

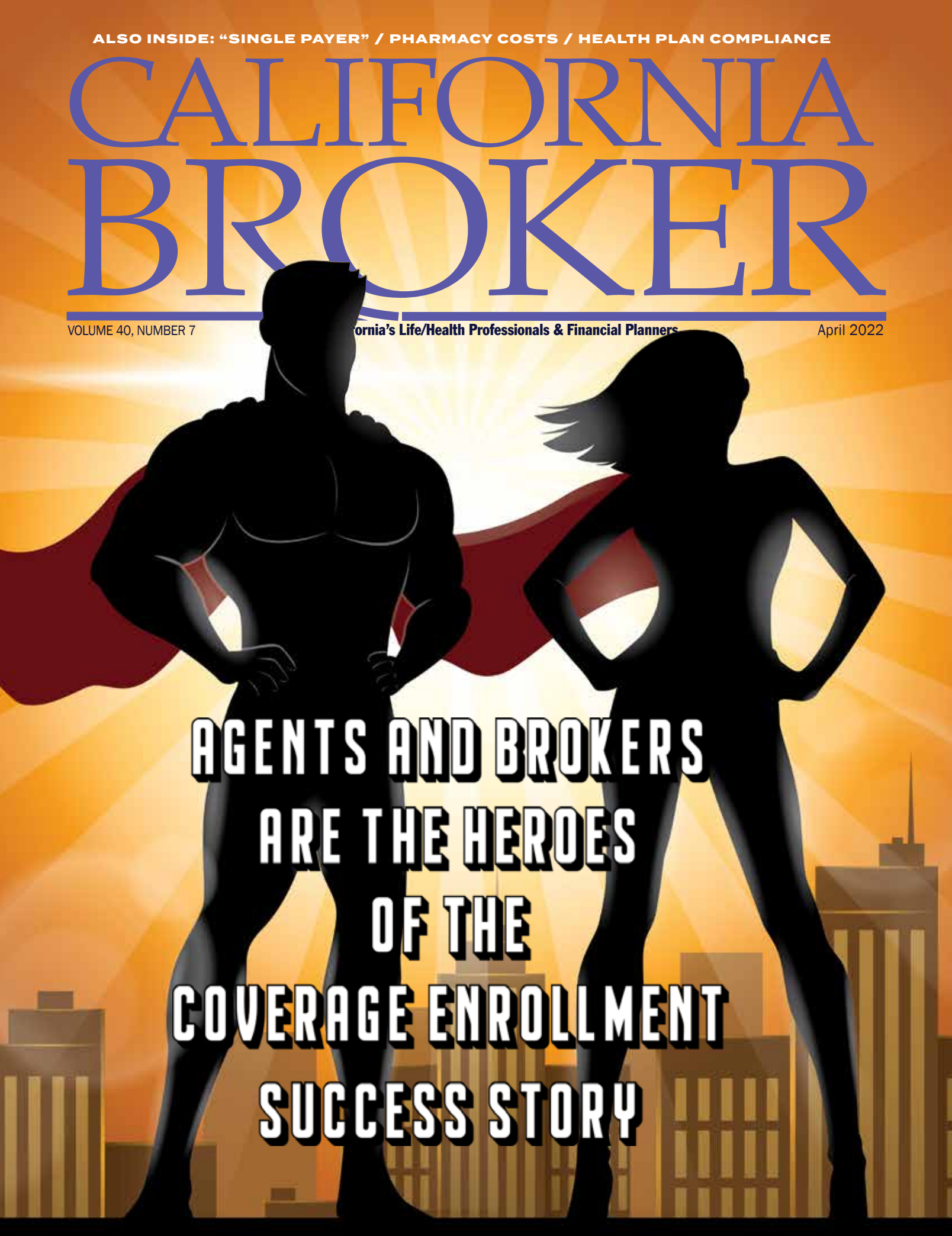
ALSO INSIDE: "SINGLE PAYER" / PHARMACY COSTS / HEALTH PLAN COMPLIANCE

CALIFORNIA BROKER

VOLUME 40, NUMBER 7

California's Life/Health Professionals & Financial Planners

April 2022

The background of the cover features silhouettes of a muscular male superhero and a female superhero standing with their hands on their hips. They are set against a bright, glowing sunset or sunrise sky with rays of light. In the lower portion of the image, a city skyline is visible with various skyscrapers. The overall color palette is dominated by warm tones of orange, yellow, and red.

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a need for mental healthcare that is
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play a vital role in helping them get the
support they urgently seek.*

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BY ADDIE MURDOCK

*Small changes = big results
Unlike many other careers, being a
financial advisor is not a 9 to 5 job.
Strike a healthy balance between
meeting client demands and excelling
professionally, as well as devoting time
to family and prioritizing self-care with
intentional time management.*

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Gilbert Z. Mares Wins Prestigious Will G. Farrell Public Service Award

By Janet Fishman, executive director and organizer for NAIFA-Los Angeles and WIFS-Los Angeles



The highest honor of the Will G. Farrell Public Service Award event went to Gilbert Z. Mares, MPA, LUTCF. The National Association of Insurance and Financial Advisors (NAIFA) Los Angeles and Society of Financial Service Professionals (FSP) Los Angeles/Pasadena hosted the Feb. 24 Will G. Farrell event. Mares began his insurance career in 1975 after having been an aide to the chair of the White House Cabinet Committee on Opportunities for Spanish Speaking People, an examiner for LAUSD, and the community director for Management Training for the Hispanic Coalition of Los Angeles County. Known for his amazing

political relationships, Mares has served NAIFA-Los Angeles in various capacities, including president, chair of Government Relations Committee, and chair of the Political Involvement Committee. His contributions to his community are numerous, including Pasadena Police Foundation, American Legion, Lions Club, and Boy Scouts. Mares exemplifies what true public service is all about.

He is very proud to be the first Hispanic of Mexican descent to receive this award. Congratulations, Gil Mares!

NAIC OFFERS TIPS ON CYBERSECURITY

The National Association of Insurance Commissioners says there are ways to be safer online. Here are some useful tips to secure your information and data:

- **Dispose of personal information by shredding documents using a cross-cut shredder.**
- **Use strict privacy settings on your computer, devices, and browsers.**
- **Keep passwords private, and do not write your passwords down. Consider using a reliable password manager.**
- **Be mindful about the personal information you share on social media.**
- **Be cautious of what you download from the internet. Navigate directly to websites when you need to initiate a download. Don't download anything or click links from sites or emails that someone sends you.**
- **If your Social Security number is requested by a vendor, ask why it's needed and how it will be used and protected.**
- **Remember that there is nothing wrong with telling someone that you aren't comfortable sharing personal information.**

Optum Launches Specialty Fusion to Simplify Specialty Care and Lower Costs

Optum recently announced the launch of specialty medication management solution Optum® Specialty Fusion™. Using Optum's data and clinical expertise, Specialty Fusion provides healthcare payers and care providers real-time insight into the most effective specialty treatment at the lowest cost to the patient. Results include a simpler experience for providers and faster treatment approvals for patients. According to an Optum analysis, the solution generally provides a 17% total cost savings in medical and pharmacy spend.

In a statement, Optum Rx Senior Vice President Kerry Tanner said, "The average specialty patient sees more than five care providers per year, while taking more than 10 drugs on average. They often have to wait for multiple treatment regimens to be approved, and need better support navigating their treatment plan and health benefits. We developed a new comprehensive, benefit-agnostic solution that supports streamlined treatment decision-making for care providers, helping patients get on their therapies faster, while driving down high costs."

Optum Specialty Fusion™ is now available to all large health plans. More info at **Optum.com**.

Insurers Are Hiring

Life and health insurers want you and you and you. That's the takeaway from a labor market survey conducted by the Jacobson Group and Aon. The insurers have been doing so well that they plan to expand employment by 1.69% over the next year, and roughly 65% of insurers surveyed say they will increase their workforce in the coming year.

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*The additional metal tier options are available for new employer enrollment and renewing employers starting with the coverage effective date of October 1, 2021. Eligibility requirements apply. **Employers must contribute at least 50% of the lowest cost plan in the metal tier they choose to set their reference plan. The preferred CCSB employer contribution strategy is to base your contribution on silver and gold metal tiers.

Covered California complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-777-6782 (TTY: 1-888-889-4500). 注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1-855-777-6782 (TTY 1-888-889-4500). Insurance companies vary by region and are subject to change.

EVENTS

LAAHU ANNUAL SYMPOSIUM

In person, April 26, Pasadena Convention Center, Pasadena, Calif.
Info at LAAHU.org.

CAHIP'S CAPITOL SUMMIT

In person, May 9-11, Kimpton Sawyer Hotel, Sacramento. Info at CAHU.org.

BENEFITSPRO BROKER EXPO

In person, May 23-25, 2022, Austin, Tx. Info at BenefitsPro.com.

New CEO for Covered California

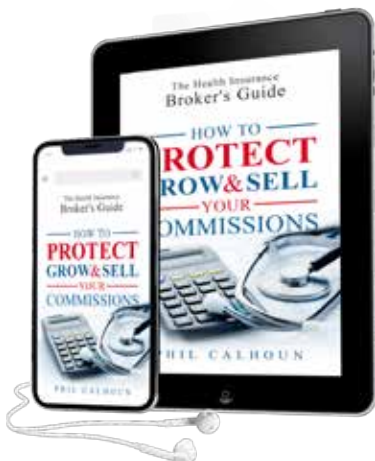


Covered California's Board of Directors announced recently the appointment of **Jessica Altman** as its new Chief Executive Officer. Altman most recently served as the insurance commissioner for the Pennsylvania Insurance Department. She will join Covered California with much experience concerning the Affordable Care Act, having played key roles in the Obama administration during the early establishment and implementation of the law, and as the chair of the Pennsylvania Health Insurance Exchange Authority, where she led the establishment of Pennsylvania's state-based marketplace. Altman's appointment follows the September 2021 announcement that Peter V. Lee, Covered California's first executive director, would be leaving after more than a decade of leading the marketplace. Altman grew up in Menlo Park and is a graduate of Cornell University and Harvard University's John F. Kennedy School of Government. She began her tenure with Covered California March 7 and is earning \$450,000 annually. **Welcome back to California, Ms. Altman!**

NO PLANS TO RAISE RATES — YET

More than 950,000 people in the U.S. have died due to COVID-19 and life insurance claims in 2020 reached \$90 billion — the biggest year-over-year increase since the 1918 influenza epidemic. Yet many life insurers recently told Forbes Advisor that they aren't planning to raise rates. Furthermore, life insurers say they won't be asking applicants if they've been vaccinated against COVID-19.

ARE YOUR COMMISSIONS 100% PROTECTED?

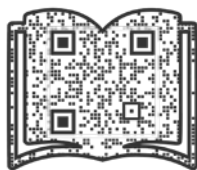


"*The Health Insurance Broker's Guide How to Protect, Grow, and Sell Commissions*," by **Phil Calhoun**, MBA, contains many insights and secrets gained over 30 years in the field.

Discover how a **Commission Protection Plan** can help you protect your hard-earned income. This book has three significant values:

1. **Protect:** The important message is to identify a Successor to may achieve 100% commission protection and avoid losing all your hard-earned commissions.
2. **Grow:** "*The Health Insurance Broker's Guide*" outlines 15 strategies for retaining clients, gaining recommendations from a variety of sources, becoming a Successor for other brokers, and earning commissions.
3. **Sell:** The time it takes to sell a book of business can range from one to five years, and when a broker takes the time to prepare, the average increase in value is 20% to 33%.

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AGENTS AND BROKERS ARE THE HEROES OF THE COVERAGE ENROLLMENT SUCCESS STORY

Deep engagement with communities is most effective when helping people enroll in marketplace coverage

BY LEONARD D. SCHAEFFER

As we enter the third year of an ever-changing pandemic, there are two bright spots. First, the uninsured rate has fallen to less than 10%, even lower than before the pandemic. Second, according to the Department of Health and Human Services (DHHS), a record 14.2 million people enrolled in marketplace coverage during the 2022 open enrollment period. This means that many more people have better access to care, particularly a regular source of care, where they can get trusted medical advice for themselves and their families. Given that the largest group of unvaccinated people is among the uninsured, this is great news. In addition, having health coverage will ensure that many more families have financial protection from increasing health care costs.

At the time of the announcement, DHHS credited enhanced marketplace subsidies under the American Rescue Plan Act and its investments in marketing, outreach, and the navigator program for the enrollment gains. Although agents and brokers have played a critical role in the success of the federal and state marketplaces, they are rarely mentioned as a factor in that success. Subsidies for a dizzying array of plans, however, would be left on the table if it were not for agents and brokers assisting customers in choosing appropriate products and applying for the financial assistance that makes coverage affordable.

In fact, agents and brokers are the unsung heroes of reducing the uninsured. According to CMS, these professionals, even when compared to navigators, prove to be the most effective alternative for helping people to enroll in marketplace coverage. For plan year 2020, agents and brokers brought 1.12 million new enrollees into the marketplace and assisted millions more with renewals. Navigators are extremely important but agents and brokers outperform them in enrolling consumers in a marketplace plan. In 2020, navigators enrolled 31,200 consumers compared with agents and brokers who enrolled 3,962,735. Agents and brokers are also more cost-effective than navigators in enrolling people in coverage. As CMS acknowledges, the efforts of agents and brokers to increase participation in the individual market results in a better risk pool and a more stable individual market.

