Initial Enrollment Period (IEP)

The Initial Enrollment Period applies to the individual turning age 65. If the individual is eligible for Medicare when they turn 65, they may enroll in Medicare Part A and/or Part B. This is a 7-month period that begins three months before the month the individual turns 65, the month of their birthday, and three months following.

Note: *if the birthday is the first the month then the seven months move back a month. As an example, for an individual with a Nov. 1 birthday, their IEP begins on July 1 and their effective date would be Oct. 1, if they sign up in one of the three months preceding.*

If an induvial waits until the last four months of their Initial Enrollment Period then their coverage will be delayed as follows:

> If enrolling during the month the Initial Enrollment Period Coverage begins, individuals on Social Security Disability for 24 months will be automatically enrolled in Medicare at the 25th month.

Note: *they will have an Initial Enrollment Period when they turn 65. It is also important to note that if they decline to be covered when first eligible and continue on their COBRA or Individual Plan, they will need to wait for the General Enrollment Period to apply for Medicare coverage and may be subject to penalties.*

Special Enrollment Period

Once the Initial Enrollment Period ends, the individual may sign up for Part A and Part B but only if they meet certain requirements of the Special Enrollment Period (SEP). If an individual is covered under a group insurance plan based on current (active) employment they have an SEP to sign up for Part A and/or Part B at time as long as the individual or the spouse is working and covered by a group health plan through an employer or if in a union plan based on work for coverage.

The effective date for coverage varies, as it is based on when the enrollment request is made, if enrolling during the SEP. After Social Security receives and processes the request for enrollment, the Medicare coverage typically begins the first month or at the individual's option, the first day of any of the following three months. Usually, a late enrollment Part B penalty does not apply. The SEP also does not apply to individuals with End-Stage Renal disease (ESRD) and coverage under Veterans Affairs or Individual Health Insurance Market Place Coverage.

Important Note: *COBRA, Individual, and Retiree plans are not considered as creditable coverage based on current employment. People under these plans are not considered eligible for an SEP and must apply during the General Enrollment Period.*

When I meet with prospects I remind them that timing is everything in Medicare. Their delays to enroll into Medicare could result in penalties for Part A and for Part B and in a delay in coverage. Individuals who lose their group coverage have up to 8 months to sign up for their Part B. The individual must have both Medicare Part A and Part B to sign up for the Medicare Advantage or Medicare Supplement

"When I meet with prospects I remind them that timing is everything in Medicare."

Plans. They may have either Part A or Part B to enroll in the Stand-Alone Prescription Drug Plan. They only have 63 days after the loss of their employer coverage to enroll in a Medicare Advantage Plan or Stand-alone Part D Plan. Individuals have 6 months from the initial date of their Part B to sign up for a Medicare Supplement Plan on a guaranteed issue basis.

General Enrollment Period

If an individual does not sign up for Part A and/or Part B when they were first eligible and they did not qualify for a Special Enrollment Period, then they must wait until the Medicare General Enrollment Period (GEP). This period runs from, January 1 to March 31 for enrollment and coverage begins the following July 1.

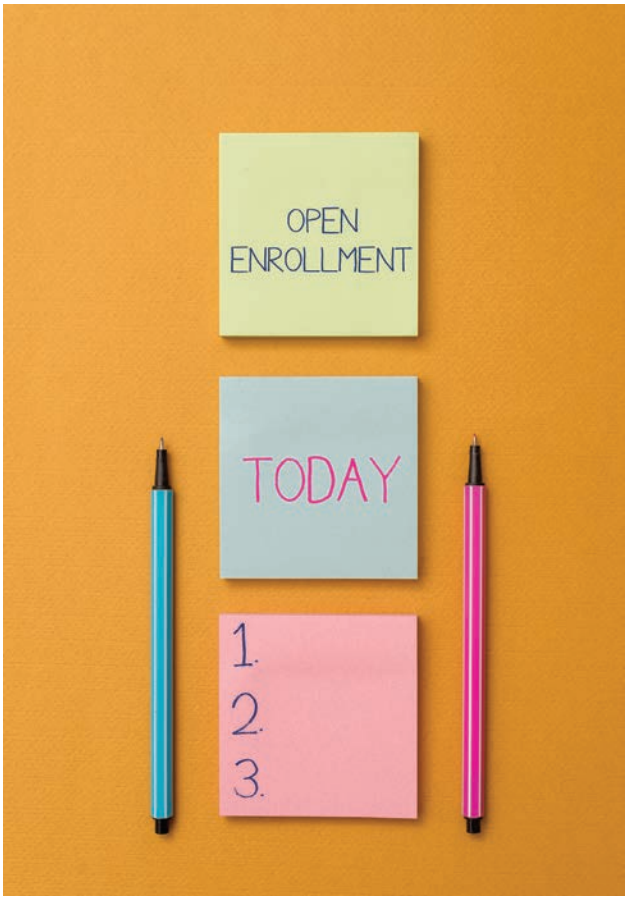
In most cases the individual, if signing up for Part B of Medicare, will be subject to the Part B late enrollment penalty of 10% for each 12-month period they were not covered under Part B. The penalty continues as long as they have Part B. Don't neglect reviewing the possible Part D penalty as well for the delay in coverage under Part D (Medicare Advantage Prescription Drug Plan or a Stand-Alone Prescription Drug Plan.) Note that Veteran Drug coverage is considered creditable coverage for Part D.

