Joint Benefits Committee Meeting
2022 Renewal Summary

Rancho Santiago Community College District

September 3rd, 2021

Keenan & Associates

2022 Employee
Benefits Renewal

Agenda

1. 2022 Medical Renewals
2. 2022 Ancillary Renewals
3. 2022 Group Medicare Insurance Plan
4. Legislative Updates

2022 ASCIP Renewal

2022 ASCIP Renewal

Medical Renewal Percentage

- Anthem Blue Cross HMO +3%
- Anthem Blue Cross PPO +3%
- Kaiser HMO +.66%

Dental Renewal Percentage

- Delta Care Dental HMO +2%

2022 Ancillary Renewal

2022 Ancillary Renewals

Renewal Percentage

- MetLife Dental PPO +0%
- VSP Vision (CICCS) -2%
- Hartford
  - Basic Life Insurance +0%
  - Voluntary Life Insurance +0%
- MetLife Hyatt Legal +0%

2022 Group Medicare Insurance Plan

Retireefirst

- Retireefirst specializes in managing retiree populations

- Retireefirst was able to obtain a quote for a Group Medicare Insurance Plan direct from Anthem Blue Cross called the “Anthem Blue Cross National PPO Medicare Advantage Plan”

- This plan matches the medical coverages offered under the CompanionCare plan but improves the prescription co-pays to match those offered under the current Anthem HMO and PPO plans

How does medical coverage compare?

Medical				
	Current	Current	Current	Proposed
	Companion Care	Anthem PPO	Anthem HMO	Anthem NPPO Medicare Advantage Plan
Deductible	$0	$250	$0	$0
Medical Maximum Out-of-Pocket	$0	$1,000	$1,000	$0
Network	Medicare	Anthem	Anthem	Medicare
Primary & Specialists Visits	$0	$20	$10	$0
Ambulance Service	$0	10%	$100/Trip	$0
Emergency Room	$0	$50 Waived if Admitted	$100 Waived if Admitted	$0
Inpatient Hospital Care	$0	10%	$0	$0
Outpatient Surgery	$0	10%	$0	$0
Skilled Nursing Facility	$0; days 1- 100	10%; days 1-100	$0; days 1- 100	$0; days 1- 100
Urgent Care	$0	$20	$10	$0
Durable Medical Equipment	$0	10%	20%	$0
Preventative Care	$0	$0	$0	$0
Vision Services	Medicare Covered Only	Medicare Covered Only	Medicare Covered Only	$0 per routine vision exams, every 12 months $100 Material Allowance every 24 months
Hearing Aids	Not Included	10% $2,000 per hearing aid every 36 months	50%; One Medically Necessary Hearing Aid per year	$1,500 Hearing Aid Allowance every 12 months
Fitness Program	Not Included	Not Included	Not Included	Silver Sneakers gym membership and fitness program

Network Differences

- **Current Anthem Network**: The medical provider network for the PPO and HMO plans are specific to Anthem as a carrier. This network is negotiated and contracted with specific providers who are willing to accept the contract terms of Anthem.

- **Medicare/Anthem PPO Medicare Advantage Network**: The Medicare network is not specific to any carrier but rather includes any and all medical providers who accept Medicare. 96% of all doctors nationwide accept Medicare. It is the largest network of providers in the nation.

How does prescription coverage compare?

RX				
	Current	Current	Current	Proposed
	Companion Care	Anthem PPO	Anthem HMO	Anthem NPPO Medicare Advantage Plan
	Retail 30 day			
Preferred Generics	N/A	N/A	N/A	$0
Generics	$9	$5	$5	$5
Brand	$35	$15	$15	$15
Non-Preferred Brand	$35	$30	$30	$30
	Mail Order 90 day			
Preferred Generics	N/A	N/A	N/A	$0
Generics	$18	$10	$10	$10
Brand	$90	$30	$30	$30
Non-Preferred Brand	$90	$75	$75	$75
	Additional Part D Specifications			
Lifestyle Drugs	Not Covered	Not Covered	Not Covered	Covered
Non-Part D Drugs	Not Covered	Not Covered	Not Covered	Covered

Lifestyle Drug Examples: *Viagra and Cialis*
Non-Part D Drug Examples: *Drugs for anorexia, weight loss, weight gain, hair growth, relief of cough and cold symptoms, prescription vitamins and mineral products, and non-prescription drugs*