Agents and brokers have also become critical to seniors enrolling in traditional Medicare or in private sector Medicare Advantage plans. The senior demographic has a decision-making process that agents and brokers understand. They use this expertise to help guide seniors through the complicated process of choosing a product that meets their needs. Ninety-six percent of Medicare Advantage (MA) and Part D plans now contract with independent agents.

The secret to agent and broker success is their deep

engagement with their communities. The observation that all healthcare is local holds true for healthcare coverage as well. Agents and brokers, in particular, have a unique knowledge of their communities and the diverse customers that they serve. It is not uncommon for agents and brokers to be involved with local sports teams, schools, community nonprofits, even city councils. Having personal relationships in their communities gives agents and brokers an incomparable ability to demystify the process of buying health insurance for all types of people. They can, for instance, distinguish the different insurance needs of an adult child coming off their parents' plan, a young family with a new baby, an early retiree, or a senior with multiple medications.

There is no greater challenge, however, than the stressful process of how low-income people find, apply, enroll and stay enrolled in public health coverage programs, such as Medicaid. I recently joined the advisory board of PointCare, a national coverage management platform for all public coverage that is the brainchild of Phil Lebherz and Everett Lebherz. While policy experts debate the issue, these two California agents decided to actually solve the problem of making public coverage work for the 75 million Americans who can't afford health care and don't know how

to access it properly. Different types of health systems use PointCare's technology to enroll patients in public coverage. Once covered, patients are financially protected, the providers that deliver their care are compensated, and the health plans that insure them grow membership.

The pandemic will likely become endemic, meaning we will learn to manage COVID-19 like seasonal colds and flus. As we turn our focus then to rebuilding our communities post pandemic, agents and brokers will play a crucial role. They will help strengthen our health care "infrastructure" by enrolling and retaining more people in affordable private and public health coverage. This will ensure better access to care, larger health insurance pools for spreading risk, and, ultimately, a healthier population. Equally important, they will help our nation return to stability by continuing their tradition of giving back to communities as engaged citizens, local leaders, and problem solvers. **CB**

Subsidies for a dizzying array of plans, however, would be left on the table if it were not for agents and brokers assisting customers in choosing appropriate products and applying for the financial assistance that makes coverage affordable.



LEONARD D. SCHAEFFER is founding chairman and CEO of WellPoint (now, Anthem), Judge Robert Maclay Widney Chair and Professor at the University of Southern California (USC).

Editors Note: The online version of this article contains hyperlinks to sources cited throughout.

Legislation

A DEEP DIVE INTO CALIFORNIA “SINGLE PAYER”

**A Guide to
Universal Health Care vs. Medicare
for All vs. Single Payer**

BY PAUL ROBERTS

In 2021, the California Assembly introduced a new bill, AB 1400, which — if passed — would have eliminated healthcare in California, as we know it today. Instead, all healthcare in California would be provided by one new “Single Payer” system called “CalCare” — with no other options for Californians.



The move would have eliminated all existing California health plans/ carriers, employer-sponsored coverage, individual coverage, provider networks, Medi-Cal, Medicare (in California), Covered California, Premium Tax Credits (PTCs), the valuable roles and contributions of health insurance agents, consumer choice and more.

Like all other Single Payer initiatives in California before it, AB 1400 was highly controversial; many Californians and California employers had varying opinions on the proposal. Perhaps the most controversial item was CalCare’s \$400 billion per year price tag (in addition to the state’s existing \$280 billion annual budget), and the major tax increases proposed to fund the initiative.

Ultimately, the bill did not make its way into law. AB 1400 failed to pass out of the California Assembly by its deadline of January 31, 2022.

California Single Payer — at least as it was proposed in AB 1400 — will not be implemented in California.

California legislators, however, are expected to continue introducing attempts to pass similar “single payer” legislation in the years ahead. The failure of AB 1400 marks the California Legislature’s sixth attempt to pass such legislation since 2003.

UNIVERSAL HEALTH CARE VS. MEDICARE FOR ALL VS. SINGLE PAYER

Many people confuse general terms used to describe alternate, government approaches to health care. **“Universal Health Care” means that everyone has access to, and is covered by, health insurance, regardless of how it is attained** — through private health insurance (employer-sponsored or individual), Medicare, Medi-Cal, CHIP, TRICARE, etc.

One of the ways federal legislators in Washington, D.C. propose to extend “universal health care” to all Americans is by expanding the existing federal Medicare program — a proposal often referred to as **“Medicare for All.” Simply stated, Medicare is a government-facilitated insurance program for seniors and disabled Americans.** The program, funded largely by payroll taxes, allows eligible persons to obtain premium-free hospital coverage — with relatively inexpensive copays, deductibles and

coinsurance.

Other coverage in the Medicare program, such as coverage for doctor visits, outpatient care, pharmaceutical drugs, etc., can be purchased separately — in exchange for relatively inexpensive premium payments. The Medicare program is successful, but it often has solvency issues; funding the massive program is always a challenge. “Medicare for All” is a proposal to extend this program to all Americans — instead of only to seniors and the disabled. Of course, this would require a slew of new taxes in order to fund the already-struggling program, among other changes. Because Medicare is a federal program, this proposal must be enacted in Washington, D.C., and would be extended to all Americans.

A “single payer” system is when only one system exists to access, receive, and pay for healthcare; all other existing systems would cease.

This type of program can be enacted federally, across all 50 states, or can be implemented by the individual states. Several states, including California, have attempted to create single payer laws over the years — all of which have largely stalled due to the costly price tag of such programs. The recent AB 1400 proposal would have created the Single Payer system only in California.

WHAT WOULD AB 1400 HAVE DONE?

As previously mentioned, California’s new “single payer” system would have been called CalCare — and operated in a similar fashion to the California Department of Motor Vehicles (DMV), which is the sole access point to operate motor vehicles in California. The program would have been overseen by a politically appointed-panel of nine individuals, including an executive director and advisory group(s).

The program, as proposed, would not have included premiums, coinsurance, or copays — however, Californians, who are already subject to the highest taxes in the nation, would certainly have paid for the program with hefty tax increases. The program is designed with equity in mind. All Californians, regardless of income level, immigration status, and personal preferences for healthcare, would have access to the same coverage and same

doctors. Private health insurance, and effectively all supplemental insurance, would have been abolished entirely.

HOW WOULD AB 1400 HAVE BEEN PAID FOR?

AB 1400 did not make it through the assembly in its first year (2021) because the bill did not contain a funding resource for the estimated \$400 billion price tag. California has a two-year legislative cycle and is currently in the 2021-2022 session. This allowed AB 1400 to be revisited in 2022, if a funding proposal was included.

When the California Assembly members returned to their Sacramento offices in January 2022, after spending time in their districts over the holidays, a funding mechanism was proposed — ACA 11. The acronym stands for “Assembly Constitutional Amendment,” which would require passage through the California legislature, voter approval, and an amendment to the California Constitution.

Funding was proposed as follows:

1. Excise taxes of 2.3%+ on California companies’ gross receipts (not profits) above \$2 million
2. Employer payroll tax of 1.25% (employers with 50+ only)
3. Employee payroll taxes of 1% (on employees earning more than ~\$50K)
4. Personal income tax increases of about 1.45%+, on a sliding scale for higher earners.

ACA 11 also assumes that the federal government would provide waivers to California, allowing California to use all existing federal funds currently reserved for Medi-Cal, Medicare, etc., on CalCare. These waivers would be subject to White House approval, which can be extra challenging, especially following presidential administration transitions. If additional funding were to be required in the future (especially because of federal waiver issues), ACA 11’s constitutional amendment would permit the California legislature to implement taxes to create new funding, without voter approval.

Furthermore, California voters

passed Prop. 98, which requires 40% of every tax dollar in California's General Fund to be spent on education. In addition, California has a "Gann Limit," which prevents the California legislature from drastically increasing spending/taxes too quickly without voter approval. Thus, amendments to the California Constitution would have been required to approve ACA 11 — if the California Assembly, California Senate, and California Governor approved such changes first.

Assembly members heard strong opposition to AB 1400 and ACA 11 from employers, insurance carriers, doctors, hospitals, California Agents & Health Insurance Professionals (CAHIP — formerly known as CAHU), California Chamber, and others.

WHY DID AB 1400 NOT SURVIVE?

California has two houses in its legislature — the Assembly (with 80 Assembly Members), and the Senate (with 40 Senators). New bills must be reviewed and passed by both houses, before being sent to the governor to review, veto, or sign into law.

AB 1400 is an "Assembly Bill" which was initiated by Assembly Member Ash Kalra, a Democrat from San Jose.

As the bill begins its cycle, it first goes through the "rules" process — where, in this case, the assembly identifies who will review the bill and how — so it can complete policy review (by a committee of about 15 assembly members), and fiscal review (by a different committee of about 15 assembly members). Once the bill passes both policy and fiscal review, it is taken up for a "floor vote," where all 80 members of the assembly vote on the bill. For a bill that does not include tax changes, such as AB 1400, to advance to the second legislative chamber, it must pass with at least a 50% vote. When the bill lands in the second house (in AB 1400's case, the Senate), it goes through the same review again — this time by senators. If approved by both chambers, it goes to the governor to sign into law (or veto). Bills with tax increases, such as ACA 11, must go through same process, but are required to obtain two-thirds vote to advance through both chambers. AB 1400's funding measure, ACA 11, would have been evaluated separately

— but only if AB 1400 were to have passed before it.

Democrats have a supermajority in both California houses, which means they occupy more than two-thirds of seats of each house. The Democratic Party Platform, which is a doctrine of collective objectives established by the party at the Democratic National Convention, places "Single Payer" type legislation very high on its priority list. Conversely, constituents (voters) expect legislators to keep taxes down, especially in California. It is effectively impossible for legislators to support both initiatives in tandem.

While AB 1400 largely thrived in the Assembly on party lines because of the Democrat supermajority, moderate Democrats took issue with the bill — likely due to the opposition heard from employer groups, medical providers and insurance professionals. Furthermore, there are four vacant seats in the assembly (as of January 2022), all of whom belonged to Democrats. This left a total of 76 assembly members for the floor vote, and a smaller Democrat majority.

At the 11th hour — literally, the very end of assembly review, on the very last day to advance bills — Kalra, (assembly member and primary author of AB 1400), pulled the bill. Doing so prevented AB 1400 from advancing to the floor for a vote, stopping the bill in its tracks. Kalra released a statement as the news broke, saying he felt there was not enough support in the Assembly to move the bill forward.


It is worth noting that 2022 is an election year in California, and many voters are paying attention to how their assembly members are voting on Single Payer and tax increases before they vote in November. Pulling the bill before taking an assembly "floor vote" allows assembly members to avoid going on record in support of, or opposition to, these issues ahead of the upcoming election.

WHAT'S NEXT?

The termination of AB 1400 in January 2022 means there is no longer a current proposal for major healthcare changes in California — for now. The California legislature had until February 18, 2022, to introduce new bills for the 2021-2022 session — but no new

Single Payer legislation proposals were introduced in that timeframe. Senators and assembly members may wait until after the election to introduce a new Single Payer bill, which would also allow the proposal to have up to two years to be signed into law — and could come as early as the upcoming 2023-2024 session.

California legislators have vowed to continue to press for healthcare changes in California, including a Single Payer system. It is important to stay active and engaged with legislators as new laws are introduced and make their way through the legislature. **One of the best ways for insurance agents to do this is by participating in California Agents & Health Insurance Professionals (CAHIP, formerly known as CAHU).**

Lastly, California could be approaching "universal health care" quicker than we think. It is estimated that only 6% of Californians are not covered by insurance. Many of those uncovered individuals are undocumented adults ages 26-50, who are currently prohibited from participating in the Medi-Cal program. Governor Newsom's 2022-2023 budget proposals, which are not yet signed into law or finalized, include an expansion of Medi-Cal that would close this gap — bringing California "universal health care" once and for all. 



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GOING BEYOND MEDICAL COVERAGE

WHY YOU SHOULD BE SELLING DENTAL AND VISION

BY JOHN WIESLER

Between COVID-19 and the Great Resignation, prospective hires and current employees are carefully examining benefits packages, which weigh heavily in their decisions to join or stay with an organization. For small businesses vying for talent in a tight market, that means offering many of the same benefits as their larger competitors. By bundling non-medical plans as part of a benefits package, your clients can round out their benefits portfolios to differentiate themselves from the competition.

According to a report from the Society for Human Resource Management, offering a range of benefits that top talent considers important can increase recruiting effectiveness by as much as 11%. Dental and vision insurance are two of the voluntary benefits that employees tend to see as both affordable and important, leading to strong enrollment.

For brokers, such plans add as much as 10-15% in commissions per client and increases the share of wallet, while strengthening client retention efforts and giving employers another way to attract and retain top talent.

TOP REASONS FOR EMPLOYERS TO OFFER NON-MEDICAL BENEFITS

Non-medical offerings are essential for employers for a few different reasons beyond the ability to attract new employees and to retain current ones:

Reduce lost work hours: Employees' poor health cost American businesses \$575 billion and 1.5 billion days of lost productivity, according to Ameritas. Providing dental and vision benefits can help employees control costs and supplement the gaps in core medical plans.

Early detection of health issues: Regular dental and vision exams provide opportunities to spot early warning signs of costly medical issues, such as diabetes and hypertension. In addition to controlling long-term costs for these and other diseases, identifying and treating these medical issues early can also mean a worker is less likely to take extended time off for more invasive treatments and recovery.