Refer to **www.medicare.gov** for information regarding the Part A late enrollment penalties.

Enrollment period hierarchy

In the case when an individual qualifies under more than one enrollment period the order that applies is:

1. Initial Enrollment Period
2. Special Enrollment Period
3. General Enrollment Period



The Special Enrollment Period and the General Enrollment Period are only available after the end of the Initial Enrollment Period. Section 1837(i)(1) of the Social Security Act outlines the eligibility for SEP enrollment.

Want to know more — and to help your prospects who have these specific types of questions?

- When and can I enroll when living outside the U.S.?
- Can I have both Medicare and Retiree Coverage?
- Can I have Veteran's Benefit coverage and Part A and B of Medicare?
- What happens to my Health Savings Account when I sign up for Medicare?
- I have individual insurance and want to continue on the plan after I turn age 65. What are my options?

You will find the answers in the "Medicare and You" Booklet, the CMS "Enrolling in Medicare Part A and B" booklet and on-line at **www.medicare.gov** and **www.socialsecurity.gov** websites.

For those of you who are members of the National Association of Health Underwriters (NAHU), review Don Mangus' article in the July 2021 issue of the Association's Benefits Specialist Magazine. NAHU also has great new flyers available that detail some of the basics about Medicare including enrollment. Find them online in the Medicare Section under the Members Only part of **www.nahu.org**.

Many individuals and Human Resource managers do not understand the Medicare Enrollment Periods and eligibility. Your prospects and clients could be subject to delays in coverage, penalties and added medical and prescription drug costs just because of the uninformed decisions they make when delaying their Medicare Part A and B coverages. Especially if their health coverage is not creditable for later enrollment. You as an informed and knowledgeable agent are a great resource and a trusted advisor who can help them to understand their options and the possible risks. CB

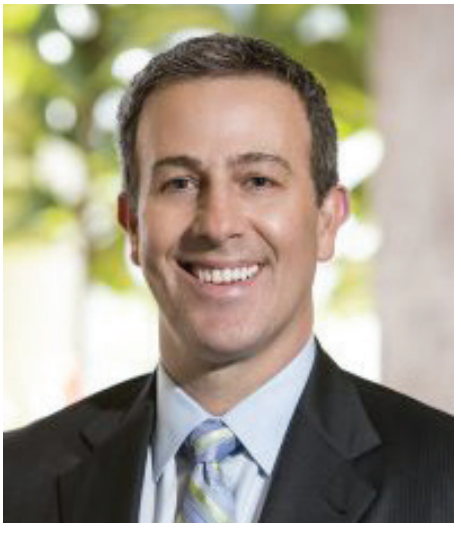
MAGGIE STEDT *is an independent agent that has specialized in the Medicare market for the past 21 years. She is the immediate past president of California Association Health Underwriters (CAHU) and past president of her local Orange County Health Underwriters Association (OCAHU) chapter. Reach her at"***maggiestedt@gmail.com.**

Spotlight on Large Group With 3 Industry Experts

The good, the bad and the ugly effects of COVID-19, upcoming legislation and more

JASON BLEAU,
VP and General Manager, Core Accounts and Small Group, Blue Shield of CA

CINDY JONES,
SVP/Department Head, Benefits Consulting, Dickerson Insurance Services – An Alera Group Company



ROB CARNAROLI,
VP of Sales, Sutter Health Plus

California Broker magazine tapped the expertise of three large group pros to weigh in on the current state of affairs. Thank you to the following for answering our probing questions:

1. What is the fall-out from the pandemic as far as large group health in California?

Jason Bleau, VP and General Manager, Core Accounts and Small Group, Blue Shield of CA

The impact has varied by business. Most large groups adapted to the effects of COVID-19 over time, but we did see some companies reduce in-force business. We recognized early on that our customers would need help across the healthcare spectrum to deal with the pandemic, particularly in supporting the return of their employees to the work site safely. We created an online resource center for brokers, employers and members that offers a listing of vaccination locations, FAQs about testing and vaccines, and how to get care if you think you have COVID-19.

