PROTECTING THE CONSUMER'S FUTURE
ORANGE COUNTY CAHIP
California Agents & Health Insurance Professionals
CALIFORNIA'S BENEFIT SPECIALISTS

C. O. I. N.

COUNTY OF ORANGE INSURANCE NEWS

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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 CAHIP-OC 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.

Would you like to be more involved in our industry?
Contact a board member today!

See page 14 for a list of members.

PRESIDENT'S MESSAGE

By: Patricia Stiffler, LPRT

Hello CAHIP OC! Hopefully this much needed rain will result in a beautiful spring.

Thank you to all who attended our Sale Symposium in February. We received some great feedback, especially regarding the amazing breakout sessions and keynote speakers. I especially want to thank all our sponsors and exhibitors for their support of our event.

Some of us recently returned from the Capitol Conference where we shared our concerns and thoughts. The legislators we all met were extremely receptive and on board with our issues. We look forward to meeting our California representatives in May.

Our next big event is the annual Take A Swing Fore the Cure Golf Tournament. It is being held at the beautiful Aliso Viejo Country Club on Monday, April 10. We still have some sponsorship opportunities available, and still have room for golfers. If you're not a golfer, feel free to register for the dinner and enjoy an evening of fun!

In May we will be presenting the Agents and Brokers Anti-Fraud Training in conjunction with the CA Department of Insurance. It will be a great way to get the mandatory course along with your fellow Chapter members. We will also present the Annual CA-HIP OC Awards.

Hope to see you all at our upcoming events!

##

CONGRATULATIONS TO CAHIP-OC MEMBERS!

Juan Lopez was presented with the Pinnacle Award at CA-HIP-OC's Sales Symposium this year. The award honors the CAHIP-OC leader whose involvement, leadership, vision, dedication and spirit have significantly contributed to the growth and success of the insurance industry. ##

The Jesse Patton Spirit of HUPAC Award was presented to member Cathy Daugherty at NABIP's Annual Capitol Conference in Washington DC, February 26-March 1st. This award has only been awarded six times in the history of NABIP! What an honor! CONGRATS CATHY! ##

Feature Article:

NABIP's Federal Priorities with Legislators in Washington D.C.

By: Paul Roberts - Director of Education and Market Development, Word & Brown General Agency

Each year the National Association of Benefits and Insurance Professionals (NABIP, formerly known as NAHU) meets in Washington D.C. for its Capitol Conference.

NABIP, which represents more than 100,000 health insurance professionals, encourages its members across the country to participate in the four-day event, which focuses on education, legislative direction, and engagement on all-things-health care with federal legislators.

Word & Brown proudly presented a highly attended educational session at the event on February 27, 2023. The sold-out session covered trending compliance items in 2023, as NABIP members prepared for visits with legislators and learned about industry changes ahead of the end to the COVID-19 U.S. National Emergency and the HHS Public Health Emergency (both scheduled for May 11, 2023).

The NABIP Cap Con (as the event is known) calls for members from across the nation to descend on Capitol Hill to meet with federal legislators, discussing ways to improve the health care experience, and to seek support for the federal priorities of the industry and NABIP.

The unified message is welcomed and heard loudly throughout D.C. Several decades (nearly a century!) of annual NABIP discussions have shaped the industry for the better – generating strong consumer protections and better operation of the benefits and insurance industries. NABIP's mission is to shape the future of health care.

The 118th Congress has been in session since January 2023; it runs until January 2025 and covers the final two years of President Bident's current term. Because the session just began, NABIP did not discuss any particular federal bills by name or by number. Instead, members and industry professionals spawned general discussions about the current direction of the industry, its problems, and the ways it can be improved by federal support and forthcoming legislation.

Following are a sample of NABIP's federal priorities, which were shared in Washington D.C. with legislators on Capitol Hill.

ADDRESSING THE COST OF CARE

NABIP encourages Congress to create and support legislation to ensure that the cost of a health care service does not vary based on the location where the care is delivered. Currently, the cost of the same X-Ray, MRI, physician's visit, etc., can differ drastically depending on where it is delivered (e.g., free-standing facility vs. hospital or outpatient hospital setting). NABIP supports site-neutral rules to deter location-based gaming of coverage to better balance the industry and to combat troublesome consumer "surprise billing."

PRESERVING AND STRENGTHENING EMPLOYER-SPONSORED HEALTH COVERAGE

NABIP has held a fervent, longstanding position opposed to modifying, or placing a cap upon, the IRS individual tax exclusion for job-based coverage.

Current federal tax provisions allow employees to deduct the funds their employers spend on their health benefits (e.g., the employer's benefit contributions) from their incomes. Current law also allows employees to fund personal contributions for the cost of coverage (employee contributions) with pre-tax dollars, under an employer's Premium Only Plan (POP). Current law also allows employers to deduct the cost of health coverage as a business expense.

Recent 2023 reports from the Congressional Budget Office (CBO) state that eliminating or modifying these current rules could garner about $600 billion in additional federal revenue – an option that is attractive to federal legislators on each side of the aisle, as they work to hit budget targets.

Moves to place a cap upon, or eliminate, the employer tax exclusion would create significant barriers for employers when offering benefits. Without tax incentives for employers to provide benefits, and with employees paying significant taxes on their health benefits, the cost of employee benefits would become overwhelming. Employers may no longer be able to provide benefits to attract and retain employees, and employees may be less likely to participate in their job-based health plans with such tax changes. Since about 188 million Americans are currently covered by a group health plan, many would lose access to affordable coverage – without any affordability guarantees in other markets (e.g., Individual market, etc.).

Also expanding upon the employer market, NABIP supports **the Commonsense Reporting Act**. This would give Applicable Large Employers (ALEs, those subject to the ACA's employer mandate) the option of reporting their offers of job-based coverage to the IRS prospectively, before annual Fall individual-plan Open Enrollment – rather than after the conclusion of a calendar year, which is the only current op-

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Legislative Updates:

California Democrat Introduces Single-Payer, Universal Healthcare Initiative

By: David Benson - CAHIP-OC VP Legislation

A new bill introduced by San Francisco Democrat Scott Wiener would institute a single-payer healthcare system for all Californians – albeit not as quickly as previous universal-healthcare proposals that we have seen in the Golden State.