Improved self-care: Insurer Cigna reported that employees who bundled dental with medical were more engaged in the management of their health. That means they were more likely to have regularly scheduled screenings and exams, and make more lifestyle changes to improve their own health. More than 70% of working adults with dental insurance see the dentist at least once a year, compared to only 40% of those without dental insurance. Similarly, employees with family dental coverage are more likely to seek regular exams for their children, lowering the likelihood they will need to take time off for a child's dental emergency.

Lower costs for other health plans: Many insurance carriers will provide discounts to employers offering different lines of coverage, helping employers offer a better

and more comprehensive range of benefits while keeping costs under control.

BE A TRUSTED ADVISOR

Despite all of the benefits that dental and vision plans offer for employers, brokers can be hesitant to upsell due to the cumbersome nature of quoting and evaluating non-medical plans. But brokers who don't evolve their benefits portfolios with non-medical may find themselves struggling to keep the competition at bay. **Employers want and need to offer well-rounded benefits packages and will seek out broker partners who can help them create and deploy the right offerings easily and securely.**

Adopt a completely digital process: Using a technology-based quote tool for vision and dental insurance greatly reduces one of the most time-consuming tasks in the business. An automated tool capable of generating comparable quotes enables a broker to save valuable time and makes it easy for employers to compare apples to apples when evaluating options. By automating repetitive, data-heavy tasks, cloud-based solutions offer

significant operational efficiencies while simultaneously freeing up staff to concentrate on the actual business — contacting prospects, engaging current customers to ensure their needs are being met and otherwise enhancing customer relationships.

Ensure data security: Regardless of what you can offer customers and prospects, the time-savings and other benefits provided by technology are all for naught if quotes, coverages, client and employee information can't be kept secure.

This is another challenge for independent brokers, who are unlikely to have security experts on staff to keep the business ahead of the growing number and variety of security issues affecting all businesses, particularly those that handle consumers' personally identifiable information. Use a technology platform that offers complete 360 data encryption across multiple networks at rest and in transition.

By using the right technologies to efficiently offer dental and vision benefits, brokers can add to their bottom lines and improve customer retention, while enabling employers to offer the well-rounded benefits packages necessary to compete in the Great Resignation. 

By bundling non-medical plans as part of a benefits package, your clients can round out their benefits portfolios to differentiate themselves from the competition.



JOHN WIESLER joined BenefitMall in 2020 as the head of General Agency Sales bringing with him more than 30 years of experience in sales and sales leadership roles. As the head of general agency sales, Wiesler is responsible for the sales strategy and growth of BenefitMall's General Agency business.

A CONVERSATION WITH INCOMING LAAHU PRESIDENT

June Taylor

Interview conducted by Wayne Guzman, LAAHU Diversity, Equity, and Inclusion Committee chair

June Taylor may not have desired the center stage, but events and a calling have propelled her to her upcoming leadership role as president of the Los Angeles Association of Health Underwriters (LAAHU).

A person of strong mind with a big heart, from the moment June said yes to becoming the first ever chairperson of the newly formed Diversity, Equity, and Inclusion (DEI) Committee and the first ever co-chair of the National Association of Health Underwriters (NAHU) DEI Task Force, there has been no stopping her passion to serve others through her work and volunteerism.

Guzman: Tell us a little bit about yourself.

Taylor: I grew up in the south and as a small girl I was part of the AME church where there were many people to support me. And to model commitment to community for me. As an African-American mother of three sons, there's not a day that goes by that I do not think about their safety — and to seek how I can make the world a better place for all of us. One way I do that is to give back through providing leadership in professional organizations as well as in women's groups for different charities.

Guzman: What were you thinking and why did you say yes to being the chairperson of the newly formed LAAHU DEI Committee?

Taylor: I wasn't thinking! My thoughts and emotions were all tied to the George Floyd incident and in that moment, I knew I had to be a voice in the DEI space. Sadly, there are too few people of color (POC) that work in the Insurance industry, and I personally would like to see that change — so, the question simply became "If not me, who?"

Guzman: As president what do you hope to change or improve within our association?

Taylor: The three things that I intend to focus on in the coming year are to:

1. Develop a full working board with a commitment to succession training
2. Shed light on the health inequities within communities that we serve
3. Increase diverse membership

Guzman: How do you balance it all?

Taylor: As a spiritual person, I start most days out with prayer. I find that it helps me to stay focused and on track with my priorities. Most importantly, I must have life balance — meaning, some good old fashion FUN with friends and family.

Guzman: Do you have any favorite hobbies or interests you would like to share?

Taylor: I absolutely love second-hand stores. I can spend hours in my local thrift store looking for vintage clothing. I find the neatest stuff. I'm also very committed to my weekly Bible study class. We have such a great time together. I simply enjoy the fellowship — it's amazing!

Guzman: What have you learned as a leader that you'd like to share with your colleagues?

Taylor: Wow, I can't believe that given all the events over the past 15 to 20 years, we are still in this place of turmoil and division, and just beginning to address diversity and equity issues. I ask myself "Why did this not happen before? And why is it happening now? How can I contribute?" It seems long overdue — so long that it blows my mind.

I realized if not me, who is going to speak up? On the initial LAAHU call, I was the only African American. I began to wish I would have been a voice long ago, so I was inspired to step up.

Guzman: So, now that we've started, and especially during COVID-19, how do you see us connecting and staying connected?

Taylor: Luckily we have great technology tools to support connection, like Microsoft teams, zoom, etc. We plan to use recognition programs, strategic communication and messaging, to encourage current active members. These folks are the best of the best and are hungry to know how to make real change in the organization that will reflect a commitment to justice, fairness and equity. We have gained momentum and nothing is going to stop us now

Guzman: Any parting words?

Taylor: Yes! Make a commitment to real change — to doing real good. Commit to regularly scheduled strategy huddles to address DEI concerns with your key team members. Make sure you have the right people on your team. This is very important. Then, inspire that team with a shared vision and goal. If you do this, you will meet so many wonderful people and make a true shift to a better society.

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Rx FOR HIGH SPECIALTY DRUG COSTS

**UNDERSTANDING
COST DRIVERS
AND MANAGEMENT
STRATEGIES**

BY JOHN THORNTON

Pharmaceuticals have been rising in cost steadily, but none greater than specialty drugs (i.e., those typically prescribed by a specialist, are often intravenously administered, and require special handling and high patient management). The Centers for Medicare and Medicaid Services (CMS) estimates that specialty drug costs have been increasing at a rate of 18% annually since 2014. The AMS 2020 Specialty Drug Trends Report stated that high-cost specialty drugs account for 51% of total drug expenses and drive 80% of all medical trend increases even though just 2% of the U.S. population uses specialty drugs.



These findings are representative of what many plan sponsors have been experiencing and are struggling to address. Understanding what is driving the costs of specialty drugs, measures being taken to manage them, and what new cost-containment strategies to deploy is important for all brokers in order to better serve their clients.

WHY ARE COSTS SO HIGH AND WHAT ROLE DO SPECIALTY DRUGS PLAY?

The lack of competition specialty drug manufacturers' enjoy is one reason for the high costs. That has prompted many to raise their

drugs' prices annually, something which has not been lost on health plan sponsors, pharmacy benefit managers (PBMs) or advocacy groups. AARP, for example, is calling for Congress to address the problem of skyrocketing specialty drug costs. In a recent release issued by AARP, Leigh Purvis, director of Health Care Costs and Access for the AARP Public Policy Institute, was quoted as saying, "The excessively high prices and price increases we see each year for specialty drugs are not sustainable. While specialty prescription drugs can provide substantial health benefits, those benefits are only available if people can afford to use them." The AARP is asking Congress to enact legislation that would enable Medicare to negotiate drug prices, place a cap on out-of-pocket costs incurred by older adults, and impose penalties on

pharmaceutical manufacturers that raise prices faster than the rate of inflation. While there was a Prescription Drug Pricing Plan provision contained in the Build Back Better Act, that legislation has yet to pass. In the meantime, plan sponsors are adopting strategies to control the cost of specialty drugs."

Specialty drug costs have been increasing over the past decade — with drugs for treating some medical conditions rising more quickly than others — as reflected in the total spends associated with these drugs. Take the top selling specialty drug, Humira®. Consolidated Medi-Span Average Wholesale Price (AWP) data shows that the total spend for this drug has doubled

over the past eight years. Other specialty drugs recording high gross spends include Enbrel®, Stelara®, Cosentyx® and Dupixent®.

Overall, drugs for treating cancer, arthritis, multiple sclerosis, anti-inflammatory conditions like Crohn's disease and psoriasis, hemophilia and cystic fibrosis are showing increasing costs and related spends. Cancer drugs, for example, increased by an average 7% in 2020 over 2019 according to data from the Evernorth 2020 Drug Trend Report and Pharmaceutical Care Management Association. An increase of that size for an already high-cost drug can break a plan. Consider that the average annual cost for one specialty drug used for a chronic condition is approximately \$85,000 according to AARP's Rx Price Watch. Drugs treating rare conditions can reach as high as \$250,000 a year for one claimant.

MEASURES TO CONTROL HIGH-COST SPECIALTY DRUGS

To better manage their specialty drug costs, many employers have resorted to measures such as increasing employee copayments and reducing the length of prescription coverage. Some are implementing phased-in approaches, which require employees/patients to first try less expensive drugs before using the more costly drugs. Of course, this is not going over well with physicians or patients — whereas less onerous utilization management approaches are proving effective and more acceptable.

Plan sponsors are also placing more pressure on their PBMs, expecting them to provide more frequent and detailed reports relating to their pharmacy expenditures and employee utilization. Employees being treated with specialty drugs, too are expected to adhere to their treatment plans for which a small percentage of plan sponsors are providing incentives. Plan sponsors should research programs that offer an integrated approach to alternate payer sources. For example, the combination of both an advanced specialty drug cost management program and a specialty drug prior-authorization service that identifies alternative and more cost-effective specialty drugs has been shown to result in a 40% average savings on specialty drugs.

While these more traditional measures do play an important role, there are other cost-containment strategies that brokers should understand and share with their clients. They include next-generation telehealth solutions and pharmacy benefit administration (PBA) services.

ADVANCED PHARMACY BENEFIT ADMINISTRATIVE (PBA) SERVICES

Another remedy for high-cost specialty drugs is a PBA service. This can help plan sponsors

The combination of both an advanced specialty drug cost management program and a specialty drug prior-authorization service that identifies alternative and more cost-effective specialty drugs has been shown to result in a 40% average savings on specialty drugs.

better manage their specialty drug costs by giving patients access to a national network of retail pharmacies with mail order capabilities. It too leverages online technologies to promote a more user-friendly service.

Using easy-to-navigate online platforms with intuitive functionality, a PBA service portal features an engaging dashboard and provides 24/7, real-time access to drug and other health care information. Accessible from any PC, tablet or smartphone, the portal incorporates quick response codes on select specialty prescription labels and provides drug videos on demand. It also provides patients with refill reminders using real-time alerts. When used in concert with a specialty drug reimbursement cost management program and prior specialty drug authorization policy, 40% savings are attainable. The service also can drive reductions in costs associated with medical stop loss.

HOW TELEHEALTH CAN SUPPORT COST-CONTAINMENT INITIATIVES

Telehealth is already making a significant impact on plan sponsors' health care costs. In 2020, McKinsey reported that up to \$250 billion of U.S. health care spending could be shifted to a telehealth care option. The savings associated with telehealth solutions are worth noting. The National Business Group on Health estimated that employers could achieve net cost savings of between \$19 and \$121 per telemedicine visit based on where the individual would have gone to seek treatment (i.e., hospital emergency department, urgent care facility, physicians' office). Individuals with critical and/or chronic medical conditions have more medical appointments than others. Replacing and/or supplementing some of these appointments with telehealth options can substantially reduce costs. The additional benefit of providing a telehealth option is that more individuals are likely to be better supported in their medical condition, and be more informed and compliant with their treatment plans. Today's leading-edge telehealth platforms can have an even greater effect in meeting the needs of those with critical/chronic conditions while containing health care

costs.

The most advanced telehealth solutions are integrated with nurse helplines staffed by experienced registered nurses (RNs) who are the patient's first point of contact. Accessible on a 24/7 basis, individuals are able to discuss their medical symptoms/problem with an RN who performs a thorough patient intake to gather all pertinent information. After updating the patient's electronic health record, the RN assesses whether the problem has been addressed or if the matter needs to be triaged and transitioned to another level of medical support, whether that be a physician, hospital, health advocate, etc. Using the telehealth option, unnecessary emergency department, urgent care facility and physician office visits can be avoided — thereby lowering the cost to the employer and employee who may not incur a co-payment.

HOW BROKERS CAN HELP

By making clients aware of all the measures they can take to reduce their specialty drug costs, brokers are demonstrating they are valuable benefit consultants and resources. When a clients' costs start decreasing, brokers can take some credit for their advocacy role. **CB**



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Understanding what is driving the costs of specialty drugs, measures being taken to manage them, and new cost-containment strategies to deploy is important for all brokers in order to better serve their clients.

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How Unbundling Pharmacy
Benefits Can Reduce
Costs and Improve Health
Outcomes

BY CHRIS BROWN

H **healthcare costs** continue to rise year after year. While employers experienced the smallest increase in decades during the COVID-19 pandemic as individuals deferred care or relied on telehealth — now the United States is expecting a more than a 5% increase in health benefits costs over the next two years, according to a recent survey from Willis Towers Watson. To counteract the impact of this spike, businesses are seeking ways to make healthcare costs more affordable and sustainable both for the company and employees.