One of the positive aspects of the pandemic was the increase in utilization of virtual and telemedicine services, especially for behavioral health. Based on our claims data, telehealth usage in 2021 is on track to meet or exceed 2020 levels, which were up nearly 2,100 percent from 2019. Blue Shield of California has supported this convenient way of accessing care for years, but the pandemic created the opportunity for innovation through emerging technologies that enabled physicians and patients to directly engage through digitized health care. It was wonderful to see the adoption rates go up. That tells us we're accelerating access to care where and when people need it.

Speaking of behavioral health, earlier this year, we launched our MyStrength app, a self-service treatment tool that empowers our members to support their physical and spiritual health with engaging wellness resources. The app gives our members personalized pathways to address challenges like depression, stress, substance abuse and other serious health issues. It also combines

a range of evidence-based models, like cognitive behavioral therapy, to improve and maintain resilience and well-being.

Cindy Jones, SVP/Department Head, Benefits Consulting, Dickerson Insurance Services – An Alera Group Company

One of the key effects of the pandemic on large employers, particularly those in the hospitality industry, has been the loss of revenue and the subsequent need to furlough or lay off employees. While we have seen many of these employers bring back staff in recent months, these unfortunate events created an administrative burden for the employers at a time when many were struggling to keep the doors open. Many employers also have downsized and are no longer considered large groups by the carriers. They are now faced with a new and unfamiliar rating methodology as well as new plan designs and decreased flexibility coupled with higher rates in many cases. Again, this comes at a time when tough financial decisions are being made while employers are competing for top talent.

Rob Carnaroli, VP of Sales, Sutter Health Plus

The increased uncertainty on future costs is a concern facing many health plans today. It is challenging for health plans to forecast future trends with 2020 data. We are all grappling with questions around whether costs will return to pre-pandemic levels, what legislative or regulatory changes may take place with testing and vaccinations, and if we will see further workforce changes and shifts in employer populations, to name just a few. We are carefully monitoring the situation to see what, if any, changes may be reversed or if they are here for the long-term.

2. What are the most effective ways to sell to large groups in California right now? Are there particular benefits or other aspects that brokers are honing in on?

Jason Bleau, Blue Shield of CA

Over the past few years, choice and flexibility have always stood out, but the most critical factor today is providing value. Products that combine strong provider relationships with significant cost savings and coordinated care offer the greatest value for members.

For instance, our Trio HMO and Tandem PPO products provide members with exceptional value through accountable care with independent physician associates and facilities. We also offer high-performance networks to our customers who have employees outside of California. We have the largest national network with 1.7 million providers contracted, which equates to extensive provider choice, access to high-quality care, and better care delivery — all at lower total cost for customers and their employees.

Larger Blue Shield customers can leverage our Connect and Engagement Point tools for clinical and member engagement — a single point of access to all their benefits, coverage and claims information. Higher engagement through technology is the key; our ability to integrate with our clients' other health service vendors in one mobile application is not only convenient but more effective. For example, when our members use Connect through the Engagement Point portal, we see up to four times more engagement in their care management — which converts directly into access to high-quality care and cost savings for employer groups.

> ***"Products that combine strong provider relationships with significant cost savings and coordinated care offer the greatest value for members."***
> —Jason Bleau, Blue Shield of CA

Cindy Jones, Dickerson

The top of mind question among large employers is, "How will COVID-19 impact my rates?" While we have yet to see the full impact of the pandemic on premiums, actuarial analysis using proven models and practices can help with formulating projections for large groups that have access to claims data. This is true of both fully insured and self-insured employers. Heightened emphasis on employee wellbeing has sparked strong interest among employers in wellness programs, that when properly designed, can have a direct impact on premiums for experience-rated groups.

Rob Carnaroli, Sutter

Employers today want real value in the health care benefits they are purchasing. Astute brokers are keenly aware that carriers often unveil "new" features and benefits that on the surface appear effective, but they amount to little more than the latest marketing ploy. Actual integrated health care that draws from resources inside a health system are far more effective than quilting together a myriad of vendors in an attempt to offer a better member experience, improve quality of care, and reduce healthcare cost. For example, in today's environment we are all well aware that there is a renewed demand for telehealth and virtual primary care and most carriers now offer some version of this service. However, many of these carriers contract with remote physicians who are far removed from the local needs of their patients. Employers — and their employees — will get more value from a health plan that's more connected with its provider network which gives it more control in the patient experience and the ability to ensure real accountability. The same discipline should be applied to other in-demand benefits such as real-time scheduling, online communication apps, walk-in-care, urgent care, symptom checkers and pharmacy delivery services.