The most recent attempt by progressive California lawmakers to have all 39 million state residents covered under one, government-funded healthcare program was last session's AB 1400. That bill would have created a new government entity, "CalCare," that would allow any California resident access to any doctor, regardless of network, and a broad range of medical services. Under AB 1400, CalCare would have reduced provider reimbursement to bring prices more in line with what the sponsors of the bill considered the "actual cost of care."

AB 1400 also included long-term care coverage and services for senior citizens and disabled people, and California residents would have been covered by CalCare regardless of immigration status. Additionally, the government program would have negotiated prescription-drug prices on behalf of beneficiaries.

However, AB 1400 failed to pass after the bill's cost was further scrutinized. The Assembly Appropriations Committee, which passed AB 1400 onto the floor last year, estimated the annual cost of a state-funded single-payer healthcare system in the Golden State at between $314 billion and $391 billion – nearly $100 billion more than the state's entire annual budget. Without a promising method to reduce costs, the bill was shelved.

This week, state Sen. Wiener introduced a bill that seeks to implement a Medicare-for-All type system in a more incremental fashion. Under the proposal, California would submit a 1332 innovation waiver to the federal government requesting that Medicaid and Medicare funds be used for a first-of-its-kind statewide single-payer healthcare system. The legislation would require California's health secretary to offer recommendations on crafting the federal waiver by June 1, 2024.

Proponents of single-payer healthcare are hoping that Wiener's legislation will prove more palatable than AB 1400. Instead of almost instantly jumping from the current system to an unaffordable single-payer system, this bill would give the Golden State greater federal funding to be able to pay for it. Additionally, by focusing solely on the federal waiver program, the bill would give the state more time to figure out how exactly to implement such a colossal program.

While lawmakers consider Wiener's proposal, one of AB 1400's former co-sponsors – Assemblyman Ash Kalra – is expected to reintroduce the aforementioned CalCare initiative. As of now, Kalra's bill is sparse on details. The California Nurses Association, the primary advocate of single payer in the state, is sponsoring 45 events across the state this weekend to rally support for Kalra's upcoming legislation. ##

CAHIP Members Lobbying on Capitol Hill

tion. The current reporting timeframe has ALEs reporting 14 months after that Fall individual-plan Open Enrollment period and after an entire year of offering coverage. Reporting prospectively would equip consumers and state Exchanges with information to determine if an individual applicant is eligible for subsidized Individual coverage, rather than evaluating eligibility after the conclusion of the year in which the subsidized coverage was obtained. This would reduce the likelihood that an individual will have to pay back a Premium Tax Credit that was incorrectly assigned and would protect employers from having to incur additional accounting and legal costs to appeal potential ACA non-compliance penalties.

Another priority for NABIP is supporting initiatives to innovate Health Savings Account (HSA) - eligible High-Deductible Health Plans (HDHPs). While HSAs were created 20 years ago, laws that accompany them have not evolved. **NABIP supports modifying HDHPs to allow plan holders to obtain primary care visits before the application of the plan's deductible**, which is currently prohibited.

NABIP opposes cost-shifting alternatives to treatment for End Stage Renal Disease (ESRD), the final permanent stage of chronic kidney disease, onto employer-sponsored plans. Current Medicare Secondary Payer (MSP) law requires the federal Medicare program to cover ESRD, for those entitled to Medicare based on ESRD diagnosis, for a 30-month coordination period. Proposals to limit this timeframe and shift costs onto employer-sponsored plans would be significant in cost and would create an unnecessary coverage mandate for the care of a specific disease. If enacted under current proposals as written, it could lead to other mandates for employers to cover other certain diseases, beyond what is already required for Qualified Health Plans (QHPs), further driving up the cost of care.

NABIP opposes civil monetary penalties from being imposed on employers for provider-network inadequacies. Current law generally penalizes employers if their networks of mental health providers are not equal in size to their networks of medical/surgical providers. Current efforts to penalize employers for non-compliance with network adequacy for mental health parity aim to penalize an entity (the employer) with no control over the network. Employers use networks formed by carriers or third-party administrators (TPAs) and do not have control over the contracted network. Instead, **NABIP requests that Congress focus on ways to encourage mental health providers to enter into networks, which would truly support network adequacy concerns.**

IMPROVING MEDICARE

Recent current law requires licensed Medicare insurance agents to begin their Medicare client-facing phone conversations with a disclaimer, record those phone calls, and store recordings for 10 years. **NABIP supports legislation to explicitly exclude agents from the current requirement to record calls with beneficiaries, in addition to future regulation that relates to recording calls with beneficiaries.** NABIP recognizes the increase in unscrupulous actors in the Medicare market and the need to combat them; however, NABIP believes these recent CMS regulations do not adequately address these entities. Instead, they inappropriately target licensed agents who are committed to acting in the best interests of Medicare beneficiaries. *Note: This requirement only applies to agents transacting Medicare benefits with consumers, but not group or individual health plans.*

NABIP also strongly supports allowing COBRA to be treated as "creditable coverage" for Medicare. Current law penalizes seniors with financial penalties if they continue an employer's plan through COBRA in lieu of Medicare, beyond their Medicare eligibility date. However, current law does not punish those same seniors when they remain covered by that employer's plan, based on current employment (i.e., not COBRA) beyond their initial Medicare eligibility date. Such coverage is considered "creditable coverage." Switching from a COBRA plan to a Medicare plan can be disruptive to care and may come with financial consequences for terminating COBRA early to meet Medicare enrollment windows. NABIP supports allowing seniors to remain on their COBRA coverage without penalty, just as seniors who remain on similar employer-sponsored coverage without penalty. Additionally, NABIP urges Congress to support forthcoming legislation that would allow seniors enrolled in COBRA coverage to transition to Medicare Part B without a penalty, just like with non-COBRA group coverage.

Lastly, **NABIP supports a new Medicare Part D open-enrolment period.** Current law allows Medicare Advantage beneficiaries to change their plans during a three-month open-enrollment period (OEP) at the beginning of each calendar year. This gives Medicare Advantage subscribers the ability to change their plans once their plan year begins, if they discover they are not covered by the right plan that meets their needs. However, unlike Medicare Advantage, this option is not available for prescription drug plans in Medicare Part D. NABIP encourages Congress to enact similar consumer protections during the OEP for Medicare Part D plans, allowing beneficiaries to change plans, accessing the plans that best fit their prescription drug needs – rather than staying committed to the drug plan originally selected during the Annual Enrollment Period (AEP).