Employers are evaluating various options to counterbalance impending cost increases, such as premium contributions based on pay or job grades, adding surcharges for working spouses, adopting Centers of Excellence and adding more telehealth services. However, as you help your self-insured employer clients navigate these decisions, an important factor to consider is pharmacy benefits, and whether managing them outside of the health plan can yield greater savings and a better experience without disrupting their employees.

CARVING IN VS. CARVING OUT PHARMACY BENEFITS

There are two ways in which self-insured employers can manage their pharmacy benefits — either “carved in” as part of the medical benefit or “carved out” and managed outside of a health plan.

Carved-in pharmacy plans are included or “bundled in” with medical benefits, and usually are run by a large health plan. In this scenario, employers, as plan sponsors, have minimal oversight of the pharmacy benefit. Because they are unable to contract directly with the carrier’s pharmacy benefit manager, employers typically are unaware of their specific contract terms — such as multiyear arrangements without competitive discounts, or the definitions that alter pricing and rebate terms — and can’t create a custom pharmacy benefits experience for them and their employees.

Carved-out arrangements, on the other hand, give plan sponsors full control over everything from selecting their preferred pharmacy benefits partner to their pharmacy network, stop-loss carrier and more. Self-insured employers in these arrangements have more visibility into their pharmacy contract, access to drug claims and other data, as well as auditing rights and a clearer understanding of discounts and guaranteed rebates. Additionally, since plan sponsors have better insights into how their plan is being run and performing from a clinical perspective, they have more options as it relates to proactive and tailored clinical management. **This is why 94% of Fortune 100 companies carve-out pharmacy benefits — and a reason the carriers are set on preventing smaller groups from doing it.**

By carving out, self-insured employers can uncover the information needed to significantly reduce costs and improve member health.


IS CARVING OUT THE RIGHT OPTION?

Pharmacy benefits provide a critical and highly utilized service to plan members, making it essential that employers have full visibility into the actual performance of their pharmacy benefits plans. By carving out, self-insured employers can uncover the information needed to significantly reduce costs and improve member health. Additionally, when your clients carve out, you can guide them on selecting a pharmacy partner that will deliver sustainable prescription drug savings, elevated service and minimal disruption to members.

Carving-out the prescription drug program comes down to three main benefits:

- **Transparency:** Full pricing and rebate transparency are a hallmark of best-in-class pharmacy benefit contracts. When your self-funded clients carve out, you can help them obtain a clean contract that includes straightforward language, visibility into plan financial performance, and a guarantee that all discounts and rebates will be passed through to the plan.
- **Insights:** The best approach to managing pharmacy benefits combines the employer's complete pharmacy claims historical data — not the medical carrier's book of business data — with expertise that addresses potential clinical risk areas and cost-savings opportunities. For example, employers in a carved-out arrangement can review their (anonymized) pharmacy claims data alongside an independent PBO with pharmacy expertise and uncover insights around their member population. These include underlying chronic conditions or forthcoming specialty drug claims that could impact the plan's budget. Considering specialty drugs can be 12 times more expensive than the average annual cost of brand-name prescription drug therapy, and specialty drug spending is forecast to continue increasing 15% year over year, gaining this level of insight is critical to making informed decisions and optimizing pharmacy benefits plans.
- **Control:** Needs and priorities for pharmacy plans are as diverse as the employer and its members. Carved-in arrangements significantly limit choice because pre-packaged plans offer very little flexibility for employers to respond to changes in the pharmacy landscape, their business and their member population. By carving out

these benefits, employers have the power to customize a plan based on company and employee needs, rather than selecting a package and formulary developed by the medical plan.

Maintaining a carved-in benefits plan may seem like a simple option. However, carving out is a critical component of optimizing health care benefits. In fact, **after carving out, employers are often able to reduce their pharmacy spend by more than 25% on average the first year**, as well as protect themselves against future drivers of increased spend, like the rising cost and utilization of specialty medications. Brokers have an opportunity to help their clients identify and address pharmacy-related factors that are driving up their plan costs by carving out and managing them separately and proactively, so they can reduce costs while continuing to provide a comprehensive benefit. 



CHRIS BROWN is director of Business Development at RxBenefits where he helps employee benefits consultants identify and solve their client's toughest pharmacy challenges. Chris has worked in several different parts of the pharmacy marketplace throughout his 25-plus year career, allowing him to acquire a wealth of industry knowledge. In 2013, Chris was

honored by the Oregon State Pharmacist Association with a Special Services Award for his successful legislative work on PBM transparency. He can be reached at **cbrown@rxbenefits.com**.

HEALTH PLAN COMPLIANCE FOR 2022:

**SOMETHING
OLD,
SOMETHING
NEW, SOMETHING
CHALLENGING
AND
SOMETHING TO
PURSUE...**

PART TWO

This article starts off where Part 1 left off in the March, 2021 issue.

BY DOROTHY COCIU WITH MARILYN MONAHAN

SOMETHING NEW – ACA CHANGES, TIC AND CAA

- ACA New Item Summary

I mentioned something new above related to the ACA: The loss of the Good Faith Penalty Relief. In addition, there have also been changes to Form 1095-C, including new indicator codes, which were designed primarily for individual coverage health reimbursement arrangements (ICHRA). There is also a rule pending on the extension of time to distribute forms, and a proposed rule pending on the threshold for electronic filing. The majority of the “new” items, however, are related to the Transparency in Coverage rules and the Consolidated Appropriations Act (CAA), including the No Surprises Act and Broker Compensation Disclosure requirements beginning in 2021.

TRANSPARENCY IN COVERAGE (TiC)

I have previously written detailed articles on the TiC that were published in Cal Broker:

- Feb.2021: <https://www.calbrokermag.com/in-this-issue/transparency-in-coverage-rules/>
- Oct. 2021: CAA, Part 1: [https://issuu.com/californiabrokeromagazine/docs/calbroker_oct_2021_issue,](https://issuu.com/californiabrokeromagazine/docs/calbroker_oct_2021_issue)
- Dec. 2021: Part 2, [https://www.calbrokermag.com/in-this-issue/caas-no-surprises-act-part-2/.](https://www.calbrokermag.com/in-this-issue/caas-no-surprises-act-part-2/)

You can refer to those articles for more information. In summary, for the purpose of this Compliance for 2022 article, I will summarize the important items.

The Transparency in Coverage rule is actually tied in with the Affordable Care Act (ACA), as the ACA did call for transparency in healthcare coverage, in addition to the CAA rules. The Transparency in Coverage final rule was issued November 12, 2020. The CAA, signed December 27, 2020, includes the “No Surprises Act,” which is from Title I of Div. BB, and “Transparency,” from Title II of Div. BB. There were later FAQs Part 49, which were issued on August 20, 2021. These FAQs included new effective dates for some, but not all of the TiC and CAA provisions. I’ll try to simplify and summarize for you, and include the “To Do” items for health plans.

THE ACA: TRANSPARENCY IN COVERAGE

There were two parts to the TiC final rule; public disclosure and online service tools. Originally, for plan years beginning on or after Jan. 1, 2022, plans/issuers (except grandfathered plans) must make public three machine-readable files that will include detailed pricing information that would show the following:

1. In-network provider rates for covered items and services
2. Out-of-network allowed amounts and billed charges for covered items and services
3. Negotiated rates and historical net prices for covered prescription drugs

The new compliance deadlines for the above items are as follows, according to FAQs Part 49:

- Delayed until July 1, 2022, but also applies to plan years beginning on or after 1/1/22
 - Delayed until July 1, 2022, but also applies to plan years beginning on or after 1/1/22
 - Delayed indefinitely, because of potential overlay with CAA provision on pharmacy benefits
- Under the ACA’s transparency in

coverage provisions, an online self-service tool for plans and issuers (except grandfathered plans) must make available to participants personalized out-of-pocket cost information, and the underlying negotiated rates, for all covered health care items and services. This includes prescription drugs, through an internet-based self-service tool, and providing a paper copy form upon request. The initial list of 500 shoppable services or items identified by the departments to disclose must be available for plan years on or after January 1, 2023. All other items and services must be made available on or after January 1, 2024.

Incidentally, the CAA price comparison tool is “largely duplicative” of TiC, but also applies to grandfathered plans, and includes a requirement to provide information over the phone. It was delayed until January 1, 2023.

Plan sponsors with fully insured plans don’t need to do a lot of extra work here, as their carriers will be doing the transparency work. However, they are required to enter into a written agreement with the carrier or issuer. I’m not sure how that will work at this time, as to whether this is something the carrier will automatically provide or if the plan sponsor employer will need

Deadlines: ACA Transparency I Coverage Final Rule (TiC Final Rule)

Mandate	Original Compliance Date	New Compliance Date
Machine-readable file with in-network provider rates for covered items and services	For plan years beginning on/after January 1, 2022	Delayed until July 1, 2022 (but as of that date will also apply to plan years beginning on/after 1/1/22)
Machine-readable file with out-of-network allowed amounts and billed charges for covered items and services	For plan years beginning on/after January 1, 2022	Delayed until July 1, 2022 (but as of that date will also apply to plan years beginning on/after 1/1/22)
Machine-readable file with negotiated rates and historical net prices for covered prescription drugs	For plan years beginning on/after January 1, 2022	Delayed indefinitely
Self-service tool with initial list of 500 shoppable items/services	For plan years beginning on/after January 1, 2023	Not delayed

To summarize the To-Dos for plan sponsors, they should be sure to comply with the ERISA and ACA requirements (old), the CAA and TiC rules (new), and understand how the No Surprises Act and CAA will change the marketplace to a certain extent.

to create an agreement of some sort. I'm sure we'll have more guidance in the future.

Self-funded plans must either comply themselves or outsource through a written agreement. As someone who works with a lot of self-funded plans, I can't see any self-funded plans doing this themselves; they will need to rely on their TPAs or other vendors (such as a PBM for the prescription portion, a PPO network or Reference Based Pricing vendor) to do this on their behalf, which means that they will need a written agreement for each of those vendors. The plan sponsor will remain liable, which could be very worrisome for the plan sponsor employers.

HOSPITAL TRANSPARENCY

Hospital transparency was a part of the ACA. Regulations required hospitals to publicly post a machine-readable file containing a list of all standard charges for all items and services, and a consumer-friendly list of standard charges for 300 "shoppable" services, by Jan. 1, 2021. As most of us have likely noticed, many hospitals to date, over a year after the effective date, have not complied. In response to the non-compliance, on Aug. 4, 2021, CMS issued a proposed rule that would make several changes to the hospital price transparency regulations, including an increase in penalties. If adopted, the new penalties would be in effect as of Jan. 1, 2022. That has now passed, so we'll see if hospitals actually comply. The good news for employers is that they have no action items for hospital transparency. (As a broker, however, I would point out to employees in open enrollment meetings that this is in effect, and perhaps encourage plan participants to seek out hospitals that are complying.)

CAA "NO SURPRISES ACT" AND "TRANSPARENCY" DEADLINES & EMPLOYER REQUIREMENTS

The chart for the original and new compliance date for all of the No Surprises Act and Transparency is quite lengthy, so I'll include that in an appendix below. For the purpose of informing readers, I will include in this article the relevant items for employer plan sponsors.

NO SURPRISES ACT REQUIRED ID CARD ITEMS

Employers must issue new ID cards to plan participants with required new No Surprises Act items, which include the following new items:

- The annual deductible in-network
- The annual deductible out-of-network
- The annual out-of-pocket max in-network
- The annual out-of-pocket max out of network
- Contact phone numbers for assistance to the participants for all parts of the plan (claims, utilization review/pre-certification, etc.)
- A website and helpful, descriptive information on how to find network providers

PROVIDER DIRECTORIES

Provider directories also have new requirements due to the CAA. Provider directories require a verification process to be assured providers listed are current, a response protocol to timely respond to inquiries, a public website or database and mandatory disclosures. In the event of network directory errors, the plan or issuer cannot require participants to pay more than the network rate, and all amounts must count toward the participants' deductible or out-of-pocket limit. The directories must also include a mandatory disclosure in a printed directory.

There is a helpful FAQ (Number 49) that is available from CMS at: <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-49.pdf>

GRANDFATHERED PLANS

It was at first a relief for grandfathered plans when they learned that grandfathered plans are not subject to certain provisions in the ACA. For example: preventive care, the TiC rule, patient protections regarding the choice of providers and emergency services. But the CAA had another idea for grandfathered health plans. Grandfathered health plans ARE subject to the CAA (see FAQ 11). Specifically, the Surprise Billing interim final rule (IFR) states that the patient

protection rules from the ACA now apply to grandfathered plans — meaning that grandfathered plans must add a patient protection notice to their plan documents. The IFR also states and rewrote rules on emergency services, which now also apply to grandfathered plans.

Under the TiC rules, the prescription drug reporting requirement does not apply to grandfathered plans, but a similar requirement in the CAA does. The departments have delayed the enforcement of the TiC rule and are working on updated rulemaking to address these overlapping requirements. The self-service tool requirement in the TiC rule does not apply to grandfathered plans, but similar price comparison tool language in the CAA does apply. So, bye-bye grandfathered plan exemptions. As they did in the prescription reporting requirement, the departments are delaying enforcement of the CAA, but not the TiC rules, and are working on updated rulemaking to address the overlapping requirements.

CAA - THE NO SURPRISES ACT: SURPRISE BILLING

I've written and Cal Broker has published detailed articles of mine on the No Surprises Act, which can be found in the October and December issues, 2021, as referenced with hyperlinks (online) earlier, so I won't get into a lot of details here for this article. I will summarize the important items for plan sponsors.