3. Is self-insurance or direct contracting impacting large group now?

Jason Bleau, Blue Shield of CA

No. We expect more and more companies will turn to self-funding as an option, especially as they grow more comfortable with risk. We've developed a number of self-insurance solutions for our customers, such as our Intelligent Health platform and our Connect and Engagement Point tools. With our Intelligent Health

reporting tool, for example, employers can leverage the largest database of health data nationally to get a quick, comprehensive view of their healthcare spending. More than 90% of the standard reports are generated in under a minute, and the reports are delivered in natural language with visuals that are easy to understand. That makes it easy for brokers to summarize information and present recommendations to their clients.

Cindy Jones, Dickerson

Self-Insurance is continuing to gain ground in the large group market (defined as 200+ employees) and picking up speed in the mid-sized market (50-199 employees). The 2020 Health Benefit Survey conducted by the Kaiser Family Foundation shows steady numbers among very large employers and large employers with well over 70% offering a self-funded benefit plan. For mid-sized employers the number is steadily increasing as carriers have developed new products and services for this market including level-funding and benefit captive programs.

As for direct contracting and the large group market, it is only being done by very large employers, while most of the mid-sized and large employers still use PPO networks. We do see some impact from the use of reference-based pricing arrangements for larger employers with strong employee concentrations in key areas.

"While we have yet to see the full impact of the pandemic on premiums, actuarial analysis using proven models and practices can help with formulating projections for large groups that have access to claims data."
—Cindy Jones, Dickerson

Rob Carnaroli, Sutter

Brokers and large employers will always be interested in self-insurance options; however, it remains the seldom used solution in our geography for smaller employers and many in the mid-market space. The fiercely competitive Northern California landscape allows fully insured carriers to be very competitive on pricing, network options, and plan benefits in order to attract and retain business. Similarly, the direct contracting efforts by large employers with health systems has largely faded away, but there remains a small contingent of sophisticated national employers who still pursue these arrangements.

4. Is there anything on the horizon legislatively with large group health that concerns you?

Jason Bleau, Blue Shield of CA

There are a few things on our radar. For example, the Consolidated Appropriations Act (CAA) and Transparency in Coverage Final Rule (TCFR) are legislative items we are actively responding to and closely monitoring to determine how they drive changes within health care overall, not just large group. We're also following discussions in the Senate Appropriations Committee about AB 570, state legislation that allows adults to add their elderly parents as dependents to their benefit plans, which could have an impact in the future.

Speaking of legislation, Blue Shield of California was one of the proponents of the state's new health insurance exchange mandate, part of the 2021-22 budget, which was passed recently by the California state legislature and signed into law by Gov. Newsom. The new requirement for California's healthcare providers and payers to securely exchange health information in real time will increase efficiency, reduce cost, and improve care coordination.

Cindy Jones, Dickerson

There are a couple of items we are paying close attention to. In 2022, all plans will have pharmacy transparency reporting due in December. This will be a heavy lift particularly for self-funded plans. We anticipate further regulatory guidance on this in early 2022.

New rules have gone into effect in relation to Non-Quantitative Treatment Limit (NQTL) testing on mental health parity benefits. Self-funded employers should consider what their action plan will be on this testing. Will they do it on their own annually (with a cost of $10k-$20k) as the rules say they should? Or will they have a vendor ready to do the testing quickly in the event they receive an audit letter? (Some audit letters have already started going out).

Self-funded employers also should ensure they understand their plan designs as it relates to Section 1557 of the ACA as these rules continue to be in flux.

"Actual integrated health care that draws from resources inside a health system are far more effective than quilting together a myriad of vendors in an attempt to offer a better member experience, improve quality of care, and reduce healthcare cost. "
—Rob Carnaroli, Sutter

Rob Carnaroli, Sutter

At the state level, many proposed legislative bills have been delayed, so the immediate impact is yet to be understood. At the federal level, we continue to monitor the requirements and changing deadlines for the No Surprises Act and Transparency in Coverage final rule. [See related article in this issue].

Most health plans are concerned with the significant infrastructure build needed to comply, while also competing with existing internal priorities. It is a significant logistical task to mobilize all the teams needed for implementation: Compliance, Legal, Information Technology, Operations, Communications, etc. CB