Note: While this column summarizes NABIP's priorities for the 118th Congress, it is not exhaustive. NABIP supports other initiatives in addition to the items mentioned in this column.

##

Capitol Conference, Here We Come

By: David Benson - CAHIP-OC VP Legislation

I could not wait to leave snowy Southern California for the warm 50+ degree weather in Washington D.C. Yes, I did bring sunscreen. All kidding aside, hundreds of members of the National Association of Benefits & Insurance Professionals (NABIP), formally NAHU gathered in Washington D.C. at the Hyatt Regency Capitol Hill to get caught up on healthcare issues of importance before we held meetings with our elected officials.

Prior to becoming a Member of Congress most elected officials worked in the private sector in a wide range of industries. Members of Congress address legislation that impacts many industries, many of which Congressional Members know very little about. It does not matter if you lean left or right, or your views are moderate, middle of the road or extreme. Most Members of Congress know very little about our industry.

The healthcare industry is very complex. As well intentioned as legislators are in crafting language for a bill there are always unintended consequences. Once the Healthcare Staffer or the Congress Member understands this, we have a starting place to build a working relationship. Each year our talking points contain factual information, and examples of unintended consequences in existing legislation and suggestions for new legislation.

This year's talking points addressed the following issues:

NAME CHANGE FROM NAHU TO NABIP

The health insurance and benefits landscape has evolved, and so has NABIP's role in supporting our members and their clients. Over the years, our membership has grown to encompass professionals who sell traditional health insurance products and those who offer non-traditional coverage options. The association has expended its capabilities to respond to new marketplace dynamics, offering its members a growing selection of professional-educational opportunities, network-building conferences and business-development tools.

NABIP and our new tagline, ***Shaping the Future of Healthcare***, protect the association's legacy of leadership while representing our current role in the modern healthcare industry. While our name has changed, our mission and vision remain the same: We believe that all Americans should be empowered to make wise healthcare and benefits decisions and have access to high-quality, affordable healthcare and related services.

ADDRESSING THE COST OF CARE

NABIP supports site-neutral rules to deter location-based gaming of coverage. The cost of a service should not vary based on the site where it is delivered. The price of the same X-ray, MRI or physician's visit should not differ if it is delivered in a free-standing facility vs. in an outpatient hospital setting.

PRESERVING AND STRENGTHENING EMPLOYER-SPONSORED HEALTH COVERAGE

NABIP strongly opposes capping or modifying the individual tax exclusion of employment-based coverage.

NABIP SUPPORTS THE COMMONSENSE REPORTING ACT

The Commonsense Reporting Act enables employers to report employer-sponsored health plan information to the IRS prospectively before annual fall open-enrollment season in the state and federal exchanges instead of 14 months after that open-enrollment period and entire coverage year has ended.

NABIP SUPPORTS INITIATIVES TO INNOVATE HSA-ELIGIBLE PLANS

Modernize the definition of an HSA-qualified high-deductible health plan to allow primary care visits before application of the plan deductible.

NABIP OPPOSES COST-SHIFTING ALTERNATIVES TO END STAGE RENAL DISEASE COVERAGE

There have been efforts in Congress to shift the cost of coverage for End Stage Renal Disease (ESRD) from Medicare Secondary Payer to employer plans.

NABIP OPPOSES CIVIL MONETARY PENALTIES ON EMPLOYERS FOR NETWORK REQUIREMENTS

NABIP supports the need for adequate mental health networks. However, efforts to penalize employers for noncompliance with network-adequacy standards for mental health parity aim to penalize an entity with no control over the network. Carriers provide networks, not employers.

NABIP SUPPORTS EXCLUDING LICENSED AGENTS AND BROKERS FROM BURDENSOME MARKETING RESTRICTIONS

NABIP supports legislation to explicitly exclude independent agents and brokers from the current requirement to record calls with beneficiaries, in addition to any future regulations that relate to recording calls with beneficiaries.

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Capitol Conference cont. from page 8

NABIP SUPPORTS ALLOWING COBRA TO BE TREATED AS CREDITABLE COVERAGE

Seniors who are enrolled in COBRA coverage but are eligible for Medicare face lifetime financial penalties for not enrolling within the mandated timeframe. However, seniors who are enrolled in similar employer-sponsored plans are not penalized, as their coverage is considered creditable for Medicare.

NABIP SUPPORTS OBSERVATION STATUS TO BE TREATED AS INPATIENT STATUS

Many Medicare beneficiaries are classified as being on "observation," which can result in significantly higher claims and prevent Medicare coverage from being applied for nursing home care for patients who do not have a three-day inpatient hospital stay.

NABIP SUPPORTS A NEW PART D OPEN-ENROLLMENT PERIOD

Open enrollment for Part D takes place during the Annual Election Period (October 15 through December 7th). Medicare Advantage offers a three-month open-enrollment period (OEP) at the beginning of every year to allow beneficiaries to switch between plans if needed. We urge Congress to enact similar consumer protections during the OEP for Part D plans to allow beneficiaries to access the plans that best fit their prescription drug needs.

Welcome New Members of CAHIP-OC!

Every year 3-4 California Agents & Health Insurance Professionals from our Orange County Chapter, formally OCAHU meet with the Congressional Members (and Staff Members) who represent Orange County to discuss the roll of the agent and some of the talking points included on our list above. Most of our meetings last 20-30 minutes. Every once in while the meeting will last close to an hour. Many times, follow-up meetings are required. They take place via Zoom or with Staff Members or the Congressional Member in the District Office.

If you would like to become part of our Legislative Committee and participate in these District or Zoom meetings, please contact me at david@dcbins.com or call me at 949 272-2120.

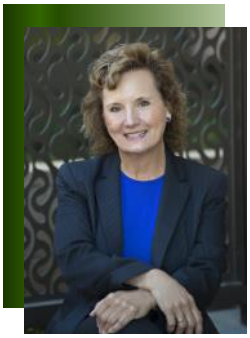
##

NABIP Operation Shout!

