Orange County Association of Health Underwriters

Volume 12, Issue 2
Nov/Dec. 2017

C.O.I.N.

COUNTY OF ORANGE INSURANCE NEWS

OCAHU CE DAY 2017

More Coverage and Photos Inside This issue!

CALIFORNIA ATTORNEY GENERAL PROPOSES MEASURE TO ESTABLISH FUND FOR HEALTHCARE EXEMPT FROM REVENUE RESTRICTIONS.

This initiative seeks to amend the state Constitution in order to pass new taxes to fill the Healthy California Trust Fund; If this passes, it could take only a simple majority vote to impose the $400 billion in new or redirected state taxpayer funds to pay for universal single payer healthcare — without any limit or oversight.

See page 15 for more information!

URGENT SINGLE PAYER NEWS!!!

See page 15!

Inside this Edition:

OCAHU's The COIN is the Proud Recipient of the CAHU Newsletter Award for 2016-2017!

This Issue's Feature Article:

Reference Based Pricing…

The Key To Solving the Health Insurance Industry's Cost Issues?

By Dorothy Cociu, OCAHU VP Communications

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Thank you for being a part of OCAHU!

Editor's Note: Special thanks to Julianne Broyles, CAHU Legislative Advocate, for her assistance with getting us the timely information provided on page 15 (literally just before press time!). Thanks, Juli!

Mark Your Calendars!

OCAHU's Annual

Business Development Summit

Tuesday, February 22, 2017

Hilton Hotel, Costa Mesa

Industry Keynote Speakers

CE Workshops

Exhibit Hall

Networking….

Mark Your Calendars and Join Us For This Incredible Day!

National Association of Health Underwriters Gold Certified 2017

OCAHU Orange County Association of Health Underwriters

Making a Difference in People's Lives. One Member at a Time.

Our association is a local chapter of the National Association of Health Underwriters (NAHU). The role of OCAHU is to promote and encourage the association of professionals in the health insurance field for the purpose of educating, promoting effective legislation, sharing information and advocating fair business practices among our members, the industry and the general public.

Letter from OCAHU President, Juan Lopez

I want to thank MaryAnn Trutanich for her leadership in organizing our CE day in September. OCAHU offered 7 CE's in various subjects from Medicare, Legislative Updates, Cyber Security, Voluntary Benefits, Alternate Benefits Strategies and more. By now we are all in the middle of our forth quarter push, providing our clients with the best benefits that meet their needs and budgets. While at the same time your OCAHU Board is preparing for our Holiday Luncheon in December and have begun the planning and organizing our extraordinary February 2018 Business Development Summit. February is also NAHU's Washington D.C. Capital Conference where we will lobby Congress with our latest VOP, which we'll bring back to our chapter and share with our members. Please mark your calendar for Monday April 16, 2018 for our BIGGEST golf tournament ever, 100% of the proceeds will benefit "Cystic Fibrosis," which OCAHU has supported for 22 years.

As you can see we have a great year planned and we're looking for your input to make it even better. Please share your thoughts with anyone on the Board or call me any time on my cell 714-357-0600.

Finally, after the forth quarter we will begin our fight again against "Single Payer" as it will not be going away any time soon. We will need everyone to lean in and help us in Sacramento, provide PAC dollars and education your clients, friends and family.

Editor's Note: If you want to join a committee, or would like to share thoughts, please contact the appropriate board representative. See page 16 for the complete board list!

We know how busy you are in the 4th quarter! Keeping your time constraints in mind, please join us for this informative webinar in place of our on-site meeting in November.

Join host Marc McGinnis from Word & Brown for this special compliance webinar. 1 Hour of CE Credit provided.

Feature Article:

REFERENCE BASED PRICING…
THE KEY TO SOLVING THE HEALTH INSURANCE INDUSTRY'S COST ISSUES??

By: Dorothy Cociu, RHU, REBC, GBA, RPA
Vice President, Communications, OCAHU

The Problem

With our US Congress and Trump Administration still unable to solve issues on health care, and with California still facing the possibility of Single Payer ballot initiatives, it's time we started thinking of the root of the problem… The COST of health care. Everyone talks about the uninsured, the discontinuance of subsidies, but how about talking about the real problem? *We have the greatest health care system in the world!* We don't have to wait in line for important services, we can call and make an appointment and get in to see a doctor, or schedule an MRI or CT scan quickly… we don't have several months' wait for basic services. Medical miracles save millions of people a year and make people's lives better. *The problem is, the costs keep going up, and no one seems to care about doing anything to stop that.* Yes, insurance premiums keep rising, but why is that? Is it because the bad old insurance companies are the problem? *No, it's not!* The true cost of the problem, in my opinion, for whatever it's worth, is that the medical providers' costs keep going up, with facilities often marking up retail rates 300%, 500%, 600% or more... That's one heck of a mark-up….and no one is doing anything about it! *Facilities, particularly, can charge whatever they want, and it's all a mystery as to how that number for a particular service or stay is actually calculated*. And better yet, the exact same service at the exact same facility could be 5 different numbers, depending on who is paying for it! What's wrong with this picture?

What's wrong with this picture is that, as many of us in the industry have been saying for too many years to count, medical care is not transparent, and the prices charged are completely arbitrary. Does anyone *not* agree with that? Well, good, we have a common starting point… So why don't we take a look at that part of the puzzle, and try to come up with ways to make health care more cost effective and predictable? And by doing so, perhaps lower the cost significantly, so more people can afford it, and maybe then the subsidy problem wouldn't even be an issue, and the young, healthy population might actually want to sign up for coverage, making the pool larger, and bringing costs down further? But how do we do that?

There is a little known (in California, at least) solution that's been successful in other parts of the country, but for reasons sort of unknown, or just not talked about (more on that later), it's been slow to hit the west coast, particularly California. It's called Reference Based Pricing.

What is Reference Based Pricing?