Vision Coverage

- Group Medicare Insurance Plan includes vision coverage as shown below. If the coverage is sufficient retirees can consider this as an alternative to the vision options through VSP.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Routine vision services • Routine vision exams	Must use a Blue View Vision provider.	
Routine vision exams are limited to 1 every calendar year. The routine vision exam is limited to a $70 maximum benefit every calendar year combined in-network and out-of-network.	$0 copay for routine vision exams	$0 copay for routine vision exams
• Eyewear	$0 copay for eyewear	$0 copay for eyewear
Eyewear is limited to a $100 maximum benefit* every 2 calendar years combined in-network and out-of-network. Covered eyewear includes prescription glasses, lenses, frames and contacts. This is a primary vision care benefit intended to cover only routine eye examinations and corrective eyewear. Blue View Vision is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care doctor from your medical network.	After the plan pays benefits for routine vision exams and eyewear, you are responsible for any remaining cost.	After the plan pays benefits for routine vision exams and eyewear, you are responsible for any remaining cost.

Portability of Benefits

- **Medicare Network**: Members can seek care from any doctor that accepts Medicare in all 50 US states

- **Country-Wide Portability**: Retirees can enroll in the plan regardless of their state of residence

What support and advocacy will retirees be given?

- RetireeFirst would provide the following assistance to all employees:
  - Medicare Enrollment – Up to 300+ languages supported
  - Billing Administration – Penalty Reimbursement
  - Provider Network
  - Prior Authorizations
  - Formulary Questions
  - Prescription Questions
  - Wellness Appointment Scheduling

What happens if my doctor doesn't accept Medicare?

- Due to the move of retirees from the Anthem Blue Cross network there is very minimal disruption expected

- If a provider says they don't accept Medicare, it is critical to understand the following:
  - Does the doctor not participate in the Medicare network?
  - Does the provider's office not do Medicare billing?

- If the provider is in the Medicare network but doesn't facilitate Medicare billing, then the following option is available:
  - The retiree can obtain the services and file with Anthem for 100% reimbursement.

What happens to actives/early retirees?

- Actives and early retirees (65 and under) will still be enrolled in the current Anthem PPO, Anthem HMO, and Kaiser plan

- When active and early retirees approach the age of 65 they will be notified and instructed on the Medicare enrollment process and what they will need to sign up for

What happens to those on the CompanionCare plan?

- **Enrollment:** Existing CompanionCare members will be required to enroll in the new Group Medicare Insurance Plan beginning April 2022 and the plan will become effective on July 1, 2022

- **Coverage:** The new plan will provide increased coverages and lower prescription co-pays which should help reduce out of pocket costs

- **Network:** Both CompanionCare and the new plan utilize the Medicare network so there should be zero disruption in providers

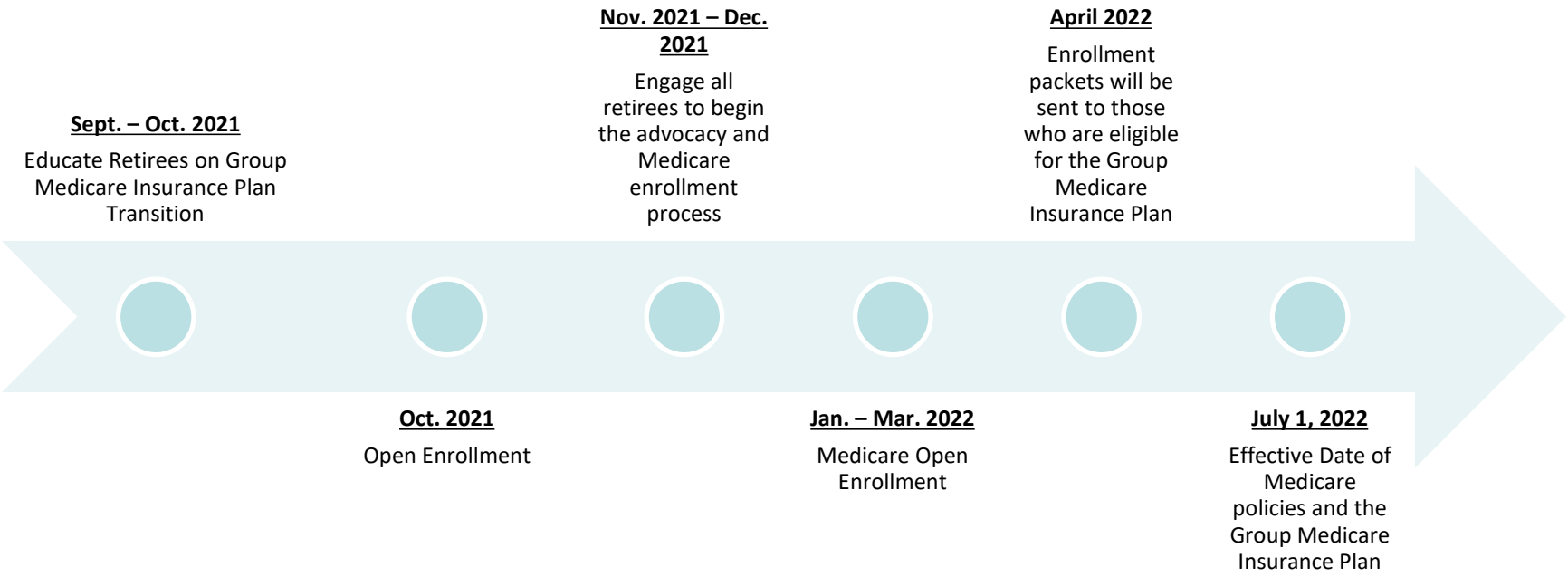
What happens to eligible dependents?