The National Association of Benefit and Insurance Professionals (NABIP) is the leading professional association for health insurance agents, brokers, general agents and consultants. Our members work every day with individuals, families and employers of all sizes to help them purchase health insurance coverage and use that coverage in the best possible way. As a dedicated group of more than 100,000 benefit specialists from across the nation, we advocate on behalf of American health insurance consumers.

One of the primary ways we engage in advocacy for the consumer is by supporting legislation that ensures the future and stability of the insurance industry. Through Operation Shout, you as a member have the opportunity to participate in this process. As legislative needs arise, you will be prompted by staff to participate in Operation Shout. Participating is quick and easy. When you click on "write" you will have the option of using the message we have already created, which takes less than a minute, or composing your own. Either method is effective and sends a strong message to your member of Congress about the important issues facing us today. You can also check back at any time to view and send archived messages. When engaging in NABIP grassroots operations, remember that we are most effective when we speak with one voice. As always, if you have any questions, please feel free to contact us!

When you meet with your federal legislators back in the districts throughout the year, we encourage you to send us your feedback on those meetings. This helps us to keep up the conversation here in Washington. If you have a personal relationship with any legislator, please let us know by filling out our grasstops survey! For more on NABIP's Government Relations operation, click here.



Reference-Based Pricing in Self-Funded Health Plans

By: Dorothy Cociu, RHU, REBC, GBA, RPA, LPRT - CAHIP-OC VP of Professional Development

Are we in a Recession or a Booming Economy? The answer to that, I suppose, depends on who you ask. Democrats in Washington brag about a booming economy, with unemployment down after some horrendous years during the COVID pandemic, and Republicans say that government spending has caused the United States to go deeper and deeper into debt, and we are in the midst of a recession. But do we care what the politicians in Washington say, when people are struggling financially, with the same goods and services we bought a year ago costing nearly $400 more per month now? Wages aren't keeping up with inflation; that's something that most of us can agree on. The cost of everything has gone up… and not the 3 to 5% the politicians are spouting… Has anyone purchased a dozen eggs lately or bought meat or poultry? For appearances and perception, many food manufacturers are "solving the problem" by reducing the quantity they package for the same or just slightly above the cost we paid last year. But consumers aren't idiots and know that the smaller package won't go as far in feeding their families, so they have to buy two instead of one… So where are the savings there?

For employers, some still have not recovered from the COVID downturn, and most are looking for effective ways to keep their own costs down overall, and a large part of that is health insurance cost. Although fully insured rate renewals stayed fairly level in 2020-2021 (they had to, as no one was seeing a doctor or getting elective surgeries or other procedures), 2022 and beyond are now seeing double-digit increases quite often, and for many employers, who see these increases year over year, it's just not sustainable. So how do we fight it? By looking at alternative ways to finance your health plan.

The keys to overall health care cost stability are tied to the actual cost of health care. Health insurance cost goes up when health care costs go up, and medical costs continue to rise. And now, with added pressures on providers due to the No Surprises Act, which restricts providers from balance billing for emergency and other services, and Transparency in Coverage (TiC) rules which now require providers and health plans to post their prices for common services, most employers are finally beginning to understand what self-funded employers using reference-based pricing have been saying for about a decade now… The number one key to keeping costs down is transparency in health care spending. Health plans using reference-based pricing have been doing that for many years now, and it works!

WHAT IS REFERENCE-BASED PRICING?

Reference-based pricing (or RBP), is a health plan financing strategy leveraged by self-funded employers that can result in significant reductions in claim costs, while still providing the freedom of choice of providers and complete transparency of the true costs of hospitals and facilities. An RBP model replaces the traditional PPO model with a fully transparent and sustainable pricing mechanism, by using a percentage of Medicare rates, or tying the cost of the claim to the actual provider cost of the service.

PPO contracts have certainly kept plan costs down over the years, but the problem is, the PPO model of discounting is unpredictable and varies greatly by provider and service. PPO contract rates have historically been generally hidden, arbitrary numbers. Although the TiC is changing this (finally!), there was no consistent starting price, or base price. So the question was often asked: What is the starting point that you're discounting from? Before the TiC requirements for providers and health plans went into effect, that was a question that no one would or could answer.

An RBP plan reimburses providers, commonly hospitals and facilities, and sometimes physicians and professional services providers, based on a multiple of Medicare rates, which range from 125% to 200% of Medicare in many cases, or on a percentage above reported provider costs. Because this rate is a rate above Medicare rates, which already have a profit margin in them, these rates are generally accepted by most providers; generally 95 to 98% of all providers accept this rate without issue.

Many plans use RBP for hospitals and facilities only. Others use it for hospitals, facilities and physician and professional services providers. You can also use a PPO network for physicians and professional services providers, and use RBP for non-PPO claims, in place of Usual and Customary Rates (UCR) for non-network services and charges.

HOW DO RBP COMPARE TO TRADITIONAL PPO CONTRACTS?

RPB plans can have "open access" to all facilities, or a self-funded employer could lower out-of-pocket costs for select 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 and professional services providers if they choose. This is quite common. Some popular PPO networks, however, won't allow plans to purchase the doctor only network currently, so changes in physician networks may be required.

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 billed rates. But, the question is, *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

Continued on page 11

covered under. A hospital traditionally hasn't wanted to 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, you would likely 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.

As an example of PPO vs. RBP, in the most simplistic case, 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. In contrast, if the **RBP plan pays 140% of Medicare**, it would pay $22,250 for the same procedure. This results in a savings of $22,750 (PPO cost of $45,000-RBP amount of $22,250) for this procedure. *Procedure by procedure, this adds up quickly for real savings.* Keep in mind, most providers already accept Medicare patients… These percentages are ABOVE the Medicare rates. Other examples of RBP pricing may be a percentage above the actual provider reported cost (reported to Medicare), such as 130% of actual cost, and some RBP vendors use the lower of the two.