statement of ownership

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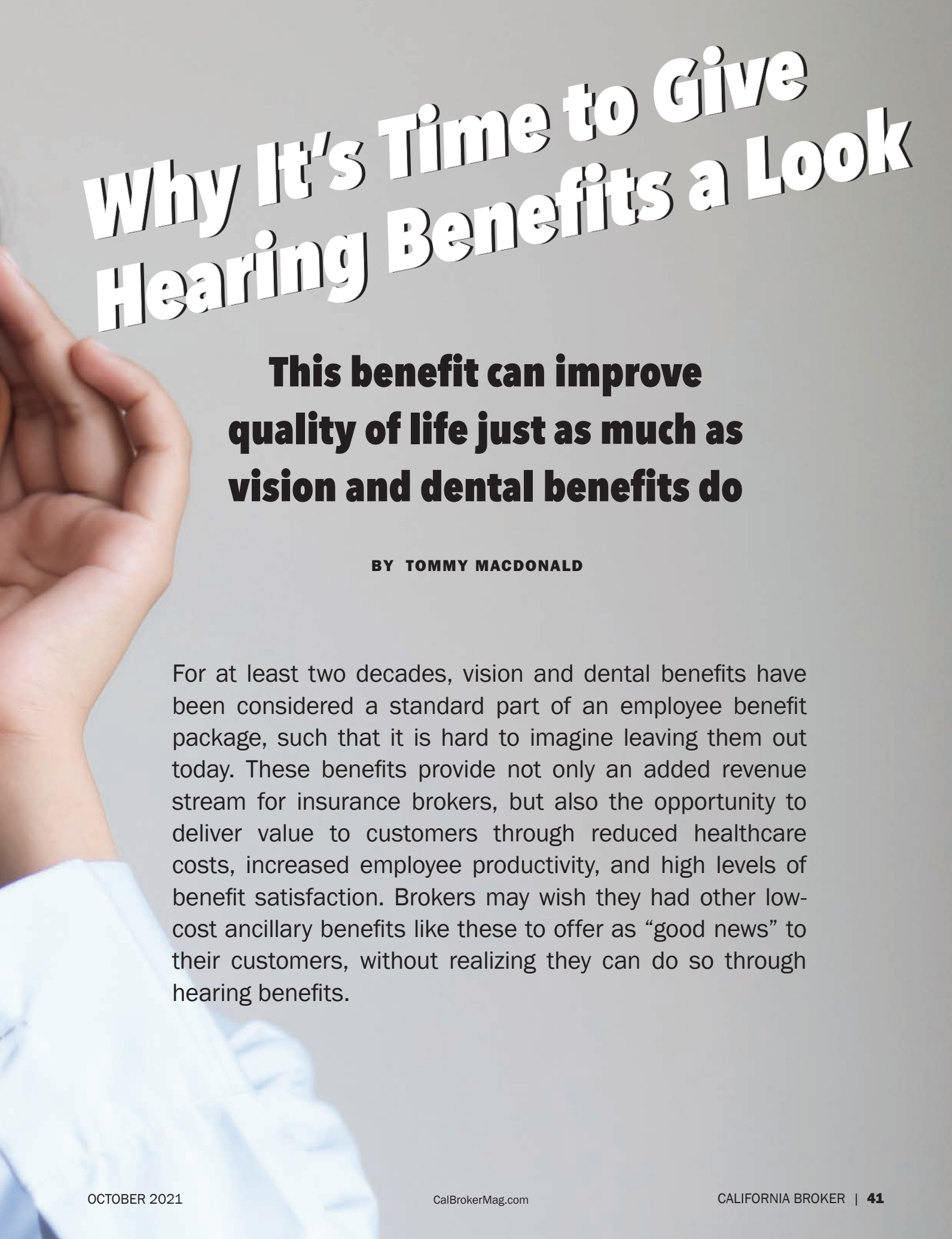

Why It's Time to Give Hearing Benefits a Look

This benefit can improve quality of life just as much as vision and dental benefits do

BY TOMMY MACDONALD

For at least two decades, vision and dental benefits have been considered a standard part of an employee benefit package, such that it is hard to imagine leaving them out today. These benefits provide not only an added revenue stream for insurance brokers, but also the opportunity to deliver value to customers through reduced healthcare costs, increased employee productivity, and high levels of benefit satisfaction. Brokers may wish they had other low-cost ancillary benefits like these to offer as "good news" to their customers, without realizing they can do so through hearing benefits.

Hearing is a critical window to the world around us and the source of much intellectual and emotional stimulation for our minds and "hearts."

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of adults reported having hearing problems.

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For at least two decades, vision and dental benefits have been considered a standard part of an employee benefit package, such that it is hard to imagine leaving them out today. These benefits provide not only an added revenue stream for insurance brokers, but also the opportunity to deliver value to customers through reduced healthcare costs, increased employee productivity, and high levels of benefit satisfaction. Brokers may wish they had other low-cost ancillary benefits like these to offer as "good news" to their customers, without realizing they can do so through hearing benefits.

A hearing benefit can improve quality of life just as much as vision and dental benefits do, yet it receives a fraction of the attention. Insurance brokers can open customers' ears to the importance of integrating a hearing benefit into their benefits package by focusing on three key areas: understanding the need, the connection between hearing and overall health, and the impact of untreated hearing loss on productivity.