Reference Based Pricing (RBP) is a health plan financing strategy leveraged by large, mostly self-funded employers that can result in significant reductions in claims cost, while providing freedom of choice of providers and complete transparency of the true costs of facilities/hospitals. Yes, I said it; you don't have to read it three times… ***Transparency…*** I'll talk more about that later. And I'll also talk about the idea of perhaps the fully insured market getting involved with reference based pricing… More to come on that as well.

A reference based pricing model replaces the traditional facility PPO contracts with a fully transparent and sustainable pricing mechanism, by using a percentage of Medicare Rates as the payment allowance benchmark. Compare this to the unknown "discount" of a PPO network, which is unpredictable and varies greatly by provider and service. PPO contracted rates are generally a hidden, arbitrary number. So, no transparency, no consistent starting (or base) price. As Ryan Day, President of HST in Irvine, a reference based pricing vendor, says, it uses a "bottom up, rather than a top down" pricing model.

Reference Based Pricing reimburses hospitals and other facilities based on a multiple of Medicare rates, which is known, fair and acceptable to most providers. Because the rates are generally higher than Medicare rates (most commonly 140% to 150% of Medicare), most facilities accept this pricing structure. According to Dave Fear Sr, Principal of Shepler & Fear in Sacramento, 90% of facilities now accept Medicare rates. So, a higher RBP model should logically be acceptable.

So how does this work exactly? Prior to services being rendered, a fair price is established based on the Medicare rates. Both the provider and the patient can be advised up front of their costs, because they are known in advance. That means that the patients (and the employer, in a self-insured health plan) have transparency of their health care costs, up front, making them predictable and known. *No more guessing games from providers.* Providers are advised up front of the RBP plan, and they agree to those payment amounts before the service is provided. As a successful type of trade-off to providers, plans usually offer a "fast pay" protocol, usually in 7 to 10 days, to incentivize providers to accept this payment model.

RBP vs PPO

RPB plans can have "open access" to all facilities, or a self-funded employer could lower out-of-pocket costs for select

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facilities known to accept RPB without issue, by plan design. So, no more PPO network for hospitals and facilities… As a comfort level to employers, RBP plans can still use a PPO provider network for physicians. This is quite common. Honestly, I can't see not using a PPO provider network for doctors (at least in the short run), because I can't see small providers understanding the RBP model; at least not yet. Some popular PPO networks, however, won't allow plans to purchase the doctor only network currently, so changes in physician networks may be required. There is talk, however, that more networks may be working on adjusting to this new model by offering stand-alone physician networks in the future.

But why would you want to get rid of the PPO contract? Many PPO contracts have shown consistent decreases in claim cost, there is no question there. Some of the largest PPO networks tout 40% to 65% off of the rates. But that's where the waters get murky…. *Forty to sixty-five percent off of what rate?* What is the base rate that the provider charges? That is a mystery to us all. And it changes based on whose PPO contract it is that the patient is covered under. A hospital doesn't tell us up front what the cost of the charges will be when someone calls in for insurance verification. Yes, the patient and the carrier or administrator can know what their co-pay is, or if there is coinsurance involved, but no one knows the cost until the bill arrives… and then we see this PPO write-off number, so we can see the tremendous "savings" to the self-funded health plan. But if five people with different health plans had the same service at the same hospital, I can pretty much guarantee that you would see 5 different facility charges (base rate), before the "discount" was subtracted. In some hospital PPO contracts, the "discount" is taken off of a contracted rate, some have per diem rates, or sometimes, it's taken off the billed rate, which, again, varies GREATLY depending on who is providing the health coverage.

Buyers Beware?

According to Ryan Day, President of HST, it's a "Buyers Beware" market. "Here we are; we've purchased something [and] we have no idea what the cost is.. We're just supposed to trust people that give us discounts… What they're off of NOBODY KNOWS, but hey, I negotiated with the hospital, I'm your carrier but don't worry… I negotiated a good deal but, by the way, you can't see it…" Does this sound at all like our current health care model?

Under the buyers beware market, according to Ryan, " You have no recourse, and we can't really tell you what the price is... and it's like *we don't buy anything else that way… We would never buy a car that way, we would never buy a mortgage that way, but when it comes to medical it's like, here I go!* I don't know how everybody got trained to just operate that way. And I think, data wasn't there before previously, and now data is there. In the sense that, WOW, I can know what Medicare's paying for that because Medicare releases all their information, and then I can see exactly what the cost is for that hospital too." Reference based pricing, according to Ryan, is a way to keep those costs in line, and make that buyer indeed, more aware.

Cost Examples

Let's take a look at a few examples. In the first example, provided by HST, a hospital charges $75,000 for a procedure and offers a 40% discount off of the billed rate, allowing $45,000, or a PPO contract rate of $45,000. This is traditional PPO discounting, or top-down pricing. In contrast, the **RBP plan pays 140% of Medicare**, or $22,250. This results in a savings of $22,750 (PPO cost of $45,000-RBP amount of $22,250) for this procedure. This is "bottom-up" pricing. That's real savings. No arbitrary starting point. We start at a known price.. the Medicare allowed price, and the plan offers payment at 140% of Medicare. Most providers already accept Medicare pricing, so this should be a relatively easy sell, since this is offering a fair price, and a higher price than they are currently getting for Medicare patients.

In another example, provided by Shepler & Fear, a General Agency that offers reference based pricing in some of their self-funded plan quotes, let's take a base rate of a service of $150. This is the rate reported to Medicare as the actual cost of the service. The provider's billed charge for that service is $900, or a 600% mark-up for that service. In this RBP example, the Medicare allowed charge for that service is $225, or a 50% mark-up (i.e. 150% of Medicare). The Medicare allowance is based at 125% of the cost (paid at $187.50). Comparatively, the PPO network allowance for that same charge is $420, or a 280% mark-up. *So if you're the self-funded employer footing the bill, would you rather pay the $225 or the $420?* If that's my company's money that's being spent, I would obviously rather pay the $225. So, yes, the PPO network price is less than the provider's billed charge, but it's still more than the RBP rate for that same service. That's the difference with reference based pricing.