As a bit of background, most health plans, whether group, individual, Marketplace or Medicare plans, offer a network of providers and facilities (PPO or EPO network) that agree to accept payment of an established, contracted rate. Non-network providers, however, generally charge higher amounts as there is no contracted pre-established rate. In many cases, out-of-network providers may balance-bill the patient for the difference between the billed charge and the amount the health plan or insurance has paid, unless prohibited by state law. It's important to note, however, that balance bills can happen in both emergency and non-emergency care.

In an emergency situation, the patient generally goes to the nearest

emergency room. That's what we all want them to do. Even if the ER happens to be a contracted PPO facility, not all of the providers working inside the ER may be contracted under their network. This often results in balance billing (charging the difference between the billed amount and the amount the plan pays). I've historically used the term "Forced Providers" in these scenarios. Common examples of these providers include ER physicians, anesthesiologists, pathology/lab/x-ray, rehabilitative care, physical therapy, neonatology, surgeons, and assistant surgeons. It would be easier if patients were trained to ask those providers "who pays you?" If that were to happen, many surprise bills may not occur, as they would know they are not contracted providers. Unfortunately, that rarely happens.

We often see surprise bills in Air Ambulance billings. I've seen air ambulance charges in the 6-figure area on numerous occasions. Sometimes this happens even when they are air lifting from a resort or remote community to the nearest hospital or trauma center just 40 miles or less away. In most cases, surprise medical bills usually DO NOT count toward your deductibles or OOP Maximums. That is something that plan participants should also be trained on, yet little of this occurs.

The Interim Final Rules apply to group health plans and health insurance issuers offering group or individual coverage, including grandfathered health plans, effective Jan. 1, 2022. So yes, this is in effect now for many health plans. They do not apply to retiree-only plans, excepted benefits, short term limited duration plans, HRAs, FSAs, or HSAs.

The provisions of CAA's No Surprises Act related to surprise billing are quite comprehensive. In summary, Part 1 of the IFRs banned surprise billing for emergency services. Emergency services, regardless of where they are provided, must be provided on an in-network basis without prior authorization. The rules also ban high out-of-network cost sharing for emergency and non-emergency services. In addition, patient cost sharing (such as coinsurance or deductible) cannot be higher than if such services were provided by an in-network doctor, and any coinsurance or

deductible must be based on in-network rates. The No Surprises Act also bans out-of-network charges for ancillary care (like an anesthesiologist or assistant surgeon) at an in-network facility in all circumstances and bans other out-of-network charges without advance notice. Providers and facilities must provide patients with a plain-language consumer notice explaining that patient consent is required to receive care on an out-of-network basis before the provider can bill at the higher out-of-network rate.

What does this mean for plan sponsor employers? They will need to meet with their brokers and consultants, as well as their insurers or TPAs and prepare notices and amend plan terms, as necessary.

It's important to note that state rules continue to apply for Balance Billing protections. Here in California, we have balance billing laws for fully insured plans, but none for self-funded plans.

ADMINISTRATIVE CONCERNS WITH 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. The federal departments appear to have expressed their disapproval of claims practices which do not look at all of the facts and circumstances, relying solely on the diagnosis codes to determine if a claim is eligible for payment. 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.

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:

- place their health in serious jeopardy

- seriously impair bodily functions, or
- cause serious dysfunction to a bodily organ or part

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. These provisions may require Plan Amendments. Plan sponsor employers should also look to their TPAs if self-funded, and check their next Evidence of Coverage document from their fully insured carrier, to see if the claims processes have been updated. Self-funded employers should also check with their TPA to see that their internal training manuals have been updated.

NO SURPRISES ACT NOTICE

Besides ID cards and provider directories, Plan Sponsors are also required to put out a No Surprises Act Notice to all plan participants, effective with their renewal dates on or after Jan. 1, 2022. A model notice was provided at: <https://www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprise-billing-providers-facilities-health.pdf>.

SOMETHING CHALLENGING

The QPA and Independent Dispute Resolution Process of the No Surprises Act: Qualified Payment Amount (QPA) & Independent Dispute Resolution Process (IDR)

Again, I've written detailed articles on the QPA and Independent Dispute Resolution Process of the CAA (see CalBroker Dec. 2021, noted earlier), but I do want to summarize for this article. I will say that these two new terms and processes will definitely be challenging for those involved in the process of making determinations, and there will be a very long learning curve before these become easy, every-day terms and administrative tasks.

The QPA is the median of the in-network (or contracted) rate in a geographic area. It also 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.

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 (IDR).

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.

THE INDEPENDENT DISPUTE RESOLUTION PROCESS

If a payer, such as a carrier or health plan, cannot resolve a payment settlement with a provider, then the payer and provider must resolve the payment dispute using methods of negotiation and arbitration. Plans and providers may use only a Certified Independent Dispute Resolution Entity (I have adopted a previously stated new acronym that I heard first from the Self-Insurance Institute of America – the CIDRE).

The No Surprises Act requires payers to send an initial payment or denial of payment of a claim no longer than 30 days after a claim is submitted. After the 30-day period, either party may begin negotiations on a claim. If the parties involved cannot agree on payment terms during the 30-day period, then they will move to an Independent Dispute Resolution (IDR) process. This process may be initiated within 4 days of the 30-day period (for a 34-day window).

Each entity will offer a final payment amount and then the arbiter will use a variety of factors to determine the final amount, including geographic areas, service codes, etc. The intent is to make it fair to both parties. Under the IDR process, they are not allowed to use lower payment rates such as Medicare or Medicaid (however, self-funded plans using Reference Based Pricing will be able to use a variation of Medicare rates, as I describe below).

The IDR does not impact the consumer or plan participant. The dispute is between the provider and

the health plan. The provider has no recourse against the consumer, and therefore, it is not an adverse benefit determination.

CMS created a federal portal website where providers and plans will submit their payment disputes, which can be found at: <https://www.cms.gov/nosurprises/consumer-protections/Payment-disagreements>.

The full website contents can be found at: <https://www.cms.gov/nosurprises>. Included in that portal is an application process for entities to become a certified independent dispute resolution entity, or an arbiter for the process. Before initiating the federal independent dispute resolution process, disputing parties, according to CMS, must initiate a 30-day "open negotiation" period to determine a payment rate. In the case of a failed open negotiation period, either party may initiate the federal independent dispute resolution process. The parties may then jointly select a certified independent dispute entity (or CIDRE) to resolve the dispute. The CIDRE and personnel of the entity assigned to the case must attest that they have no conflicts of interest with either party. If the parties cannot jointly select a CIDRE or if the CIDRE has a conflict of interest, the federal departments will select a CIDRE for them.

After a CIDRE is selected, the parties will submit their offers for payment, along with supporting documentation, into the federal portal. The CIDRE will then issue a binding determination selecting one of the parties' offers as the out of network (OON) payment amount. Both parties must pay an administrative fee (\$50 each for 2022), and the non-prevailing party is responsible for the CIDRE entity fee for the use in this process.

When choosing an arbiter, there can be no conflicts of interest on either side. The arbiter cannot be an employee or former employee of a disputing party within the past year or a former employee of the federal government within a year of the time which the employee left the employment of the government. They cannot have a financial, professional, or family relationship with either party. In addition, the arbiter cannot be owned, either directly or indirectly, by an insurance carrier or medical provider.

The arbiter also cannot be an affiliate/subsidiary of a professional trade association for the group health plan, carrier, or providers.

The arbiter needs to have sufficient expertise in the arbitration and claims administration of health care services, managed care, billing, coding, medical and the law. They must also have expertise which is considered sufficient in the field of medicine, especially where the payment determination depends on the patient acuity or the complexity of the medical procedure, or the level of training, expertise, experience and quality and outcome measurements of the provider or facility that furnished the medical service or services. Arbiters are required to maintain current accreditation from a nationally recognized and relevant accreditation organization, such as the Utilization Review Accreditation Commission (URAC), or employees must have requisite arbitration and topical training. So, the bottom line is, not everyone can apply and be accepted as a CIDRE (also, the payment they receive is pre-determined and not overly lucrative, so I don't see thousands of CIDRES stepping up to apply).

When submitting "offers" of payment, both parties must submit an "offer" for the OON payment in dollars and a percentage of the QPA represented by that dollar amount, within 10 business days of the CIDRE selection. Providers must provide the size of their practice by the number of employees that they employ, and whether the provider is a specialty provider. Health plans must provide their coverage area, QPA geographic area, and must state whether the plan is fully insured or self-insured. Health plans must also state the QPA for the applicable year of the claim dispute.

The QPA, or the median in-network rate, is the primary factor in a final payment determination. The CIDRE must assume the QPA represents a reasonable market-based payment. The CIDRE must begin with the presumption that the QPA is the appropriate OON amount. The CIDRE must also consider the QPA, or the offer closest to it, as the final payment amount.

It is NOT the role of the CIDRE to determine whether the QPA was calculated correctly. Their job is to

simply consider the information that is submitted by both parties and consider whether any "additional criteria" is already reflected in the underlying QPA, to assure there will be no "double-dipping." The CIDRE can also consider whether information that shows efforts to alter the service codes have occurred, which might result in "up-coding" or "down-coding" billed amounts. Down-coding may show that the QPA is artificially low, for example. However, the CIDRE is permitted to consider "additional criteria" that may lead to a higher payment amount than the QPA.

Such additional criteria includes:

- the level of training, experience and quality of care, as well as the outcome measurements
- the acuity of the patient and complexity of services
- a good faith effort to enter the network by the health plan and provider
- market share held by the provider or facility in the region
- teaching status, case mix, scope of service of facility; or
- contracted rates over the prior four years.

This additional criteria could cause the payment rates to increase for providers, so it's likely that providers will include as much of this as possible in their submissions. Part 2 rules made it clear that the IDR entities will not give equal weight to both the QPA and additional factors, and that the IDR entities will be instructed to "select the offer closest to the QPA" unless the certified IDR entity determines that credible information submitted by either party is materially different from the appropriate out-of-network rate.

If the "credible information" demonstrates that the QPA is "materially different" than what an appropriate payment for the OON service should be, the CIDRE may choose a higher amount.

The CIDRE cannot take into account:

- a provider's usual and customary charges
- a provider's "billed charges"
- rates paid by any public payer payment or reimbursement rates such as Medicare, Medicaid, CHIP or TRICARE, or past arbitration decisions as a precedent.

That is not to say that a plan using referenced-based pricing in place of a network, for example, cannot use some form of rating above Medicare rates (such as 150% of Medicare). The interim final rule clarifies that the CIDRE cannot consider which "offer" is closest to 150% of Medicare; however, the federal departments noted that in-network contracted rates are frequently based on a percentage of Medicare rates. Because the basis of the Qualified Payment Amount is the in-network contracted rates, if the QPA is calculated using a percentage of Medicare, then the CIDRE can take into account this percentage of Medicare value. In this case, the percentage of Medicare value represents the QPA and not a particular offer from the disputing parties.

In a nut-shell, "you can't come in with a 150% of Medicare offer, but if the QPA is based on a percentage of Medicare, then that can be taken into account by a CIDRE," stated Chris Condaluci, Self-Insurance Institute of America's legal counsel, on a recent podcast interview with me on the Independent Dispute Resolution Process rules (Benefits Executive Roundtable, S3 E8, <https://advancedbenefitconsulting.com/s3e8-no-surprises-act-independent-dispute-resolution-process-how-it-will-work/>, air date Nov. 2, 2021).

The parties may continue to negotiate after the IDR process begins. If an agreement is reached, the initiating party must inform the federal departments within 3 business days after agreement, and the final payment must be made no later than 30 business days after they have reached agreement. If the parties cannot agree on a payment rate, the CIDRE must make a final payment determination 30 business days after its selection. The federal departments may extend the 30-business day period on a case-by-case basis if the extension is necessary to address delays due to matters beyond the control of the parties or for "good cause."

The determination of the IDR entity is binding on the parties and is not subject to judicial review, except in narrow circumstances, such as fraud. The IDR process will use a "baseball-style" arbitration process, meaning that the CIDRE is required to pick one of the two "offers" which is closest to the QPA. The

**APPENDIX – CAA No Surprises and Transparency Effective Dates
(does not include all effective dates; only those specifically mentioned here)**

Mandate	Original Compliance Date	New Compliance Date
Price Comparison Tool	Plan years beginning on/after Jan. 1, 2022	Plan years beginning on/after Jan. 1, 2023
ID Cards	Plan years beginning on/after Jan. 1, 2022	Not delayed
Provider Directories	Plan years beginning on/after Jan. 1, 2022	Not delayed
Balance Billing Disclosures by Plans/Issuers	Plan years beginning on/after Jan. 1, 2022	Not delayed (model form and instructions issued)
Surprise Billing	Plan years beginning on/after Jan. 1, 2022	Not delayed (guidance issued)
Broker/Consultant Compensation Disclosure (Group)	Dec. 27, 2021	Not delayed (some guidance issued)
Compensation Disclosure by Issuer (Individual)	Dec. 27, 2021	Applies to contracts executed on/after Dec. 27, 2021, between agent/broker and issuer (guidance issued)

amount of the offers will determine that amount. It could be that the QPA itself is the final amount, or it may be higher or lower than the QPA, depending on the offers submitted.

All in all, as I said, it will be a complicated process, with a long-learning curve.

CAA BROKER COMPENSATION DISCLOSURE

I've already provided information on broker compensation disclosure in past articles, as have numerous other authors. In summary, I will just provide the basics of this part of the CAA.