Understanding the need

The rate of hearing loss in the workforce is lower than vision or dental problems, but not by as much as you might think.

According to a recent survey by the American Speech-Language-Hearing Association (ASHA), more than half (51%) of adults reported having hearing problems. While the vast majority of hearing loss can be treated with proper fitting of hearing aids, only 11% of those reporting hearing problems actually sought treatment. Trying to live and work with untreated hearing loss takes a massive toll on health and productivity, but most people do put off treatment — and cost is the biggest factor.

According to 2018 Hearing Tracker research, the average price paid for a pair of hearing aids was a significant $4,744, and most commercial health plans do not cover hearing aids. As this investment is substantial for most Americans, many delay treatment for as long as they can, and the rest still likely feel stressed about the cost outlay.

At TruHearing, we know this better than anyone. Our entire mission is focused on improving the lives of Americans with hearing loss by offering affordable hearing healthcare services and hearing aids. We are touched every day by moving stories about the difference hearing aids make in people's lives, including in the lives of our own employees.

Brynn, who just recently joined TruHearing as an Order Administrator, went without hearing aids for six years due to the expensive price, choosing to live with her profound hearing loss rather than go into debt for treatment. She worked multiple jobs during that time and says that her productivity and overall mental wellbeing suffered significantly because of it. Brynn shares that it was especially difficult to function without her hearing aids during the pandemic because everything turned virtual, and lip-reading became almost impossible.

When Brynn started work at TruHearing and gained access to our insurance coverage, she was fitted with her new hearing aids for a fraction of the cost, and her life changed

significantly. Brynn now keeps a growing list of new sounds she's able to hear, and she has been able to flourish in her career and personal life.

Hearing benefits help make stories like these possible. With hearing benefits, audiology exams for employees can be fully covered, and hearing aids can be deeply discounted and offered with various coverage limits based on employer choice. Individual providers and plans vary in richness, so it is important to find the right fit. Offering a plan that significantly reduces cost will reduce stress for employees and increase the chance that they get the care they need sooner.

Hearing and overall health — and costs

Hearing is a critical window to the world around us and the source of much intellectual and emotional stimulation for our minds and "hearts." People who have untreated hearing loss tend to feel isolated during social interactions. It is not fun to keep asking people to repeat what they have said, and eventually people stop trying. Those with hearing loss often withdraw, and opt out of social opportunities, which can lead to isolation, loneliness and eventually depression.

This is especially significant given the well-documented cost of depression in the workplace. According to a 30-year research program by Analysis Group and Harvard Medical School that tracks the cost of major depressive disorders (MDD) in the U.S., the economic burden of MDD reached $326 billion in 2018. As of 2010, the study documented that an employed person with major depression has an annual average healthcare cost of over $10,000, which is more than twice that of an employee without depression ($4,584).

Access to hearing healthcare can help. Research shows that treatment for hearing loss can increase social engagement. In one study published in the March 2016 American Journal of Audiology, adults with hearing loss experienced a significant decline in loneliness after just four to six weeks of hearing aid use. This can quite literally alter an employee's outlook on work and life.

Productivity impact

With so many workers now accustomed to the frustration of dropped sound during Zoom calls or struggling to understand someone speaking through their mask, we should be more sympathetic than ever to those struggling with hearing loss.

It is critical to understand that hearing loss is not only an issue faced by the retired community. While rates of hearing loss increase with age, approximately 60% of people who experience hearing loss are under 65, according to the CDC. And the impacts are very real.

Memory impairment and confusion can worsen for those who struggle to hear on a daily basis, directly impacting productivity. Strain from hearing loss can also reduce collaboration between colleagues, hurting teamwork and reducing opportunities for problem-solving.

Through TruHearing's first annual "Hearing in the Workplace" survey, we surveyed working individuals and explored the impact of untreated hearing loss on their productivity. The study found that almost all respondents reported significant challenges to doing their jobs prior to wearing hearing aids.

Types of productivity issues varied, with "asking coworkers to repeat what they said" topping the list (87%), followed by "frequently missing parts of the conversation" (84%). Of those surveyed, 37% said they lost more than five hours a week making up for these types of challenges, and nearly 20% said they lost more than 10.

For the relatively low cost of a hearing benefit, employers could see significant productivity gains, while helping employees achieve a significantly improved quality of life.

You can make a "resounding" difference

The next time you go to the dentist or order a new pair of contacts, think about how easy it was to do so — thanks to your benefits package. For those with hearing loss, gaining access to the care they need should be that simple.

Insurance brokers can serve as a trusted adviser to clients by bringing awareness to this need and by providing access to a new, low-cost, high value offering to enhance their overall benefits package.