Consumer Fear of Medicare Acceptance

There is a wide-spread consumer fear of providers not accepting Medicare rates and being turned down for care. I think a lot of this is confusion between the difference of Medicare payments and Medicaid (MediCal in California) payments. According to the American Hospital Association, hospitals received only 89 cents for every dollar spent by hospitals caring for Medicaid patients in 2008, and 91 cents for every dollar spent on Medicare patients in 2008.[1] This underpayment is then offset by charging much higher rates for other patients. According to that same report, 53% of hospitals received Medicare payments less than cost, while 56% of hospitals received Medicaid payments less than cost. There are arguments,

1). American Hospital Association Underpayment By Medicare and Medicaid, Fact Sheet, 2009

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Legislative Update

Rob Semrow, Vice President, Legislation

OCAHU Members and Friends...

I know it's a busy time for all of us in the industry as we work through another fast paced and always challenging 4th quarter filled with issues wide ranging and far-reaching. I thought I would share a quick state of where we are as of this writing and a few tidbits of what's to come.

We've watched as the federal government has not been able to resolve issues on ACA and instead of providing a clear path, most feel they've muddied the waters and continued to step on each other as they've done so. On the state side, we had a dramatic year, filled with the proposed threat of a single payer system that was expected to cost more than the state's current operating budget, without really fixing many of the current system's issues. And for those who are feeling that this issue is dead, or that it's so costly it couldn't happen, I say…'Balderdash'…Not only because I enjoy the term, but because I have watched and talked with the California legislators long enough to know that they are capable of anything….realistic or not. So, we will see Single Payer, in some form or other back in the headlines and presented to Californians in some manner in 2018.

As we work through the 4th quarter, there are some additional issues for us to be aware of. While the details of them are still coming out as of this writing, I will share the overview of these.

California has passed SB 17 and the bill has been signed that impacts prescription drug companies and consumers. For existing drugs, SB 17 requires advance notice be given to public purchasers like Medi-Cal and CalPERS, as well as private purchasers including health plans and insurers, for any prescription drug price hike over 16% in the prior two years. This will impact future increases by drug companies and potentially give consumers and those who serve them more power in negotiations.

AB 265 prohibits prescription drug manufacturers from offering discounts for brand-name drugs if a less-expensive equivalent brand is available, thus limiting higher priced drugs being given when unnecessary.

Others bills are being worked on and we will make sure that we get that information out as well.

Now on to the fun of the federal side, where there continues to be a lot of confusion, frustration, rumors and pushes to do something, *errrr* anything *t*hat can pass as doing something. While most of the details have yet to be released, the push to allow individuals to join "association health plans" or purchase plans across state lines is back and may have some legs. If you have attended one of the OCAHU meetings where we've discussed this, you know this is not an answer for most Californians. Our mandates and requirements are some of the strictest in the country. These proposed plans would save money by not having to offer some of the ACA requirements as well as many of the California state mandates. Another push revolves around expanding accessibility and lengths of time for short-term policies. Another concept that as currently proposed would *not* offer deep solutions.

Stay tuned as these and other developments are sure to add to the busiest season of the year for our industry and focus on the road in front of you now. Remind your clients that as a member of OCAHU you are connected to a group of dedicated industry professionals who are working with legislators to try to create responsible and responsive change that has a positive impact. Most of what is being bantered about has not been planned out and cannot or will not be implemented until we have completed this busy time.

Best of luck in these challenging times my friends!

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Live From NAHU and WarnerFest!


Did you know
THAT BETTER HEALTH CARE IS NOW AVAILABLE FOR LESS COST THAN YOU THINK?
St. Joseph Hoag Health has teamed up with leading health insurance carriers to offer innovative, cost-effective plans to businesses in Orange County. It's a way for everyone to get what they want — better care, better health, and all at a lower cost.
Contact us at (949) 381-4777 or visit our website StJosephHoagHealth.org/For-Brokers to sign up for ongoing updates.
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COIN COMPLIANCE CORNER

What Agents and Your Clients Need to Know!

November/December, 2017 Legal Briefing

From Marilyn Monahan, Monahan Law Offices

This is a summary of some recent developments of interest to consultants and employers:

ACA: Highlights

2017 IRS Forms 1094/1095 – Final Versions: Final versions of the 2017 Forms 1095-A, 1094-B, 1095-B, 1094-C, and 1095-C have been issued by the IRS, along with final instructions.

2017 IRS Forms 1094/1095 - Filing & Distribution Deadlines: The IRS has not (so far) announced extensions for filing and distributing the 2017 1094/1095 forms. The deadlines are:

Employer Obligation	Due Date
Furnishing 1095-Cs to Em-	**January 31, 2018**
Filing 1094-Cs and 1095-Cs	**February 28, 2018**
Filing 1094-Cs and 1095-Cs with the IRS (electronically)	**April 2, 2018**

Affordability: The IRS has announced that the affordability percentage for 2018 will be 9.56% (down from 9.69% for 2017).

Also, the federal poverty level (FPL) for 2017 in the 48 contiguous states and D.C. is $12,060 for an individual. When using the FPL affordability safe harbor, employers may use the poverty guidelines in effect within 6 months before the start of their plan year, so this number may be used by calendar year plans.

Transitional Reinsurance Program Fee: The transitional reinsurance program fee does not apply for the 2017 benefit year, but if you are paying the 2016 fee on your self-funded plan in installments, the second payment is due November 15, 2017.

PCORI Fee: The IRS recently announced that the PCORI fee for policy and plan years that end on or after October 1, 2017, and before October 1, 2018, is $2.39. (IRS Notice 2017-61.)