For a 5-year plan performance case study of ClaimDOC, LLC, an RBP vendor, go to: Brokers - ClaimDOC, LLC (claim-doc.com)

PROVIDER PUSH-BACK

Be advised, however, that 2 to 5% of the time, you could have provider push-back, where the provider refuses to accept this rate, and sometimes won't accept a patient whose health plan uses RBP. This can often be resolved with a phone call from the RBP vendor or TPA's resolution team that walks the provider through the numbers and explains how RBP works. Most often, after this explanation, these providers accept the RBP rate. However, there is still a 1 to 2% chance of providers not accepting the RBP rate, and perhaps generating a balance bill to the patient. This is where the quality of the RBP Vendor's patient advocacy team comes into play, as well as the upfront and ongoing education of the employer and its plan participants receive. Who you use as your RBP vendor, and the level of pre-implementation training and education, as well as ongoing education, can make a *huge difference* in the patient satisfaction of an RBP plan (ie, the employees and their dependents on an employer's health plan).

WHAT SHOULD EMPLOYERS KNOW ABOUT REFERENCE-BASED PRICING?

The most important things that employers should know about reference-based pricing, according to Omar Arif, senior Vice President of Growth of ClaimDOC, is "RBP can be a wonderful tool to unlock transparency and price controls for your organization. It can also make health benefits much more affordable for your employees."

However, employers should understand that in order to be successful with an RBP plan, you need real expertise to help implement it. It's not as simple as a PPO plan. It takes a tremendous amount of up-front education, training and constant education to the employees and plan participants; it's not a one-and-done type of plan. Education is like relearning the health insurance system. That is not an easy task, and takes a high level of understanding, and a lot of tools, including written materials, videos, and other education tools. But if done right, it can save your health plan considerable money over the long run.

"You need a consultant that is an expert to help you through the process," stated Omar. "Don't think you can get it done with your brother-in-law or golf buddy. You need an expert, not a friend."

As an employer, if you want to save 20-30% or more off of your PPO self-funded health plan, you should look at RBP, but remember, it's not simple and it's a long-term process.

Many good vendors offer RBP repricing and services. Some of the major players include ELAP, ClaimDOC, HST, AMPS, 6 Degrees, Payer Compass, to name a few. What makes ClaimDOC different from its competitors?

"ClaimDOC is the only major player among the group you just mentioned that isn't private equity-backed or publicly traded," stated Mike Sigal, VP of Sales Development at ClaimDOC. "We're a private family- owned business, which means our first priority is to our clients, and not our shareholders. We have a beefed up service department that is much different than people familiar with our space are accustomed to."

Any employer currently in the RBP space will tell you, the level of service, advocacy and negotiation abilities of the RBP vendor is critical. You need a vendor who is on the employer's side, and works with the plan participants to resolve claim disputes. Member success is the way to grade your RBP plan. All RBP vendors can reprice the claims to an RBP rate. The difference is in how they work with the plan members and resolve their issues.

"Our Pave the Way program is a great example," stated Mike Sigal. "You can't compare us to other RBP vendors. You have to stack our product up against another RBP vendor, plus advocacy service, plus legal service. Then decide if you want it all done by one team in the same building or patched together by different vendors."

ClaimDOC has a Client Experience Snapshot from one of the clients, Mittera, available for review. According to this report, Mittera reduced their monthly cost per enrolled employee and their monthly cost per covered life, and have acquired excellent overall experience from both the employer and employee level. You can review the Mittera Client Experience Snapshot

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and other success stories here: Brokers - ClaimDOC, LLC (claim-doc.com).

Sometimes providers will be hesitant to work with RBP plans, and insist on a contract, or the RBP vendor or client decides they'd like to pursue a direct contract with a particular, perhaps widely used provider. ClaimDOC states that they will enter into contracts only when it makes sense at reasonable rates for their clients. Who decides when to enter into a contract with a provider or facility? "It's generally a collaborative effort between ClaimDOC, the broker, and the plan sponsor. We want to make sure we're upholding our responsibility as a fiduciary to the plan, so we won't cut bad deals with hospitals just to make balance bills go away," stated Omar.

PROVIDER BALANCE BILLING

Reference-Based Pricing always has the risk of a provider balance billing the patient after receiving the reduced payment from an RBP health plan. In this phase, it's imperative that the employer work with a skilled RBP vendor that has a robust patient/member advocacy program dealing with providers who balance bill, to avoid collections actions by the provider which could impact the plan participant's financial situation and credit scores. How this works and how successful it is can make all of the difference to the plan participant.

"We take action from the first notice, which is unique," said Omar Arif. "We also do a great job of communicating with the member to keep them comfortable. Never in our company's 10-year history has a member paid more than their deductible and OOP max. We also do a great job of communicating with the provider; we let them know how and why the reimbursement was reasonable. If they want to appeal, we'll work with them, but the balance bill needs to go away."

Sometimes, on rare instances, the employer/plan sponsor may need legal assistance to resolve a claim. Although several RBP vendors have legal assistance available, ClaimDOC claims to do it better.

"Our legal team is really the program administrator of our network replacement program. Member advocacy looks to them when there are issues, and provider relations has them get involved with facility negotiations, then obviously they do the litigation defense on any disputes," stated Omar. "They even handle collection issues and credit impairment reversals. We don't farm out our legal work to third parties who pass it on to paralegals, and we certainly don't leave the client to defend themselves when problems come up. We protect the plan and members from any predatory billing practices for the life of every claim. Even if the member leaves the plan, even if the plan leaves ClaimDOC."

THE ROLE OF A CO-FIDUCIARY

One particular difference that only a small number of RBP vendors can claim is that they have taken a co-fiduciary role in the plan. For those of you familiar with ERISA, a plan fiduciary has decision-making authority over the plan, and therefore has liability. They are required by law to make plan decisions based on the best interest of the plan and its participants. Often, RBP vendors avoid fiduciary liability. ClaimDOC has taken on this role whole-heartedly, to show the employer plan sponsor that they will act in an appropriate manner while representing the health plan. Having "skin in the game" so to speak, often gives employers more confidence in the role of the RBP vendor. "I believe they do feel better knowing they have the full protection in place," stated Omar." We've never lost a court case and we've never had a member pay above their deductible and out of pocket max. We take our fiduciary role very seriously."