Under existing ERISA rules, group plans may not engage in "prohibited transactions" with "parties-in-interest." A service provider is a "party-in-interest." But there is an exemption if the services provided are necessary, provided under a contract or arrangement that is reasonable, and provided for reasonable

compensation. The CAA amends these rules to place new requirements on plans. Under the rules, no extension or renewal of a contract or arrangement for services between a "covered plan" and a "covered service provider" (CSP) is reasonable unless the terms of the CAA are satisfied. A "covered service provider" (CSP) includes brokerage and consulting services. A CSP must disclose a summary of services and a description of "direct" and "indirect" compensation reasonably expected to be received (moreover); changes to disclosed information must also be reported.

These rules do not apply to government employer plans exempt from ERISA. The effective date was Dec. 27, 2021; and it does not apply to contracts executed prior to Dec. 27, 2021. According to guidance in the Field Assistance Bulletin that was issued, regulations will not be issued. Brokers

will need to distribute these notices with renewal dates going forward.

Under the CAA, the term "covered plan" means a group health plan. The term "covered service provider" means a service provider that enters into a contract or arrangement with the covered plan and reasonably expects \$1,000 (as adjusted) or more in compensation, direct or indirect, to be received in connection with providing brokerage or consulting services. The term "compensation" means anything of monetary value, but does not include non-monetary compensation valued at \$250 (as adjusted) or less, in the aggregate, during the term of the contract or arrangement. The term "direct compensation" means compensation received directly from a covered plan. The term "indirect compensation" means compensation received from any source other than the covered plan, the plan sponsor, the

covered service provider, or an affiliate. The term “responsible plan fiduciary” means a fiduciary with authority to cause the covered plan to enter into, or extend or renew, the contract or arrangement.

SOMETHING TO PURSUE — PLAN COMPLIANCE

I know that I’ve given you a tremendous amount of information in this article. To summarize the To-Dos for plan sponsors, they should be sure to comply with the ERISA and ACA requirements (old), the CAA and TiC rules (new), and understand how the No Surprises Act and CAA will change the marketplace to a certain extent. There are administrative tasks that plan sponsors must complete to be in compliance with the No Surprises Act, which were spelled out in this article (ID cards, provider directories, notices to employees, to name a few). Much of the TiC requirements will be performed by outside vendors, but plan sponsors will need written agreements with them.

All of these changes could and likely will increase plan costs, so employer plan sponsors should be prepared to adjust their budgets if necessary.

As plan sponsors navigate through the old and new rules and compliance requirements, they rely on service partners, such as their brokers or consultants, to help them. These relationships grow stronger with time and assistance. Just remember, as I said in the beginning of this article, we’ll get through it, as long as we work on it and stay positive. So, as you work with those plan sponsors, assisting them with Something Old, Something New, Something Challenging and Something to Pursue, I hope that you find this article helpful to all of you. **CB**

Author’s Note: I’d like to thank Marilyn Monahan of Monahan Law Office for assisting me with my client seminar/webinar preparation and participation, and therefore her assistance with this article. Marilyn can be reached at **(310) 989-0993**, or at **marilyn@monahanlawoffice.com**.



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the host of the *Benefits Executive Roundtable Podcast* and is a frequent contributor to *CalBroker* magazine and other written publications. She is a benefits broker/agent specializing in mid-size and large group health plans, ERISA, ACA, CAA, TiC and other areas of health plan compliance. She is also a frequent CE class instructor for NAHU, CAHIP, its local chapters, SIIA and other professional associations. She can be reached at 714 693 9754 x 3, or at **dmcociu@advancedbenefitconsulting.com**.

References & Resources:

ERISA Resources:

U.S. Department of Labor, Employee Benefits Security Administration (EBSA):

- Reporting and Disclosure Guide for Employee Benefit Plans
- Compliance Assistance Guide: Health Benefits Coverage under Federal Law, including Self-Compliance Tool for Part 7 of ERISA: Health Care-Related Provisions
- Understanding Your Fiduciary Responsibilities under a Group Health Plan
- An Employer’s Guide to Group Health Continuation Coverage under COBRA
- J. Hanley, Deskless Yet Informed, *Benefits Quarterly* (4th Quarter 2019)
- DOL Voluntary Delinquent 5500 filing - DFVCP Fact Sheet at: **<https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/dfvcp.pdf>**.

CAA Resources:

Department of Labor (DOL)

- DOL: Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA): **<https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf>**
- DOL: Understanding Your Fiduciary Responsibilities under a Group Health Plan: **<https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/publications/understanding-your-fiduciary-responsibilities-under-a-group-health-plan.pdf>**

Centers for Medicare & Medicaid Services (CMS)

- CMS: Website on Surprise Billing: **<https://www.cms.gov/nosurprises>**
- CMS: Model Disclosure Notice Regarding Patient Protections Against Surprise Billing: **<https://www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprise-billing-providers-facilities-health.pdf>**
- CMS: Federal portal where providers and plans will submit their payment disputes: **<https://www.cms.gov/nosurprises/consumer-protections/Payment-disagreements>**.

CERTIFIED AGENTS! ARE YOU READY FOR THE 2022 MEDI-CAL REDETERMINATION?

Special Enrollment Period for individuals no longer eligible for Medi-Cal

BY WAYNE GUZMAN

It has been more than two years since the public health emergency was declared on March 18, 2020. Since then, new federal laws have been passed to help families, individuals, and businesses during this pandemic, including the Coronavirus Aid, Relief, and Economic Security Act (CARES) and the FFCRA Families First Coronavirus Response Act (FFCRA). These acts included many elements, such as expanded unemployment and disability programs, new employer tax credits and loan programs, extended tax filing dates, and much more.

Still, one area that may not be top of mind when we think of these new laws was the assurance that those who have been on Medi-Cal were not removed from this program during the public health emergency. As a result, the percentage of the existing Medi-Cal population pending possible termination has swelled over the last two years. Well, that is very likely to change in 2022 as it is quite probable that we will move out of the public health emergency, and those no longer eligible for Medi-Cal will be removed from the system and directed to other sources for obtaining their state-required health insurance.

HOW BIG, HOW MANY AND WHEN?

Current estimates indicate that of the more than 14 million individuals currently on the California Medi-Cal program, between 10 and 20% will likely no longer be eligible for Medi-Cal. This will create a Special Enrollment Period (SEP) where they will need assistance in choosing a healthcare plan suitable for them and their families generally within 60 days of losing their coverage. With these events likely to begin between July and September of this year, it is important that agents begin to prepare accordingly.

The good news for agents is that the redetermination will occur over 12 months and not all at once. Covered California will continue to let agents know of prior Covered CA clients who are losing Medi-Cal; moreover, under California SB 260 they will be assigned and the agent simply needs to help the individual affirm.

HOW CAN CERTIFIED AGENTS HELP?

Agents should be mindful and recognize that most of these individuals have been on some sort of managed care plan versus Fee-For-Service. They are accustomed to having rich health and wellness benefits including dental via the Denti-Cal

program at little to no cost.

Additionally, agents should take the time to understand the dynamics of the situation and familiarize themselves with the following recommendations:

- **Understand** the Medi-Cal population including mixed households: parents/guardians on-exchange and children on Medi-Cal; and the dual-eligible Medicare population (Medicare and Medi-Cal eligible beneficiaries)
- **Leverage** Covered California agent notification that makes agents aware when a former client who was eligible for Medi-Cal in the past is now eligible for a Covered California plan.
- **Offer** in-language support and develop cultural competency to understand unique differences among healthcare consumers, including inherent health disparities that exist within the Medi-Cal population.
- **Provide** educational resources, tools, and develop a contact list and relationship with your local Medi-Cal office.
- **Educate** yourself by attending workshops and other learning opportunities.
- **Remain active** and engaged by participating in community-based outreach events focused on supporting this population.

NEXT STEPS?

Since the advent of the ACA exchanges launched on Jan. 1, 2014, California health insurance agents have continually risen to the challenge to help ensure the uninsured by reaching into underserved diverse communities and connecting with community members and leaders often where the agents live and work. These agents have helped many individuals navigate the complex health system and obtain affordable quality health insurance coverage, whether on-exchange, off-exchange, through Medi-Cal, or Medicare. Once again, we can demonstrate our unique value and dedication to helping all Californians by delivering education and personal service during the upcoming 2022 Medi-Cal redetermination.

For more information on how you can help in 2022, please feel free to contact:

Wayne.Guzman@blueshieldca.com. 



**Certified Eligible Statistics – Medi-Cal Population
December 2021 (Date Represented: September 2021)**

Figure 1: Total Medi-Cal Certified Eligibles – September 2018 through September 2021

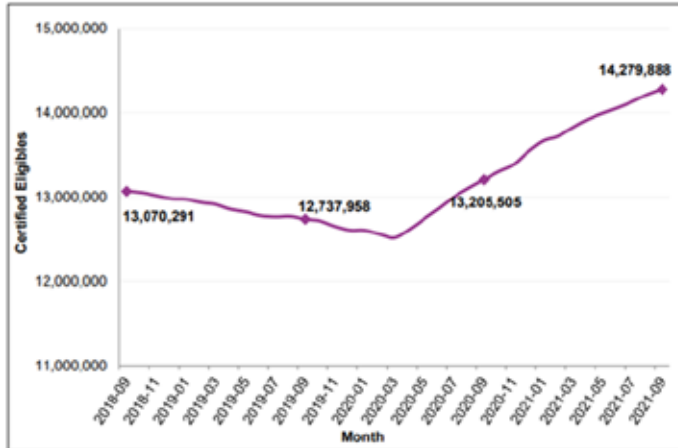
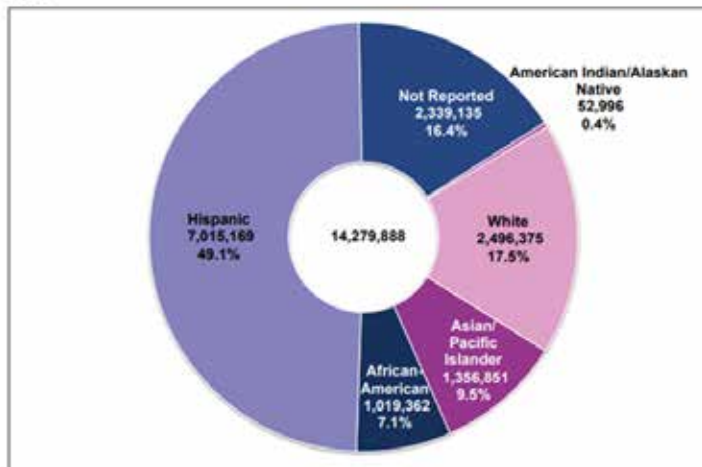


Figure 6: Distribution of Medi-Cal Certified Eligibles, by Race/Ethnicity – September 2021



WAYNE GUZMAN, SHRM-SCP, is senior manager, Statewide Outreach for Blue Shield of California. He also serves as LAAHU Diversity, Equity, and Inclusion Committee chair; NAHU Diversity, Equity, and Inclusion Committee

past chair and member; and IEAHU past president.

Guzman joined Blue Shield in September 2020, and in his current role oversees a team dedicated to serving the health and wellness needs of our many diverse communities throughout the state.

Since 1989, Guzman has worked in the insurance and financial services industry, successfully helping employers understand and solve some of their most challenging issues especially in the areas of health insurance, employee benefits and compliance.

He is a graduate of California State University, Long Beach with a B.S. in Business Administration-Finance. He also holds industry certifications with the Society for Human Resource Management, AHIP, Covered California, as well as his California Life, Accident and Health, and Property & Casualty insurance licenses.

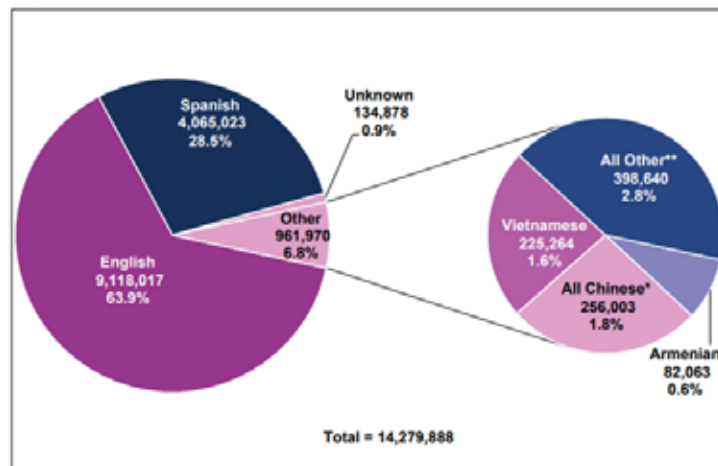
Guzman grew up and resides in Southern California actively volunteering and serving in many non-profit organizations including the Hemophilia Foundation of Southern California, Cedar House Life Change Center, the Diversity, Equity, and Inclusion Committees for the Los Angeles and National Association of Health Underwriters, and the Society for Human Resource Management.