SBCs: The new templates for the Summary of Benefits and

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HIPAA Privacy & Security Updates—From Dorothy Cociu, COIN Editor and HIPAA Privacy & Security Consultant & Trainer

I promised in the last issue to report on the NIST/HHS/OCR Annual Privacy & Security Conference in Washington, DC, so that's what I'll focus on.

Each year, the National Institute for Standards & Technology co-hosts the HIPAA Privacy & Security Conference with the Department of Health & Human Services and the Office of Civil Rights. I have been an attendee most years, including this year.

Let me start with the current status of complaints and OCR cases. According to Iliana Peters of OCR, they have received over 158,293 complaints to date (through September, 2017). They have had 25,312 cases resolved with corrective action and/or technical assistance. OCR expects to receive 17,000 complaints in 2017 alone.

Breaches are always of interest to all of us. OCR reported between 2009 and September 30 2017, they have had approximately 2,017 reports involving 500 or more individuals, with 48% of large breaches involving theft and loss, 17% hacking/IT related, 26% involving laptops and other portable storage devices, and 21% paper records . Individuals affected are approximately 174,974,489. In addition, approximately 293,288 reports of breach were reported for less than 500 individuals.

In the areas of enforcement, it is important to note that there are two distinct areas of enforcement; the Audit Program (much of which OCR considers "free consulting by OCR," except for cases referred over to enforcement for compliance review or other investigations), which is often used to help to set protocols for future enforcement, and *actual enforcement areas,* including complaint investigations and compliance reviews.

Compliance reviews are often driven by breach reports, referrals from state attorney generals, FTC, DOJ, news reports of breaches or ransomware that were not reported, etc.

Both complaint investigations and compliance reviews can

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CE Day 2017 Photo Coverage

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however, to these numbers, as that report was created in 2009, and things have changed since then. *Even if this were the case, if RBP payments are based at an amount of 140% to 150% of Medicare rates, the hospitals are still making a profit on those services being provided.*

According to Dave Fear, Sr of Shepler & Fear, the Medicare system now pays Medicare providers in a more equitable manner (125% of the cost, or a 25% markup above cost).

Another consumer fear is that most hospitals don't accept Medicare patients, so perhaps they wouldn't accept my plan with reference based pricing, since it's based off of Medicare rates.

According to Medicare specialist Ryan Dorigan, Regional Sales Manager, AGA, " [Only] the VA (government-funded care for veterans) and Shriners (free orthopedic and burn care for children) are pretty much the only two [that do not accept Medicare]. Other military hospitals for active-duty soldiers probably don't either. A quick Google [search] also points to facilities run by Indian Health Services as nonparticipating hospitals. There are likely some other odd exceptions, *but the vast majority of hospitals in the US participate in Medicare Part A for inpatient services*. More clinics, physicians, and providers, such as the Mayo Clinic, do not participate in Part B, which covers physician fees and outpatient services." But for facility care, consumer fear of not being able to receive care at hospitals and facilities is no longer true.

According to Ryan, it's pretty simple to see if your local hospital accepts Medicare patients. You need only logon at Medicare.Gov and use the hospital locator to find hospitals anywhere in country that accepts Medicare.

Dave Fear Sr, from Shepler & Fear, stated that in many of the "sunbelt states," you will see hospitals advertising to seniors to use their hospitals. If the hospitals were losing money on Medicare payments, according to Dave, they certainly would not advertise to get more of them…

Another fear may be the facility provider over-billing in other areas if they are locked into a RBP payment model. If they are, for example, limited to 140% of Medicare, and receiving only $22,500 from the example above, we would want to be sure they are not adding additional charges for fraudulent services, or overcharging on complications that would generate new items to bill on. So perhaps the old fashioned hospital bill audit program would be something to consider if using a RBP model.

Implementation & Education

It's important to note, however, that education of the employees and HR department of the employer is key here. *What we need to prevent is the provider push-back, or their desire to try to balance bill the patient.* For this to work most effectively, covered employees and dependents should be given advance education of RBP. " I recently attended the SIIA conference in Phoenix where they put on several panels by employers who talked about their experiences with RBP," commented Dave Fear Sr. " The learning curve is somewhat steep because there are a lot of things that must happen for RBP to be successful. It's not just the money savings, but it is the way that people obtain their health care and interface with their providers. Thus employees and employers must invest some time to implement RBP carefully. Agents need to work with RBP vendors who can help develop employee education programs, communicate the issues and then provide follow up customer service to both employees and local health care providers so that all parties are on the same page. This is not an easy task nor is it inexpensive. Brokers need to work with TPA's who have RBP service staffs and with RBP administrators who have strong back room service – including a legal team that can work with providers who are resistant to non-balance billing provisions of RBP programs." But, if done properly, it can and has been successful.

In a small amount of cases, these employers need to know that provider push-back can occur. In those situations, anyone interested in in RBP model needs to know how to handle those situations. "You want employer groups, before they even make their decisions, to know all the ins-and-outs," said Ryan Day. " I'm not trying to sell you a bag of goods, saying like 'Hey everything's roses over here; don't worry about balance billing… its never going to happen.' That's not it. You're *going* to get balance billing. It's going to happen 2% of the time,[but] when it happens, here's what we're going to do." So, for most self-funded employers using RBP, it's 98% effective without balance billing, but you have to be prepared to handle that 2%. In HST's RBP product, they offer a patient advocacy team to handle those situations.

What are the Savings?

What types of savings are self-funded health plans that have implemented RBP seen? Most RBP vendors estimate about 20% overall claims savings (the highest cost of any self-funded health plan) when you use reference based pricing. In addition, there are premium savings of 8 to 20% on excess loss premiums, reductions on aggregate factors, and in some cases, savings on RBP administration fees vs. network access fees. So, overall, in a million dollar health plan, that can be substantial.