In addition to creating a new revenue stream for their businesses, insurance brokers who add hearing benefits to standard employee packages have an opportunity to make a real difference by mainstreaming hearing care and lightening the financial, mental and emotional toll associated with hearing loss. CB

TOMMY MACDONALD *is CEO of TruHearing, the market leader in hearing health. TruHearing and the insurance companies it partners with are improving the hearing healthcare industry by making hearing healthcare affordable for more people than ever before.*

Call (601) 842-0183 or email **bob.parenteau@truhearing.com** *for more information on how to incorporate hearing benefits into your plan.*

COULD AN ANNUITY HELP SAVE YOUR CLIENT'S RETIREMENT?

BY ROBERT RECCHIA

THE IMPENDING RETIREMENT OF waves of baby boomers is fueling increased interest in annuities as one potential solution to providing a guaranteed income for life. These retirees are concerned that their savings may not be enough to meet their income needs throughout retirement, given increased longevity and healthcare expenses, along with inflation. This is driving the dramatic growth in products and services designed to optimize and protect income, as opposed to a strict focus on accumulation.

Congress has taken interest and is now taking action to encourage retirement plan sponsors to offer guaranteed lifetime income options, or in other words, annuities.

Why consider an annuity

An annuity can provide much of the certainty that retirees need. Think of an annuity as a guaranteed income for life, no matter how long you live. And it lets you withdraw both principal and interest without the risk of outliving your money.

Yes, the unique benefit of an annuity is that your monthly income can consist of both principal and interest. Income amounts are calculated as though you withdrew your principal in equal payments spread over a period equal to your life expectancy. However, if you live longer than your life expectancy, your annuity insurer guarantees that your income will continue unchanged even though in theory your principal has run out. Using an annuity, a retiree may be able to live on a much higher monthly income for any given amount of savings than otherwise would be possible and not worry if the income will ever diminish or run out.

There are many more annuity variations than we can cover here. Deferred annuities accumulate money for distribution at some future date. Immediate annuities generally begin monthly income payments immediately based upon a lump sum deposit of money previously accumulated. In this article, we are discussing only immediate annuities.

How an annuity works

Only insurance companies can issue annuities. Although the insurer cannot know how long you will live, just like you can't, the insurer does know that over a large population of annuitants how long their annuitants will live on average. The insurer's actuaries and underwriters have both the resources to calculate your life expectancy and the income amount they can guarantee and have the capital reserves to back up their guarantees if they are wrong. Annuity income is backed by the guarantee of the insurance company and is not insured by any government institution.

The Straight Life Annuity

In this contract, the offered monthly income continues unchanged as long as you live. Income stops, however, on the last payment date before your death. Conceptually, the annuitants who live less than their life expectancy generate the cash flow for the insurer to continue paying the longer-lived annuitants. Generally, once the annuity income begins, you cannot change or undo your annuity contract. Since it is possible that you could die shortly after your annuity income begins, many retirees would prefer to have an annuity that has secondary guarantees.

Secondary guarantees can hedge the possibility of early death and therefore may have broader appeal. These guarantees not only guarantee monthly income until death but in addition can guarantee monthly income:

- Until at least the initial annuity premium has been paid out as monthly income (called a refund annuity).

- For a specific minimum period of time, such as 10 years, 15 years or 20 years (called a life with period certain annuity).

- For the duration of the longer of your own life or another designated life, such as a spouse. Payments may continue to the survivor unchanged or at some reduced level such as 50%, 66% or 75% (called a joint and survivor annuity).

- With a combination of one or more of the above features.

Some insurers can issue annuities that also allow limited lump sum cash distributions (with proportionally lower income thereafter) under certain circumstances. Inflation indexing is also an option with many insurers. The more guarantees you choose, the lower the initial monthly income will be.

The prospect that retirees, often with limited means, can suffer severe financial losses during retirement is a significant societal concern. For this reason, Congress has been working on potential solutions. The Secure Act, passed in 2019, took a major step toward encouraging annuity distribution options in retirement plans by providing a Safe Harbor so that plan sponsors could offer annuity distribution options with limited fiduciary risk. The Secure Act II, not yet final, will require retirement record-keepers to produce annual reports to participants illustrating the annuity income they could receive from their retirement plan. If passed, plan participants will begin receiving annual reminders of their potential annuity income and this enhanced awareness could lead to increased interest in annuity payout opportunities.