Contact: Wayne.Guzman@blueshieldca.com



**Certified Eligible Statistics – Medi-Cal Population
December 2021 (Date Represented: September 2021)**

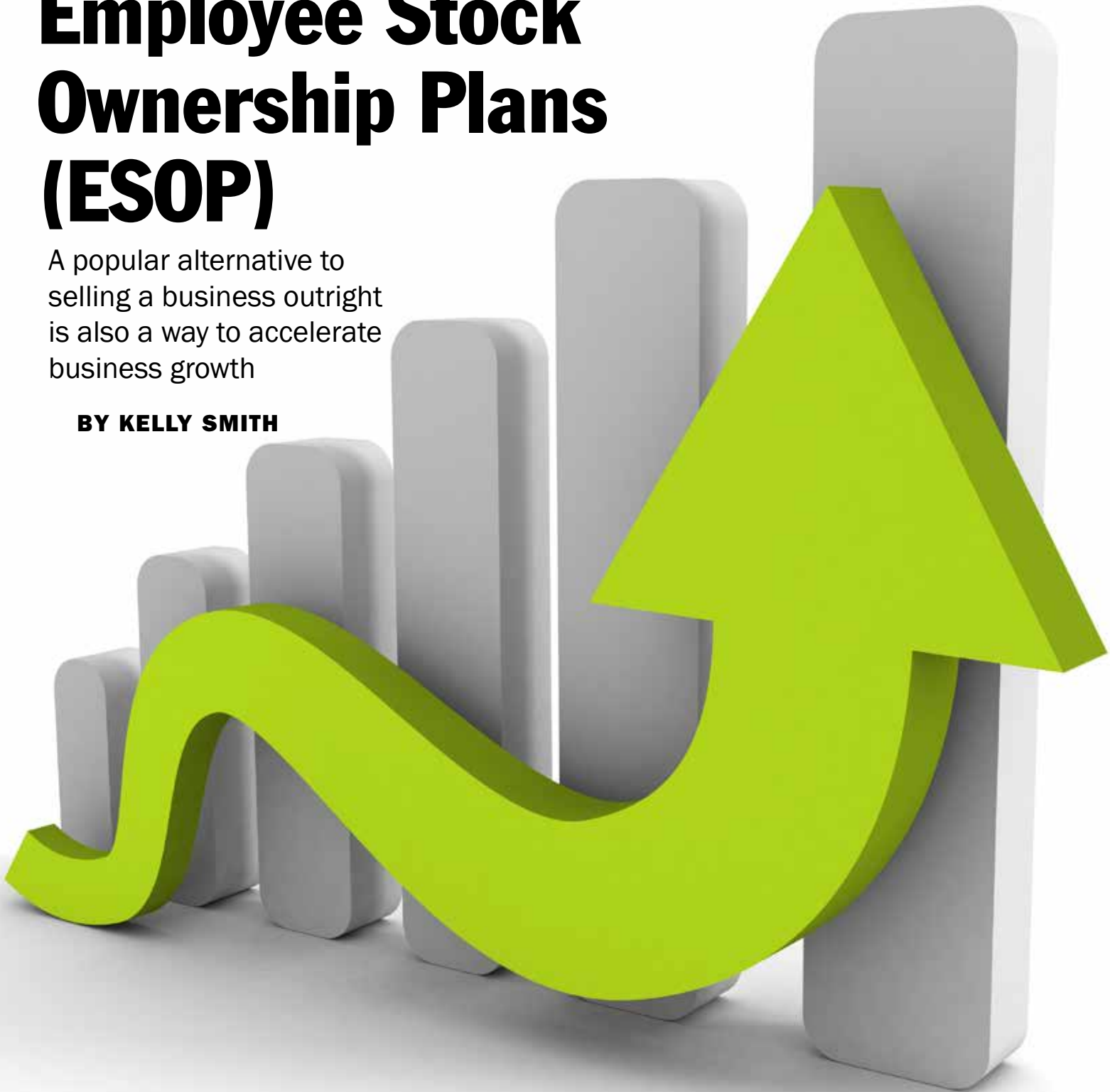
Figure 10: Distribution of Medi-Cal Certified Eligibles, by Primary Language – September 2021



New **ERA** of Employee Stock Ownership Plans (ESOP)

A popular alternative to selling a business outright is also a way to accelerate business growth

BY KELLY SMITH



Dear Reader,

To begin with, the article title only tells part of the story.

Most people who have any familiarity with Employee Stock Ownership Plans (ESOPs):

- a. don't understand what ESOPs actually offer
- b. don't elaborate on the current benefits to ALL of the employees, but will instead,
- c. espouse the usual scenario where a business owner wants to exit their business and pass it on to their own children.

In exploring that particular option, some discover that their plan to pass their business to their own children is no longer viable, since one now wants to be a famous blogger/influencer, and the other wants to quit business school and go off to "find themselves" while selling shaved ice on the beach in Waikiki or other some such adventure.

This scenario leaves the owner with the only viable option being to sell to an outside buyer. And if successful, be taxed heavily on the capital gain (such as, in California for example, incurring a tax as high as 38%). But as is often the case (over 80%), owners sell whatever depreciated assets are remaining, close the doors and walk away.

Enter what is becoming a favorite alternative: sell the company to the employees via the ESOP. This option avoids the closure of the business, doesn't trigger a capital gains tax, and provides a better chance for valued employees to keep their long-term jobs and be participants in the future profits and growth of the company.

The essence of this article is to add one more option. This option describes the fact that under the new environment for qualified plans and tax related issues, the ESOP now becomes one of the premier ways of accelerating the growth of the business — and to a higher, eventual value. Therefore, with the business owner's collaboration, at an earlier stage than the succession-exit, perhaps as early as their late 30s or 40s, with some proprietary designs, the ESOP is no longer limited to the tax-favored selling of a viable business. It has become one of the most effective ways to BUILD the business.

As well, we are helping to insulate many current companies from the "Silver Tsunami." This term was recently created to describe the increasing number of companies owned by baby boomers that will enter the seller's market over the next 10 years. Boomers have become a factor in the reduction of the ratio of buyers for those companies. The result is many viable businesses just close their doors and walk away.

HISTORY OF ESOPs

ESOPs are not just a current program. Historically, ESOPs have been around (in practice), for a few hundred years, going back to the days of the sharecroppers, working in concert with the landowner. In the post-Revolutionary era, some of our founding fathers — spearheaded by George Washington, Thomas Jefferson and Alexander Hamilton — enacted legislation for tax breaks to the remaining companies in the fishing industry, to assist them in their recovery of the damages caused by the Revolutionary War. But ONLY if ALL the employees were sharing in the profits and equity of those companies that were accepting the tax-savings aid.

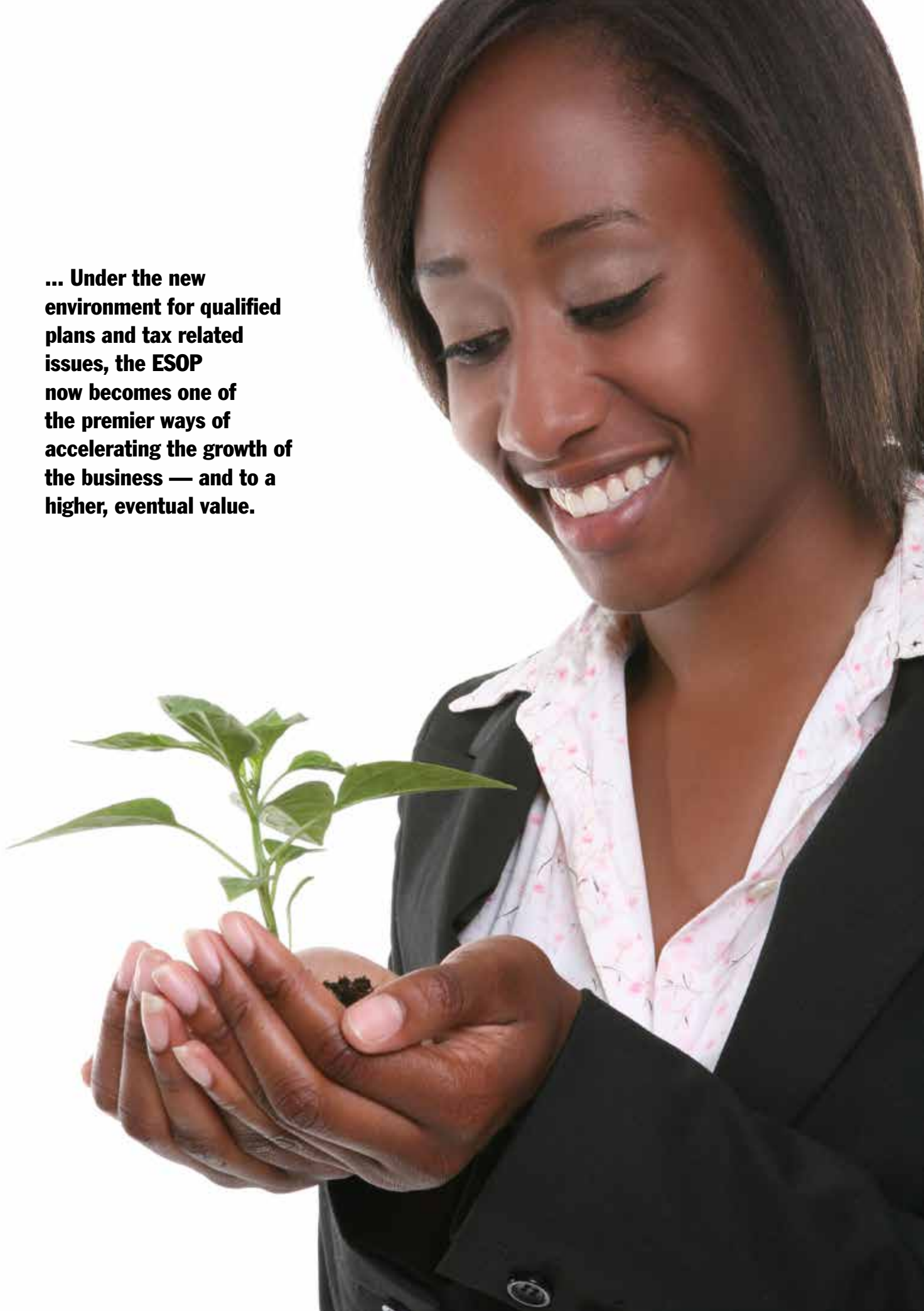
Later, in the 1800's, a few companies (such as Proctor and Gamble and Sears & Roebuck), did a similar arrangement by giving shares of stock to long-term employees for their retirement. This model was formalized in the Revenue Act of 1921 as a framework for Stock Bonus Plans.

In the 1950s, economist and lawyer Louis Kelso established many models that enabled employees to use the company assets to facilitate loans for the purpose of buying the company from the departing owners.

Several other financial and legislative actions encouraged the growth and spread of the ESOP. It became legitimized as part of ERISA, right alongside pensions, profit sharing, Keough, etc. Going forward, ESOPs kept their value to companies for many different uses (avoiding collapses, expansions, exits, etc.) with the selling-succession and exit model being the mainstay. This is how Kelso first designed the ESOP and the programs that followed stayed in that lane. Since that model is structured to allow the employees to attain a loan to buy the stock, the general terminology labeled those transactions "**leveraged ESOPs.**" This is how I was introduced to them, at a conference I attended

Enter what is becoming a favorite alternative: sell the company to the employees via the ESOP. This option avoids the closure of the business, doesn't trigger a capital gains tax, and provides a better chance for valued employees to keep their long-term jobs and be participants in the future profits and growth of the company.

... Under the new environment for qualified plans and tax related issues, the ESOP now becomes one of the premier ways of accelerating the growth of the business — and to a higher, eventual value.



during my first month in the life insurance business, where the main speaker was Louis Kelso. Of course, I was still memorizing my sales talk, and trying to stay alive, selling individual, personal policies to my friends, my family and Kappa Sigma fraternity brothers.

As I later worked my way into the business market, from ages 28-30, my market wasn't filled with 65-year-old business owners, selling or gifting their businesses. My business owner profiles were in their early to mid-40s. They were focused more on minimizing taxes, starting pensions and 401k(s) and thinking that they should be buying term insurance, since it was "cheaper" to have more profits to reinvest back into the business — or to support their lifestyle.

When discussing estate planning with an older alumnus of my fraternity, we discussed different forms of depreciation as a tool to redirect profits back into a real estate company. This could work, since the depreciation was a NON-cash deduction instead of actual expenditures such as improvements. This created more capital to accelerate acquisitions of more and more rental units, etc.

I examined that principle, and made the connection to that seminar on ESOPs. **Using the concept of transfer of non-cash, depreciation to an operating business, such as construction, restaurant, etc., I could advise a contribution of company stock into an ESOP instead of cold-hard-cash into a pension plan.** It would be the very same deduction, but my approach would be a "code" deduction (as with depreciation), as opposed to a "checkbook" deduction. This would allow the owner to retain their profits for growth by reallocating them to what I would later trademark as "TERC"[™] (Tax-Exempt-Retained-Capital[™]). This created what I would later trademark as "FIFI"[™] (Fully-Insured, Financial Infrastructure[™]). In the same process, this established the foundation that would later allow businesses to avoid the capital gains tax, via a 1042 exchange.

NEW ERA OF ESOPs

This brings us to the new era of ESOPs by employing the seldom-used format of contributing newly-issued shares of stock on a year-to-year basis. **With solid support by Congress and think tanks — both conservative-capitalistic and progressive-socialistic — ESOPs are now being implemented on a wider scale.** ESOPs are being employed as one of the only ways to solve the problems that exist for the majority of businesses in the United States today — moving profits to Main Street instead of Wall Street. One legislative program that reinforces that is "The Main Street Employee Ownership Act of 2019" along with many others now in process in Congress as well as in various state legislations.

Other good examples include the recently passed Secure Act and Cares Act. These benefit companies with ESOPs, or those that are contemplating an ESOP. In the past, an ESOP would have to be completed by Dec. 31 of the year in which participants contribute to the stock on a deductible basis. Now, participants can wait to complete in the next year — by the time (in the next year) that they file their taxes to affect the legal installation of that ESOP for the previous year. This is somewhat similar to being able to take a tax deduction for last year on an expense for this year — essentially a retroactive ESOP.