I asked Dave Fear Sr. what types of savings he's seeing in the RBP plans he's sold. "That really depends on the carriers and we are seeing changes constantly as those carriers learn about RBP and how it works. Currently we are seeing products with RBP programs come in 10% to 30% [overall] less than those with traditional PPO's. A lot depends on geographic areas (as is true with Medicare reimbursement payments too) and the underlying plan design. I'm not seeing huge discounts on the specific and aggregate premium rates yet, but am seeing aggregate attachment points lower when

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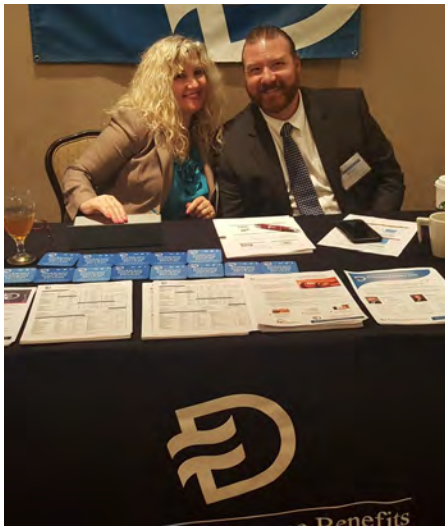
Event Photos— CE Day, 2017



The look of wonderment!

CAHU Health Care Retreat 2017

OCAHU Takes Home Multiple State Awards!

The California Association of Health Underwriters hosted its annual Health Care Summit on September 11-13, 2017 at Pala Resort. Several OCAHU members were in attendance.

OCAHU was the proud recipient of several state-wide awards, including:

- ***Outstanding Local Chapter Newsletter- Large Chapter (The COIN)***
- ***Outstanding Local Chapter Website -Large Chapter***
- ***Outstanding Chapter Membership Growth***
- ***CAHU Presidential Citation Award -Patricia Stiffler***

Congratulations to all of the Committee Chairs!

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RBP is used compared to a PPO plan. So far the claim savings I'm seeing are strong for facilities and not as strong for physicians. But then again, the facility costs have always been the higher cost of the two anyway."

MaryAnn Wessel, Vice President at EBA&M, a Costa Mesa-based TPA, reported that they are seeing approximately 9.6% off specific rates and 8.5% off aggregate factors for RBP plans.

US Benefits, an excess loss carrier in Irvine California, is quoting a range between 9 to 20% off specific rates and 8 to 13% off aggregate factors for RBP plans, depending on the percentage of Medicare being used. They report that it's "still relatively new but there has been quite a bit of interest in seeing this as an option in comparison to traditional PPO's."

In self-funded plans, the specific and aggregate premium are small portions of the total cost of the plan. Aggregate factors represent the worst case scenario for claims. It's the claims savings themselves that are the largest portion of the savings.

Why is California Lagging Behind?

So why haven't we seen this type of pricing model much in California to date? After all, California is often looked at as a pioneer in health care concepts. "I agree that California is a pioneer in new concepts, but unlike other states," commented Dave Fear Sr., "it is also dominated by powerful health care systems which are tough to regulate and control. These systems have great power in their ability to demand higher payments from payers (health plans, insurers, self-funded employers). Without naming names, I think that some health care systems border on anti-trust activities with their domination of the health care marketplace."

I asked Dave Fear Sr. if he could offer a few simple recommendations to those considering RBP. "Find a good broker/consultant to work with and then work with a TPA who has relationships with RBP vendors who can provide proof of savings through detailed claim reports. Some brokers will ID RBP vendors first, then the TPA second and that is ok too. But many TPA's have developed good relationships with RBP vendors so you can work through

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COIN Compliance Corner Legal Brief *, Continued from page 9*

Coverage (SBC) must be used as of the first day of the first plan year on or after April 1, 2017. If you have a calendar year plan, the new templates should be in use during the upcoming open enrollment season.

Age Rating Bands: New age rating bands for children between the ages of 0 and 20 will take effect for plan or policy years beginning on or after January 1, 2018 (so they will impact calendar year plans). The new age rating band rules apply to individual and small group plans.

HIT: Section 9010 of the ACA imposes a fee on health insurers and HMOs (known as the Health Insurance Provider Fee, Health Insurer Tax, or HIT). A moratorium was placed on the fee for 2017, but the moratorium does not apply for 2018. Since the fee will increase costs for insurers/HMOs, it will most likely also result in increased premiums on fully insured plans and HMO coverage.

Contraceptive Mandate: Existing ACA rules on the contraceptive mandate allowed exemptions and accommodations for certain religious objectors. On October 6th, two sets of interim final rules were issued, and both were effective that same day.

The first set of rules broadens the exemptions currently allowed for entities that object to providing contraceptive coverage based on sincerely held *religious beliefs*. As expanded, these exemptions could apply to a church, an integrated auxiliary of a church, a convention or association of churches, or a religious order; a non-profit business; a for-profit business (either closely held or not closely held); any other non-governmental employer; or a private institution of higher education that offers a student health plan. In addition, a process has been created by which a willing employer and insurer may allow an objecting individual employee to obtain health coverage without contraceptive coverage.

The second set of rules creates new exemptions for certain entities and individuals that object to coverage of some or all contraceptives based on sincerely held *moral convictions*, but not religious beliefs. The exemptions could apply to non-profits, for-profit businesses (if not publicly traded), and private institutions of higher learning that offer student health plans. In addition, a process has been created by which a willing employer and insurer may allow an objecting individual employee to obtain health coverage without contraceptive coverage.**Municipalities: Highlights**

San Francisco Health Care Security Ordinance (HCSO): The 2018 health care expenditure rates have been announced—they take effect January 1, 2018, for all employees covered by the HCSO:

- $2.83/hour for large businesses (a business with 100 or more employees worldwide)
- $1.89/hour for medium-sized businesses (a for-profit business with 20-99 employees worldwide and a non-profit with 50-99 employees worldwide)

In addition, revised HCSO rules were recently published and take effect on October 29, 2017.