PAVING THE WAY WITH PROVIDERS

All RBP vendors have programs to assist employers, but ClaimDOC takes it one step further with it's "Pave the Way" program. What is it and how does it help? "Pave the Way is ClaimDOC's proactive provider outreach," stated Mike Sigal. "We do this by collecting top provider reports from the group. We also get what we call Provider Nomination Forms from the members. This starts during open enrollment and it's open year-round. Basically, if you have a physician and you want to make sure they'll accept the program, you can reach out to ClaimDOC via a paper one-page form, email, web link, or even call in. We'll take the information and reach out to the provider to educate them on the program. We get a 91% acceptance rate across the country when we do that outreach. We're happy to share a video link that explains in further detail: Passion Behind Pave the Way - ClaimDOC, LLC (claim-doc.com)."

So if you're an employer struggling to keep your health plan costs down, or you're a broker representing health plans wanting to save substantial amounts, you may want to consider self-funding with RBP. Reference-Based Pricing doesn't work for all plans, but it does work for a lot of them. Whether we're in a Recession or Booming economy, most employer plan sponsors are open to claim savings. To find out if your health plan or your clients' plans are good candidates, reach out to ClaimDOC via Mike Sigal at 714 916-4210 or Omar Arif at 469-939-7286.

But remember, you need experts to make it successful. ##

Author's Note: ClaimDOC would like to thank health benefits broker and self-funded and RBP expert and plan consultant Dorothy Cociu, President of Advanced Benefit Consulting, for her assistance with this article as a contributing writer. For more information on this topic, you can listen to her weekly podcast series, Benefits Executive Roundtable, Season 4, Episode 12, where Dorothy interviews Mike Sigal and Omar Arif on Reference-Based Pricing, available on all podcast platforms, or at: https://advancedbenefitconsulting.com/s4e12-examining-reference-based-pricing-in-self-funded-plans/

Continued on page 13

Reference Based Pricing, cont. from page 12

You can also contact Mike and Omar at:

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469-939-7286 cell
Oarif@claim-doc.com

Mike Sigal
V.P. of Business Development
714-916-4210 cell
Mike.Sigal@claim-doc.com

REFERENCES AND SOURCES:

Reference-Based Pricing…. The Key to Solving the Health Insurance Industry's Cost Issues?, by Dorothy Cociu, printed in the County of Orange Insurance News (The COIN), November, 2017; content used with permission.

Mittera Client Experience Snapshot and 5 Year Plan Performance Case Study, ClaimDOC, LLC, available at: Brokers - ClaimDOC, LLC (claim-doc.com)

CAHIP Podcast Series

CAHIP's Podcast Series is back at: ***http://anchor.fm/cahu*** and ***https://www.cahu.org/podcasts*** or on Spotify! (search CAHU) or at cahip.org. Designed to allow CAHIP members to share with their office staffs, employer clients and consumers!

Latest Podcasts:

- **CAHIP Winter 2023 Federal Updates Part 1 with Marcy Buckner**
- **CAHIP Winter 2023 Federal Updates Part 2 with Marcy Buckner**
- **Medicare Updates for 2023**

CAHIP-OC Board of Directors and Staff 2022-2023

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Why Get Involved in CAHIP-OC?

- *Learn more about our industry*
- *Become a better consultant to help your clients*
- *Network with professionals in all areas*
- *Be a resource to your colleagues*
- *Make an impact with legislation*

The Value of Your Membership

By: Gonzalo Verduzco - CAHIP-OC VP Membership

What do you get for your investment as a California Agents & Health Insurance Professionals, Orange County (CAHIP-OC) member?

LEGISLATIVE UPDATES AND ALERTS

Through communication and membership meetings, we keep your finger on the pulse when it comes to healthcare reform and upcoming changes.

PROFESSIONAL DEVELOPMENT

We are committed to helping agents and brokers reach new heights in their careers through Continuing Education course, seminars, conferences and more.

NETWORKING

CAHIP Orange County provides a rich forum for sharing ideas, asking questions and learning new technologies. You can make new connections with brokers, agents, carriers and vendors.

AND IT DOESN'T STOP THERE!

- National Association of Health Underwriters (NAHU) and California Agents & Health Insurance Professionals (CAHIP) will protect your right to serve your clients needs.
- The opportunity to make an impact on our industry by getting involved in legislative efforts both National and statewide.
- You will obtain timely, informative news
- You will attend continuing education seminars on the hottest insurance topics, locally, statewide and nationally at a discount.
- You will share information with top producing insurance professionals.
- You can participate in grassroots efforts that respond to local, state, and federal legislative issues.
- You will benefit from a variety of member-only discount programs.
- NAHU's Code of Ethics demonstrates to your clients your commitment to professionalism.
- You will play an active role in the future of the health insurance industry.
- You will receive a subscription to America's Benefit Specialist, the National Association's monthly magazine, and bi-monthly OCAHU newsmagazines.
- With NAHU following trends in Large and Small Group Managed Care Plans, Individual Health Plans, Long Term Care Insurance, Disability Insurance, and Medicare, you will benefit from membership no matter your specialty.

MEMBERSHIP NEWS

We'd like to welcome the newest members of CAHIP-OC!

Andres Arevalo	**Michael Corcoran**	**Anthon Lopez**
Larry Baca	**Kim Dannettell**	**Paul Pascual**
Peter Cabot	**Brandon Humphrey**	**Patricia Scoma**

Interested in Joining? Many ways to join:

- **Contact our Membership Team:**

Gonzalo Verduzco
☎ (714) 345-2558
✉ gverduzco@wordandbrown.com

Briana Hudson
☎ (714) 451-5772
✉ briana@dickerson-group.com

- **Talk to a Member** *(see page 14 for board roster)*
- **Visit our website at www.ocahu.org**
- **Use our QR code**

JOIN CAHIP-OC

CAHIP-OC Annual Sales Symposium

National Association of Benefits and Insurance Professionals

NABIP

Shaping the *future* of healthcare

How to get more value from your NABIP membership

The activities below provide a blueprint for extracting the greatest value from your membership:

- Visit NABIP's Micro Site - **www.welcometonabip.org**
- Take advantage of NABIP's **Mentorship Program**
- Read America's Benefit Specialist Magazine each month and learn something new
- Listen to the NABIP **Healthcare Happy Hour Podcasts** on a weekly basis for up-to-date talking points
- Attend the NABIP **Power Hour** webinar monthly for in depth topic discussions and socialize with fellow members
- Attend Local Chapter meetings for opportunities to learn and network
- Volunteer to serve on a committee (Membership, Social, Programs/Expo, Legislative, etc.)
- Recruit one new member – best way to learn is to teach someone else about the NABIP value proposition
- Meet with a NABIP Board member and find out what motivates them to give their time and money
- Attend Day on the Hill and meet with your state legislators to discuss bills you support or oppose
- Attend NABIP Capitol Conference – annual legislative fly-in to Washington DC (IMPORTANT ONE)
- Attend NABIP Annual Convention to meet members from across the country and vote for NABIP incoming Secretary and other membership matters
- Contribute to NABIP-PAC – Political Action Committee contributions help us to have our voice heard on legislative issues at the national and state level. Contribute monthly to each!
- Participate in Operation Shout – click and sign letters to **your** elected officials regarding important grass roots efforts
- Earn your **Registered Employee Benefits Consultant** designation - acquired from The American College
- Complete all 12 modules of the **Leadership Academy**.
- Sign up to receive **Broker 2 Broker** emails on NABIP.org where you can post questions and respond to fellow members from around the country
- Share with your clients that you are a member of NABIP and working to protect their access to private health insurance and other benefits!

More information at www.nabip.org

CAHIP Women's Leadership Summit Photos

CAHIP-OC 2022 Annual Report

Income	
Dues	$9,719
Corporate Sponsorships	$33,025
Monthly Meeting Registration	$6,820
Continuing Education Day	$7,440
Business Development Summit	$33,551
Senior Summit	$20,000
PAC Contributions	$1350
Charitable Events	$137,922
COIN Newsletter Advertisements	$860
Miscellaneous Income	$0
Interest Income	$10
Total Income	***$250,697***
Cost of Sales	
Monthly Meetings	$7.556
Charitable Contributions	$141,864
Continuing Education Day	$7,614
Business Development Summit	$19,247
Senior Summit	$0
Total Cost of Sales	***$176,281***
Expenses	
CAHIP-OC Administration / General Chapter Management	$41,776
Membership & Recruitment	$200
Legislative Activities	$10,104
Conferences / Education	$24,884
Total Expenses	***$76,964***


SENATOR
Dianne Feinstein
California
SH331


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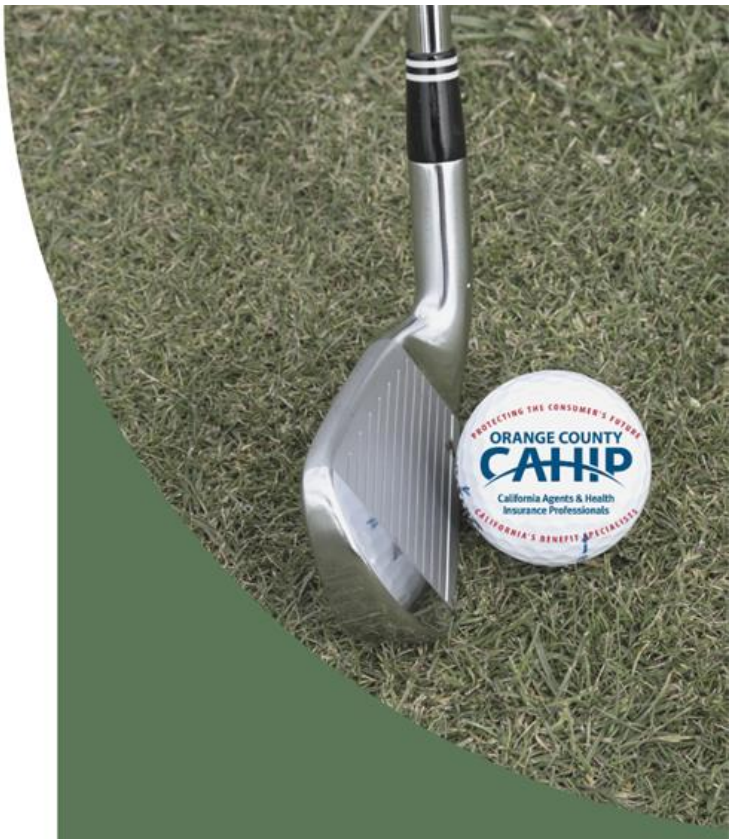
NABIP Capitol Conference 2023 Photos



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SUPER TICKET PACKAGE

$250 per person

Entry fee includes Golf & Super Ticket (scratcher card for prizes, 10 raffle tickets, 1 Grand Prize ticket, 2 mulligans, 4 drink tickets, and entry to all contests), Lunch & Awards Dinner.

SPONSORSHIPS AVAILABLE!

26th Annual Charity Golf Classic

TAKE A SWING FORE THE CURE

APRIL 10TH, 2023

ALISO VIEJO COUNTRY CLUB

33 Santa Barbara Drive
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REGISTER @ OCAHU.ORG

NAHU Agency Dues Model

By: Gonzalo Verduzco - OCAHU VP Membership

The National Association of Health Underwriters represents our profession and our clients' interest in affordable access to quality health insurance and related benefits throughout America. Membership enhances our ability to advocate before state and federal decision-makers on the issues that impact our clients and our businesses. The Agency Dues Model 2022 program simplifies dues and payments (one amount per month based on your agency size) and provides full membership (and related benefits) to all of your employees who work on health, dental, vision and related benefits for employers or individuals.

EAMs in Agency	2-4	5-9	10-15	16-24	25-39	40-50	51-74	75-99
Monthly Cost	$65	$120	$275	$530	$665	$800	$1,100	$1,700

The NAHU Agency Dues Model 2022 is available to agencies of two to 99 that enroll 100% of EAMs. It offers a streamlined billing process with one invoice, one renewal date and one payment each month to cover all your eligible employees. EAMs are producers in your agency who sell employee benefits, individual health insurance, Medicare or other health related products, as well as account managers and compliance professionals who are on staff and work with clients. This would not include those agency employees who work exclusively on life insurance or commercial and/or personal property and casualty insurance. With this fixed agency dues model program, all eligible agency members will receive the benefits available as a member of NAHU.

Note: Agencies with members in the chapters listed below are subject to an additional fee to support the chapter's advocacy efforts. This adjustment is set on pro-rata basis.