Let's look at a scenario that is now newly available. Say we have a company with a gross revenue of \$40 million and a net, taxable profit of \$1 million. It has a qualified payroll of \$8 million — allowing a tax-deductible contribution of stock into the ESOP for as much as \$2 million. This is more than the amount needed to eliminate the current \$1 million, thus allowing us to create a \$1 million net operating loss (NOL) which can be carried forward indefinitely.

In many of our more recent cases, we also examine the possible use of an 831b Captive Insurance Company. This will insure the property casualty risks of the operating business — cost segregation, enterprise zone, etc. and many others — to employ the highest use of deductions, to carry forward indefinitely with minimum amount of cash expenditures. For example, in the case we just described between only the ESOP and the 831b Captive Insurance Company, we can provide for a deduction of more than \$4 million of NOL. This impacts the amount of future taxes owed to the IRS and whichever state tax body, allowing the business owner to continually retain those profits. To maximize this TERC, we will possibly use premium financing on the life insurance, and even sometimes the 831b Captive Insurance Company to insure the property casualty risks of the operating business. All of this will enhance this newly created growing structure and vector all of the components to match the timeline-runway for the business owner's maximum exit amount. But the ESOP is the usual starting point, due to the new, increased congressional support and growing awareness and popularity.

There are multiple scenarios to add, including how we manage hypotheticals in multiple models and comparative studies, the viable options, with case studies.

That bears waiting for a future opportunity to "drill down" much deeper, whether in a workshop or a series of articles or seminars. **CB**



KELLY SMITH SR CLU ChFC, has worked in the insurance and financial services Industries for more than 40 years. He obtained undergraduate degrees in finance and marketing, with a secondary emphasis in accounting and economics.

Smith consistently qualified as a life member of the Million Dollar Round Table (MDRT) for all of his 42-years of membership, including his rookie year. He holds a 17-year membership of the Court of the Table and an 11-year member of the Top of the Table. As the youngest member of the MDRT Quarter Century Club, Kelly stays very active in MDRT through the MDRT Mentoring program as well as the MDRT Knights Foundation.



SUPPORTING THE EMOTIONAL WELL-BEING OF EMPLOYEES IS WORTH THE INVESTMENT

Increasing investment in emotional health improves retention and productivity

BY RICK PORTERFIELD

Companies large and small have focused on employee wellness for years. Today, according to recent research by Guardian Life, 79% of organizations say improving the health and wellness of their employees is *extremely or very important*. Many employees, however, have a need for mental healthcare that is largely unmet, and companies can play a vital role in helping them get the support they urgently seek.

Unless otherwise noted, readers should know that all data provided in this article is from Guardian Life's 10th Annual Guardian Workplace Benefits Study Mind, Body, and Wallet, 2021.

Each year, one in five adults in the U.S. are affected by a mental health condition; sadly, more than half of them receive no treatment, according to the National Alliance on Mental Illness. Additionally, there has been a decline in employee self-reported emotional health of 12% in the last five years, signaling a profound shift. What's more, as a percent of total disability claims, mental health-related claims have doubled in the past decade from 7% to 14%.

It's become clear that support for employee emotional health is no longer a "nice to have" benefit. It is becoming a must-have for employees' overall well-being. Just ask employees. We surveyed employees as part of our recent workplace benefits study and found that almost half of working Americans believe their employer isn't doing enough to address concerns about workforce mental health.

Supporting emotional well-being also should be important to companies themselves: Three of four employees we surveyed cited stress and burnout as their biggest mental health challenges. Such stress can impact company performance as well as employee retention.

COVID-19 has brought more challenges, negatively affecting 28% of employees' emotional health and work/life balance. The blurred lines between work and home life, with the pressure to be "on," even outside traditional working hours, contributes to workers' burnout.

Our survey also found that younger workers are faring worse than their older colleagues. While 53% of baby boomers and 41% of Gen X and millennials report their mental health is very good or excellent, roughly half (52%) of Gen Z workers report that they are *extremely or very concerned* about their mental health.

Men and women also have varying perceptions about their emotional health. Forty-eight percent of men report their mental health is *excellent or very good* compared to 37% of women. In the wake of the recent exodus of millions of women from the workforce, companies should take notice and look for ways to help caregivers — women *and* men — balance their responsibilities at home and work.

CURRENT CHALLENGES AND THE NEED TO OVERCOME THEM

Many employers offer an Employee Assistance Program (EAP). But, in general, EAPs were designed to react to short-term, critical issues, and utilization rates remain low, according to SAGE Journals. One study by Mental Health America found that less than 4% of employees utilize their organization's EAP.

Sadly, the stigma still associated with mental illness could be a reason why. We've come a long way in understanding the importance of mental health care, but 47% of people still believe going to therapy is a sign of weakness. And 30% of employers believe that there's still a stigma associated with EAPs.

Another reason for low utilization of EAP programs is **lack of communication**. A third of employees say they do not know enough about the EAP program available to them. More broadly, less than a third (28%) of employees strongly agree that their employer does a good job of educating them about available benefits and how to use them.

Clearly there are opportunities for improvement in engaging employees in benefit conversations. The open enrollment period for

employee benefits is the traditional time for such communications, but it is also when employees may be overwhelmed by the process.

Ongoing education should continue throughout the calendar year to ensure that employees take full advantage of their benefits. Empathetic and enlightening communications also can help remove the stigma around mental health care that, sadly, still exists.

REMOVAL OF BARRIERS TO CARE

Also critical to employee mental health is eliminating barriers to care. These barriers include the time it takes to get an appointment with a qualified therapist or counselor, which can be significant.

Cost is also often a barrier as well. No- or low-cost options, including telehealth appointments and research-backed exercises and tools, make care more accessible.

THE OPPORTUNITY FOR CHANGE

There has never been a better time for innovative approaches by employers. Our research affirmed that companies that have increased their investment in mental health benefits have seen improvements in both retention and productivity recovered per engaged employee per week. Moreover, according to the World Health Organization, "Mental Health in the Workplace" study, for every dollar invested in scaled up treatment for common mental disorders, there is a return of \$4 from improved health and productivity.

Importantly, supporting employee emotional health is an opportunity for companies to live up to their oft cited maxim that "people are their greatest asset." **By proactively supporting employee emotional well-being, employers can do more than talk the talk. They can tangibly demonstrate concern and support.**


The good news is that many companies are increasing their investment in the emotional health of their workforces. In 2021, employers put more monetary resources than ever to support mental health services.

Last year, the perceived value of mental and emotional health resources more than doubled to 35% from 2016, when only 15% of employers surveyed agreed that expanding the use of mental and emotional health resources (including EAPs) was extremely important.

THE WAY FORWARD

Looking ahead, companies can better support emotional wellness for employees by focusing on:

- Mental health resources beyond Employee Assistance Programs to remove barriers to care
- Tailored employee communications through diverse channels to ensure every cohort in the organization feels included, knows how to access care, and feels comfortable and secure when using the benefits
- Simplified processes, from enrollment to filing claims to renewals, that make it easy to access the benefits provided

Simply put, given the high incidence of mental health conditions affecting workers, it is time to recognize that status quo benefits and communication about them have not sufficiently met employees' needs. Employers have a crucial role to play in reversing the decline in employee self-reported emotional health, and the **time for action is now.** 



RICK PORTERFIELD is regional director, Northern California & Pacific Northwest, for The Guardian Life Insurance Company of America,[®] which is focused on inspiring well-being.

The Key to Striking a Healthy Work-Life Balance: Small changes = big results

BY ADDIE MURDOCK

Unlike many other careers, being a financial advisor is not a 9 to 5 job. And while we often have flexibility with our hours, it's no secret that the work we do can be all-consuming and overwhelming. So how do we strike a healthy balance between meeting client demands and excelling professionally, as well as devoting time to family and prioritizing self-care? The answer: **intentional time management**. Though there's no one-size-fits-all solution for time management, there are several small tactics you can implement into your daily life to help you achieve a sustainable work-life balance.

SMALL CHANGES CAN LEAD TO BIG RESULTS

Often, we feel we must make huge life changes to see results — but that isn't the case. **When looking to revise our current habits, it's important to make small, manageable ones that are realistic.** In fact, one of my recent Million Dollar Round Table (MDRT) book club reads, "Atomic Habits" by James Clear, helped me realize just that. The following are some of my best tips, learned from both other advisors and time management books, that have personally helped me accomplish a better work-life balance:

1. Create a to-do list for the next day. It's so easy to get pulled in a million different directions when you don't have a set list of priorities. I've gotten into the habit of creating a to-do list the night before, so I can come into work with a clear vision of what my day will look like.

2. Time block your calendar. Dedicating portions of your day to a specific task and physically blocking that time on your calendar can be a powerful time management tool. For example, I will block 20 minutes in the morning to only answer emails. For those 20 minutes, I eliminate any distractions and devote my undivided attention to clearing my inbox. Additionally, I often use "layered" time blocking, where I block time on my calendar for a task that I know I can pair with another task. For instance, I will often schedule a phone call with a client while I'm driving from one meeting to another to maximize my time. **Time blocking does not have to be reserved solely for work.** I like to time block for any family functions or personal appointments and color code them accordingly. By doing this, I can see how heavily I am leaning in one direction, either work or family, and reprioritize as needed.

3. Set device limitations. We are all guilty of scrolling through Instagram or checking Facebook when we have work to do, so setting limitations on your apps can provide much

needed structure to your day. Whether you want to set a time limit or restrict the hours you engage with an app, you can go into your phone's settings and set your personalized restrictions. As my mother always says, **"It's not either/or — it's AND."** Therefore, I don't believe in removing things that bring you joy, such as games or social media, but rather enjoying them appropriately and in moderation.

BEATING THE BURNOUT

Because of the nature of our work, it's all too common to face burnout. This is especially true during year-end, where most people are winding down and spending more time with family but is typically the busiest time for us. With the pressure of meeting quotas and impending deadlines, it can be difficult to maintain a healthy work-life balance. During this time, it's especially important to check-in with ourselves and recalibrate. When I do this, I can usually see clearly which aspect of my life is being neglected and refocus my energy. I like to ask myself the question: What can I do right now to be a better me? Whether that's carving out 15 minutes for a yoga practice or reprioritizing my tasks at work, it's so important to take the time to look inward — even during our busiest times.

Lastly, while the topic of work-life balance is often discussed as two separate entities, **I find I am happiest when all my identities are at play.** Letting your identities crossover, versus keeping them apart, is a great way to strike a balance between work and family. Whenever possible, I welcome my kids into my work and involve them with what I'm doing. I'm often surprised at how interested they are, and it makes me feel good that I can engage them with that area of my life. **It's important to remember that our clients trust us not just because of our credentials, but because of our authenticity.** I often remind myself of the Whole Person Concept, an initiative laid out by MDRT, that supports advisors in their quest to live a well-balanced life. By nurturing other areas outside of work, such as our relationships, health and spirituality, we can bring our best and whole selves to work. **CB**



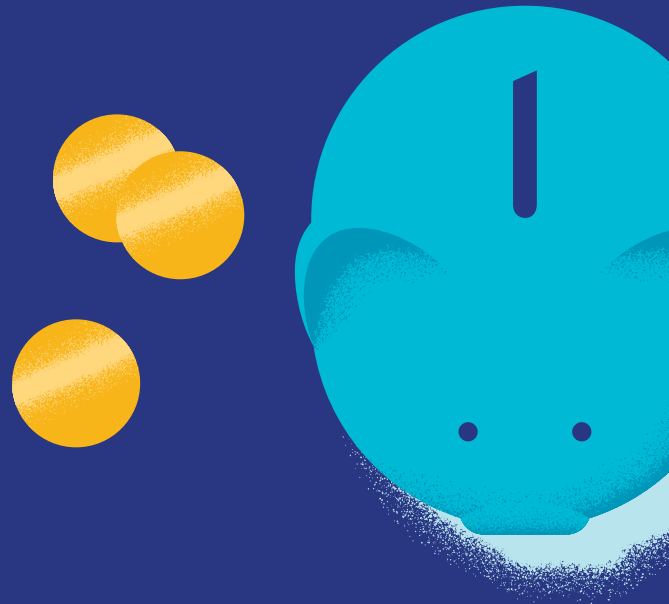
ADDIE MURDOCK is a nine-year, Top of the Table MDRT member and a principal with The Burgess Group (TBG). Her primary focus is international markets, primarily Latin America and Asia, and she has been with the firm since 2002. Murdock currently resides in San Diego, Calif., with her husband, two kids and dog, Muchacho.



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Board of Directors Meeting
6:30pm - 8:00pm
Vanguard Event

TUESDAY, MAY 10

8:00am - 10:00am
Registration, Breakfast, Vendor Time,
General Session
Justin Wallin
CAHIP Single Payer Poll Results <https://www.jwallin.com/>
11:00am - 11:30am
Member Town Hall
11:30am - 12:30pm
Lunch
12:30pm - 3:30pm
General Session: Review 2022
Legislative Talking Points
3:30pm - 4:30pm
House of Delegates
MEMBER ONLY and IN-PERSON ONLY
4:45pm - 5:00pm
Announcements

WEDNESDAY, MAY 11

8:00am - 12:15pm
General Session
Keynote speakers
NAHU Leadership Panel
Marshall Allen,
author of "Never Pay the First Bill"
and Christin Deacon, Health Care Leader
12:30pm - 5:00pm
Legislative Visits

THURSDAY, MAY 12

Legislative Visits



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