San Francisco Paid Parental Leave Ordinance (PPLO): Compliance will extend to **employers with 20 or more employees beginning on January 1, 2018.**

San Francisco's Lactation in the Workplace Ordinance: This ordinance goes into effect January 1, 2018.

Santa Monica's Minimum Wage Ordinance: Santa Monica's Minimum Wage Ordinance also includes a mandatory sick leave provision, and it is changing effective January 1, 2018. As of January 1, 2018, workers can earn up to 40 hours (small businesses) and 72 hours (larger business) of sick leave.

Berkeley's Minimum Wage Ordinance: On October 1, 2017, the minimum wage increases to $13.75/hour.

El Cerrito's Minimum Wage Standards Ordinance: As of January 1, 2018, the minimum wage increases to $13.60/hour.

Mountain View's Minimum Wage Ordinance: As of January 1, 2018, the minimum wage increases to $15.00/hour.

Palo Alto's Minimum Wage Ordinance: As of January 1, 2018, the minimum wage increases to $13.50/hour.

Richmond's Minimum Wage Ordinance: As of January 1, 2018, the minimum wage increases to $13.00/hour.

San Jose's Minimum Wage Ordinance: As of January 1, 2018, the minimum wage increases to $13.50/hour.

Santa Clara's Minimum Wage Ordinance: As of January 1, 2018, the minimum wage increases to $13.00/hour.

Sunnyvale's Minimum Wage Ordinance: As of January 1, 2018, the minimum wage increases to $15.00/hour.

This is not intended to be a comprehensive list of all municipal ordinances impacting the workplace. In addition, employers should be advised to check the websites of the cities in which

Legal Brief Continued on Page 20

Membership News

New Members and Renewals!

WELCOME NEW MEMBERS!!!!

OCAHU is proud to announce it's list of new members since September 1st!

Emanuel Alvarez
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Gale Gajardo
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Please Renew Your Membership Today!!!

URGENT NOTICE: CALIFORNIA ATTORNEY GENERAL PROPOSED MEASURE TO ESTABLISH FUND FOR HEALTHCARE EXEMPT FROM REVENUE RESTRICTIONS

California Healthcare Roadblock Removal Act-

Given Green Light for Signature Gathering for Single Payer Health

The California Attorney General Xavier Becerra (D) has issued the formal Title and Summary to Proposed Initiative 17-0019 on October 24, 2017. The sponsors of the initiative had originally titled it the California Healthcare Roadblock Removal Act. However, the title is officially now 'Establishes a Fund for Healthcare in California Exempt from Revenue Restrictions.'

This initiative seeks to amend the state Constitution in order to pass new taxes to fill the Healthy California Trust Fund (as established by the initiative). If this passes, for example, it would only take a simple majority vote to impose the $400 billion in new or redirected state taxpayer funds to pay for universal single payer healthcare — without any limit or oversight.

Next, the proponents must collect 585,407 valid signatures and turn them in by May 11, 2018.

For Agents, this means the biggest barrier (money) to a universal single payer system will be on the November 2018 ballot. Local chapters leaders should look for new materials and information from CAHU about the initiative to share with agents and their clients. Additionally, local PACs should prepare to move into high gear on raising the necessary dollars to educate consumers, clients, employers and organizations about the havoc and fiscal damage if this initiative poses for all Californians.

ESTABLISHES A FUND FOR HEALTHCARE IN CALIFORNIA EXEMPT FROM REVENUE RESTRICTIONS. INITIATIVE CONSTITUTIONAL AMENDMENT. Creates trust fund within the state treasury solely for funding healthcare and healthcare-related expenses to encourage Legislature to enact healthcare policy and funding mechanisms. Allows Legislature to raise any taxes dedicated to the fund by majority vote and to deposit state and federal monies into the fund. Exempts fund's revenues from constitutionally required: annual state spending limit, minimum-funding guarantee for schools, and state budget reserve deposits. Permits Legislature to establish rules reserving or delaying disbursement of monies deposited in fund, subject to annual cap. Summary of estimate by Legislative Analyst and Director of Finance of fiscal impact on state and local government: **No direct fiscal impact on state and local governments. Any future impact would be dependent on actions by the Legislature and Governor. The measure makes it easier to increase state tax revenues dedicated to healthcare spending. It could also have a variety of impacts on the state budget—including on the state's spending limit, and spending on healthcare, education, debts, and reserves.** (17-0019.)

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New Age Rating Bands Effective January 1, 2018 For Individual and Small Group Plans

By: Dorothy Cociu, RHU, REBC, GBA, RPA, OCAHU VP Communications

In Marilyn Monahan's Legal Briefs this issue, she briefly mentioned the new age rating bands effective in 2018. I wanted to expand on this as I think it is important that agents properly inform their employer clients.

Background

The Affordable Care Act (ACA) established "fair health insurance premium" rating rules for individual and small group health plans. Under the ACA rules, premium rates for adults could not exceed a 3 to 1 ratio. This means that an insurer cannot charge a 64-year-old more than 3 times what it charges a 21-year-old.

The rules also state that, when setting rates within the 3 to 1 ratio, insurers may use one-year-age bands for individuals age 21 through 63. Thus, for each year of age, the insurer may charge more. The individual's age as of the date a policy is issued or renewed is used to determine which age band applies. As a result of a one-year age band rule, an employee who, for example is 56 may pay more than an employee who is 55. For individuals age 64 or older, however, only a single age band may be used; therefore, all individuals age 64 or older are charged the same amount. These rules are not changing.

For children, who are defined, for purposes of the rule, as individuals from 0 to 20 years of age, insurers have been required to use a single age band. So, whether a child is 2 or 20, the insurer under the existing ACA rules would charge the same premium amount. *The new regulations will change this, impacting how insurers can calculate premiums for dependent children age 20 and younger.*

For individual or small group health plans, the new regulations take effect on or after January 1, 2018, and could impact the amount of premium insurers can charge for covered children under the age of 21. This could impact the administration of health plans and open enrollment preparation/planning. So, be sure your clients are aware of these changes.