20% Geographical Adjustment	
Local Chapters	All State & Local Chapters
Atlanta, GA	Massachusetts
Lexington, KY	Minnesota
Baton Rouge, LA	Nebraska
Springfield, MO	New York
Dallas, TX	North Carolina
Houston, TX	West Virginia
Lubbock, TX	
San Antonio, TX	
Wichita Falls, TX	

30% Geographical Adjustment
All Local Chapters in the Following States:
California
Connecticut
Florida

Enrolling in the Agency Dues Model is easy. The steps are listed below. If you have questions, please contact btretter@nahu.org or (202) 595-7564.

ENROLL IN NAHU'S AGENCY DUES MODEL IN 4 EASY STEPS:

1. Contact Bob Tretter at btretter@nahu.org to get an eligibility form and eligible agency member (EAM) spreadsheet.
2. Complete eligibility form and fill out the spreadsheet listing all current members from your agency as well as new eligible members. Send back to Bob Tretter at btretter@nahu.org.
3. Once confirmed, you will receive an itemized invoice outlining the monthly cost for all your employees for the program. Your itemized invoice will prorate the dues for any current members to sync everyone onto your agency membership.
4. Each EAM you enrolled will receive a welcome email with their NAHU log-in information and a description of all benefits. You may update your agency membership anytime through the agency membership account.

JOIN CAHIP-OC

Ease Broker Blog

Did you know Ease has a blog with valuable information that can help you and your clients? This blog is not focused on their specific technology, but some of the important topics surrounding the broker community. Below are a few recent blogs.

- 10 Insurance Marketing Terms to Store in Your Back Pocket
- An Insider's Look into 2023 Insurance Trends
- Ease Report Reveals Even Small Shifts in Benefits Costs Can Impact SMBs

If you're interested in reading more please **visit www.ease.com/blog/** and subscribe to get updates of new blog postings.

Follow CAHIP-OC on Social Media!

https://www.facebook.com/OCAHU/

https://www.linkedin.com/groups/4100050/

https://twitter.com/orangecountyahu?lang=en

Support CAHU PAC!

You don't have to be a member to contribute to the PAC!

CAHU-PAC advocates on behalf of licensed insurance agents and their clients in California on numerous issues of vital concern including their role in solicitation of health, long-term care, annuity and life insurance products, insurance market reform, rising health care costs and regulations affecting agents and brokers.

NABIP Healthcare Happy Hour

Subscribe to NAHU's Healthcare Happy Hour

http://nahu.org/membership-resources/podcasts/healthcare-happy-hour

Latest Podcasts:

- **Compliance Corner Committee Members Talk RxDC Reporting**
- **Special Guest Rick Israel Shares Touching Story on the Importance of Succession Planning**
- **NABIP's Marcy M. Buckner Answers Your Unanswered Cap Con Questions**
- **Capitol Conference 2023 Recap with Special Guest Greg Stancil**
- **Capitol Conference 2023 - Know Before You Go!**
- **NABIP Submits Comments on New Medicare Marketing Proposed Rule**
- **Capitol Conference 2023 - NABIP's Legislative Priorities**
- **NABIP Submits Several Comments to HHS/CMS**

California Association of Health Underwriters Political Action Committee
2520 Venture Oaks Way, Ste 150
Sacramento, CA 95833
FPPC # 892177

CAHU PAC CONTRIBUTOR COMMITMENT FORM

LAST NAME FIRST NAME MIDDLE

OCCUPATION (Required for FPPC reporting purposes)

EMPLOYER (if self employed, name of business; Required for FPPC reporting purposes)

WORK ADDRESS (Please provide street address only, no P.O. Boxes) ☐ Check if address for Credit Card

CITY, STATE, ZIP PHONE FAX

HOME ADDRESS (Please provide street address only, no P.O. Boxes) ☐ Check if address for Credit Card

CITY, STATE, ZIP PHONE FAX

CONTACT EMAIL ADDRESS LOCAL CHAPTER

PRECIOUS GEM STONE CONTRIBUTION LEVELS

Levels	Annual	Monthly Minimum	Diamond Levels	Annual	Monthly Minimum
Ruby	$250 - $499	$21/month	One Star	$1,000 - $1,999	$85/month
Emerald	$500 - $719	$42/month	Two Star	$2,000 - $2,999	$170/month
Sapphire	$720 - $999	$60/month	Three Star	$3,000 - $3,999	$250/month
			Four Star	$4,000 - $4,999	$340/month
			Five Star	$5,000 - $6,000	$420/month

NOTE: POLITICAL CONTRIBUTIONS ARE REPORTED TO THE FPPC. YOUR NAME, AS A CONTRIBUTOR, WILL BE A MATTER OF PUBLIC RECORD.

PAYMENT METHOD: (attach check or select method below)

Payment Method	Card or Account #	Exp. Date	Security Code	Monthly Amount	One-Time Contribution
Check Enclosed					$
Visa/MC/Amex				$	$
Auto-checking withdrawal	PLEASE ATTACH A VOIDED CHECK			$	

Bank Draft / Credit Card Authorization: *I (we) hereby authorize the CAHU PAC to initiate debt entries to my (our) checking account and or credit card. Monthly or one-time debits to be made as shown above. Monthly contributions will continue to be drawn until CAHU PAC is notified in writing to cease. I understand that if I should request changes to the amount withdrawn or a cancellation of these charges that it may be 30 days before these changes to become effective.*

Signed: _____ ***Date:*** _____

Please return this PAC Commitment Form to:
Mail: CAHU PAC 2520 Venture Oaks Way, Ste 150, Sacramento CA 95833
FAX: (916) 924-7323 Questions: (800) 322-5934

Revised: 10/2019

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- THE C.O.I.N. -

Don't miss our upcoming events!

UPCOMING EVENTS

26th Annual Take a Swing Fore the Cure Charity Golf Classic
- Aliso Viejo Country Club
APRIL 10, 2023

CAHIP Capitol Summit
- Kimpton Sawyer Hotel-Sacramento, CA
MAY 8, 2023

20th Annual Celebration of Women in Business Luncheon & Charity Fashion Show
- Balboa Bay Resort
JUNE 2, 2023

Visit our website for more details

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