A broker specializing in annuities could offer participants a service to:

1) shop multiple competitive annuity markets in addition to the Plan's record-keeper to help make certain that participant's annuity income is the highest possible

2) Research and compare insurer financial health and/or diversify annuity incomes across two or more insurers to diversify insurer insolvency risk

3) Help participants determine which of the multiple annuity payout options are most suitable for their needs

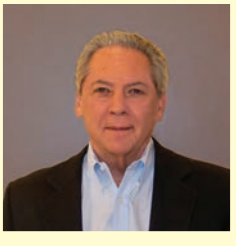
4) Help participants determine the appropriate portion of their retirement savings that should be applied to an annuity.

Many plan sponsors may be interested in establishing a relationship to provide these services assuming

1) their advisor accepts being a fiduciary to their Plan

2) provides service in an unconflicted fashion.

If you were retiring today wouldn't you want to at least seriously consider a guaranteed income for life as part of your retirement financial plan? CB



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Vaccine Hesitancy Strains Health Care Cost Containment – Who is Responsible?

Those who chose to protect themselves and their family should not subsidize the care of those who haven't

BY DR. MORDECHAI PAVLOVSKY

Much of the discussion around vaccine hesitancy focuses on the idea of personal choice and personal behavior. But what happens when personal choices, including not to get vaccinated against COVID-19, ends up costing insurance companies and employers hundreds of thousands of dollars? Why shouldn't that financial cost be put on those seeking treatment who have refused a proven safe and effective means to preventing serious illness and in many cases hospitalization? These are questions the stakeholders in the health care insurance industry must urgently answer.

This question is not a new one, however. Historically, there is a strong correlation between an individual's environment and the healthcare choices they make, otherwise known as social determinants of health. For example, someone who works two jobs and lives far from a gym may have a hard time staying in physical shape or, someone who lives in a food desert may have limited access to healthy meal options. Examples like these have shifted the industry's thinking from individual responsibility to systemic factors contributing to health outcomes. Because of this, our interventions are often targeted at entire populations, not individuals. We can think about how the tobacco and alcohol industries have taken measures not to advertise directly to children, understanding that the environment children are exposed to can significantly impact the choices they make.

Globally, we are facing another issue that's prolonging the COVID-19 pandemic: vaccine misinformation and disinformation. We are aggressively combating this in the United States by developing culturally sensitive programming to reach entire communities with high vaccine hesitancy rates. Part of this work is to acknowledge historical equity issues contributing to people's decisions around vaccination, and developing interventions to communicate clear, correct information to those populations.

However, if the health care industry is tackling vaccine hesitancy on a systemic level, how can we as insurance providers assign financial responsibility to individuals based on their COVID-19 vaccination status? **The answer may be found in both precedence and science.**

There is a decades-old precedent in how to address individual choice for a societal issue in healthcare: tobacco use. We frequently use financial levers to influence how we want people to behave while protecting their rights to make choices. For example, smokers can smoke, but we assess taxes on each pack of cigarettes to discourage smoking. Health insurance companies, life insurance companies, and some employers, will put a surcharge on tobacco users, not only to mitigate their own costs, but to also discourage the act all together. **We, as a society, routinely impose financial fines on various behaviors considered dangerous or reckless to others. It would not be unreasonable to assess the same costs on those who are unvaccinated commensurate with the risk and strain they impose on our health care system.**

The science provides clear evidence. Similar to smoking, we can clearly identify the independent risk factor currently responsible for increased hospitalizations and the vast majority of COVID-19 deaths: lack of vaccination. While many other health conditions have multi-factorial contributors that are too hard to pinpoint or assess, the vaccine has been shown to reduce hospitalizations and deaths significantly. It is hard to justify sharing the financial risks of COVID-19 across a population when we can clearly identify those who chose to modify their risk, and those who haven't. Those who have chosen to protect themselves and their family should not subsidize the care of those who haven't.

As insurance providers, we need to think about what financial instruments we have to encourage vaccinations and limit excessive COVID-19 related healthcare expenditures. Employers who bear financial risk from lost productivity and rising healthcare costs should also start assessing what tools they have to motivate vaccination and limit exposure from COVID-19 related expenses. We should support those who chose to be vaccinated and acknowledge their effort in protecting our health and financial wellbeing. CB

DR. MORDECHAI PAVLOVSKY *joined Sutter Health | Aetna as the Chief Medical Officer and Head of Operations & Innovation in April 2021. In his role, Dr. Pavlovsky develops and leads Sutter Health | Aetna's overarching strategy and operational plan, as well as ongoing clinical operations. He also is the liaison between Sutter Health, Aetna, and CVS Health® innovation and transformation teams.*

Pavlovsky is also an emergency medicine physician at Sutter Health Alta Bates Summit Medical Center (ABSMC). He pursued his master's degree in business administration to improve his understanding of the healthcare ecosystem and to learn where there are areas of opportunity. Most recently, Dr. Pavlovsky completed his master's degree in business administration from the University of California, Berkeley Haas School of Business.

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