In California, small group employers are employers with 1 to 100 employees. Aggregated (control) group rules do apply.

The new rule applies to both individual and small group health plans, whether they are offered through Covered California or outside of the exchange. ***The new rule, however, does NOT apply to grandfathered plans.*** Whether the new rule applies to grandmothered (transitional) plans will depend on state law. In Califor-

Continued on page 21

HIPAA Privacy & Security Updates, continued from page 9

result in civil monetary penalties or settlements. OCR's Iliana Peters informed attendees that they would rather enter into settlements, which are a smaller percentage of what the could have received in civil monetary penalties, allowing them to set up corrective actions plans to be sure they problem is resolved. Less than 1% of all cases result in civil monetary penalties.

To update us on the latest auditing program, OCR's Linda Sanches reported that desk audits for covered entities have now been completed for the 2016 audit program. *They are now focusing all desk audit efforts on Business Associates.* On-site audits will begin once they complete the desk auditing of business associates.

To date in this round of auditing, they have completed 166 covered entity audits (privacy and breach 103, security 63), and 41 business associates audits, all of which were in the categories of breach and security.

The desk audits performed in 2016-2017 were 90% provider, 8.7% health plan, and 1% health care clearinghouse.

Entities that failed to respond to the desk audits have remained in the audit pool and may be subject to compliance reviews.

A "highlight" of the conference, in the opening session, new OCR Director Roger Severino, made the news by stating that is highest priority is the "big, juicy, egrigious case" in 2017. Clearly, he wants to make news in the big one, and use it as an example to other covered entities.

"I have to balance that law enforcement instinct with the educational component that we do." Severino stated. "I really want to make sure people come into compliance without us having to enforce. I want to underscore that."

But clearly, he wants the big one, and soon. Already this year, OCR has entered into eight settlements with covered entities to resolve HIPAA violations discovered during investigations of complaints and data breaches and has issued one civil monetary penalty. 2017 HIPAA Enforcement Actions included (previously reported in the COIN) Memorial Healthcare System – $5.5 million; Children's Medical Center of Dallas- $3.2 million (Civil monetary penalty); Cardionet – $2.5 million; Memorial

Continued on page 20

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Legal Update, continued from page 14

they do business to find out about the latest news affecting employers, notice and posting requirements, and related issues.
##

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OCAHU is Proud To Announce our March, 2018 Program:

March 13, 2018

Legal Update With COIN Regular Legal Updates Contributor,

Marilyn Monahan, Esq.

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HIPAA Privacy & Security Updates, continued from page 14

Hermann Health System (MHHS) – $2.4 million; MAPFRE Life Insurance Company of Puerto Rico – $2.2 million; Presense Health – $475,000; Metro Community Provider Network — $400,000; Luke's-Roosevelt Hospital Center Inc. – $387,000; The Center for Children's Digestive Health – $31,000.

The largest HIPAA settlement of 2017, also as previously reported in the COIN, was Memorial Healthcare System, which is a health system consisting of 6 hospitals and various other facilities in South Florida. The settlement of $5.5 million resolved potential violations of HIPAA Rules relating to the impermissible accessing of ePHI by employees and the impermissible disclosure of PHI to affiliated physician office staff. The settlement underscored the importance of audit controls and the need to carefully control who has access to the ePHI.

I look forward to the next issue's updates!

##

New Age Rate Bands, continued from page 17

nia, *grandmothered plans have not been reauthorized*.

The New Rule: Multiple Age Rating Bands for Children

As a result of the CMS regulations issued in December, 2016, one age band for all children from 0 to 20 years of age will no longer be used. **Instead, under the new rule, insurers may use:**

- **A single age band for individuals age 0 through 14**
- **One-year age bands for individuals age 15 through 20**

Please keep this in mind when preparing for your upcoming renewals for 2018. *All children between birth and age 14 will be given the same premium amount, but once a child reaches age 15, the insurer could charge more for that child each year from that point forward. This means that dependent contributions will be more tedious to administer from the human resources perspective.*

Under the regulations, when determining the premium for family coverage, under a per-member rating system, the total premium is determined by adding the premium cost for each family member. With respect to family members under the age of 21, "*the premiums for no more than the three oldest covered children must be taken into account in determining the total family premium.*"

Application for Young Employees Under Age 21

While this rule is most likely to be felt by employees who pay for dependent coverage, ***the age bands also apply to all individuals who are age 20 or younger, whether they are covered as employees or dependents. So if an employer has employees under the age of 21, they will be subject to this rule.***

Effective Date

The effective date of this change is all plan or policy years on or after January 1, 2018, so for group plans, your renewal dates on or after January 1, 2018.

##

NEW RATE BANDS…

- ***SINGLE AGE BAND AGES 0-14***
- ***ONE YEAR AGE BANDS AGE 15 THROUGH 20***

Feature Article, Continued from page 13

them too."

Should We Be Looking at RBP in Fully Insured and Other Scenarios?

Personally, I believe we should be looking at reference based pricing throughout the marketplace. We are facing the high likelihood of a strong pro-single payer campaign in 2018, when single payer will be on the ballot. Why not stop the in-fighting in Washington and the states and instead look at ways to actually lower the cost of health plan coverage? If RBP is a viable option, which is certainly looks like it is, then we should encourage our fully insured health insurance carriers to embrace this model, rather than fight it. ***I would like to challenge the health insurance carriers in California to start offering at least one plan in their product portfolios that use reference based pricing. Let the carriers get good cost-savings data on those plans. Use that data to offer long-term reductions in the cost of those health plans. By doing that, we could all win.*** If people could afford these plans, as an alternative, more individuals and employers would likely choose to purchase coverage, lowering the number of uninsured, and perhaps even get the young, healthy ones to want to buy coverage, because suddenly, it would be affordable to them…even without a subsidy. And maybe, just maybe, we'd have the kind of ammunition we need to show the people of California, as well as throughout the nation, that single payer won't bring down health costs, and that the market itself is offering ways to solve this problem on its own.

Are Politicians in California Now Clinging to the Medicare Concept to Push Single Payer Through?

Another thing to consider is that California's politicians are now starting to grab onto the Medicare model as a way to bring Single Payer to the voters in a ballot measure, and write legislation to pay all providers at the Medicare rates. There is talk that by doing that, they could possibly get people on board with Single Payer. But is that realistic? Is it fiscally responsible?

According to Senior Care expert Harry Thal, "The payment for Medicare is lower than commercial plans which negates the rational of using Medicare rates for a single payer system. The commercial rates hospitals are paid offset the lower Medicare (and still lower Medi-Cal) reimbursements. If single payer were to be adopted using Medicare rates, the hospitals would all close down."

So what are the possibilities? Can the Medicare model help Single Payer? "I think it's important to note that with Medicare and the volume of patients, most hospitals will continue to accept Medicare payment rates but they do have a choice," commented Ryan Dorigan. "Medicare beneficiaries can still enroll on to private managed care plans and the hospitals are free to work out their own contracting arrangements with each private plan. This blend of the government setting rates but allowing a private market place to improve those rates and provide more comprehensive coverage is the way that true Medicare works every day. I think the closer we get to crafting a bill which combines the Federal government setting prices and creating transparency but still allowing a free market to reduce costs and waste in the system then the closer we will be to a true solution. True Medicare is not a single payer mandate which would prohibit any type of a private plan option and that is why I think an extension of Medicare as it exists today is the best option that we have right now."

Is Reference Based Pricing the Solution; The Middle Ground?

I think we're all in agreement that something has to be done to control costs, and something should also be done to help fight the Single Payer threat in California. Is Reference Based Pricing the solution? Is it the middle-of-the road pricing model that could bring down costs and help to solve the health care crisis? Is this something CAHU should consider supporting, and perhaps suggesting in future state legislation?

It may not be 100% the answer, but I believe looking further into reference based pricing is a good start. **I encourage the carriers to give this some thought and perhaps work with the industry to see RBP as a possible way to bring down costs, and not see it strictly as competition.** ***Then maybe we all can win.*** ##

Editor's Note: The opinions in this article are those of the author and those of the contributing experts. They are not necessarily the opinions of the Orange County Association of Health Underwriters, the California Association of Health Underwriters, or the National Association of Health Underwriters.

MARK YOUR CALENDARS FOR OCAHU'S

January Meeting - January 9, 2018

The Rules of HSAs, FSAs, and HRAs Today

Kristin Khale, 1 Hour of CE, Carlton Hotel (formerly the Radisson Hotel), Newport Beach, CA, 11 am to 1 pm

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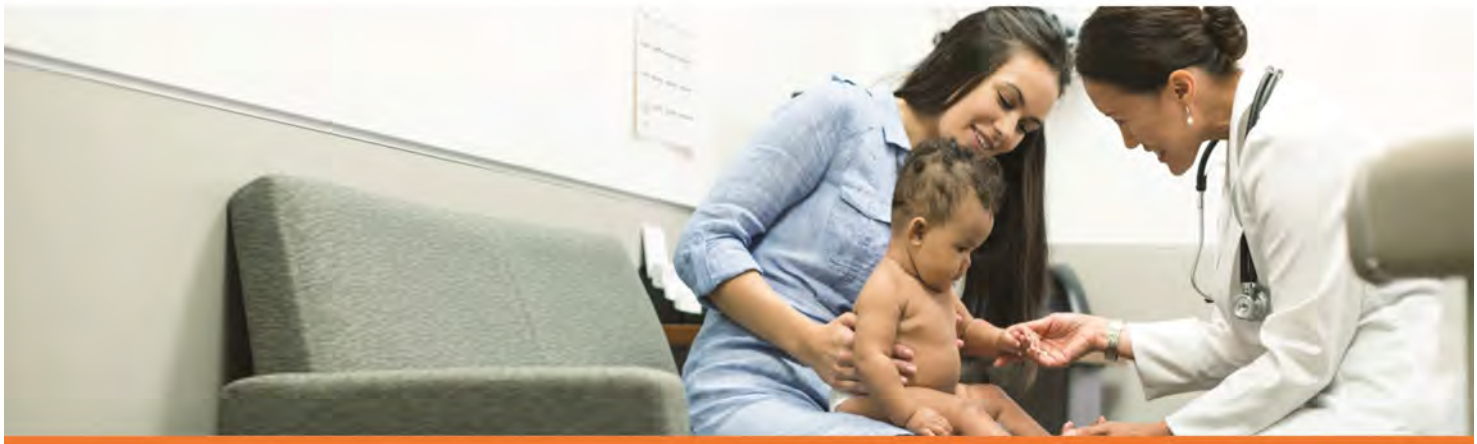

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SCHEDULE OF EVENTS

November 14th, 2017, Marc McGinnis, Word & Brown, Webinar: 10-11 am, 1 CE Unit, Avoiding Compliance Pitfalls (see page 4 ad)

December 12th, 2017: Holiday Luncheon and Program, 11 am to 1 pm, JT Schmid's Anaheim, Benefiting CHOC! (see ad page 21)

January 9, 2018: The Rules of HSAs, FSAs, and HRAs Today; Kristin Khale, 1 Hour of CE, Carlton Hotel (formerly the Radisson Hotel), Newport Beach, 11 am to 1 pm

February 22, 2018, Business Development Summit, Hilton Costa Mesa—mark your calendars!

March 13, 2018; Legal Update, Marilyn Monahan, Esq., Leave Laws & Benefits (Consumer Education Program—bring your clients!), Carlton Hotel (formerly the Radisson Hotel), Newport Beach, 11 am—1 pm