- **Eligible Underage Dependents**: For eligible underage dependents they will continue to enroll on the District's active plans

- **Eligible Overage Disabled Dependents:** : For eligible overage disabled dependents they will continue to enroll on the District's active plans

- **Eligible Spouses**: For eligible spouses who are not Medicare age they will continue to enroll on the District's active plans

What is the timeline?



Legislative Updates

Legislative Updates

- **July 2021**
  - No Surprises Act: Interim Final Rule Released
  - Additional IRS Q&As on American Rescue Plan's COBRA Subsidy
- **August 2021**
  - COVID 19 Presumption for Disability Retirement
  - Transparency Requirements for Health Plans

Thank you for choosing Keenan.

We truly appreciate your business and look forward to working with you and RSCCD employees for many years to come.

We believe in forming a mutually beneficial partnership and welcome your feedback on how we may serve you better.

NO SURPRISES ACT: INTERIM FINAL RULE RELEASED

On July 1, 2021, the U.S. Department of Health and Human Services (HHS), the Department of Labor, and the Department of the Treasury (collectively, the Departments), along with the Office of Personnel Management (OPM) released an interim final rule with comment period, implementing portions of the No Surprises Act, which was enacted as part of the Consolidated Appropriations Act of 2021. Absent any change, this interim rule will become final on September 13, 2021, and will go into effect in 2022.

BACKGROUND

The No Surprises Act protects health plan members **who receive emergency care** from balance-billing, commonly referred to as "surprise billing," by out-of-network (OON) providers. Effective January 1, 2022, and applicable to group health plans and health insurance issuers for plan years beginning on or after that date, the No Surprises Act will cap a plan member's cost-sharing obligations for OON services to the plan's applicable in-network cost-sharing level for the following three categories of services:

- Emergency services performed by an OON provider or facility and post-stabilization care if the patient cannot be moved to an in-network facility.
- Non-emergency services performed by OON providers at in-network facilities, including hospitals, ambulatory surgical centers, labs, radiology facilities, and imaging centers.
- Air ambulance services provided by OON providers.

As noted by the HHS in their July 1 press release, "Researchers estimate that one of every six emergency room visits and inpatient hospital stays involve care from at least one out-of-network provider, resulting in surprise medical bills."

For additional background on the No Surprises Act, please see our previous Briefing on the subject here.

GENERAL PROVISIONS AND DEFINITIONS

The interim final rule implements many of the law's requirements for group health plans, health insurance issuers, health care providers and facilities, and air ambulance service providers. The rule clarifies that the No Surprises Act does not apply to retiree-only plans, excepted benefits, short-term limited-duration plans, Health Reimbursement Accounts (HRAs), flexible spending accounts (FSAs), or health savings accounts (HSAs). It also does not address the independent dispute resolution process for settling disputes between payers and providers; regulations on that aspect of the No Surprises Act are expected in the next few months.

If a plan or coverage provides or covers any benefits for emergency services, this interim final rule requires emergency services to be covered:

- Without prior authorization.
- Regardless of whether the provider is an in-network provider or an in-network emergency facility.
- Without limiting what constitutes an emergency medical condition solely on the basis of diagnosis codes.
- Regardless of any other term or condition of the plan or coverage other than the exclusion or coordination of benefits, or a permitted affiliation or waiting period (for covered services other than air ambulance services). The interim final rule clarifies that the No Surprises Act does allow the application of coordination of benefit rules (to the extent they do not otherwise conflict with the emergency services billing requirements) affiliation or waiting period requirements, and applicable cost-sharing requirements.

Emergency services include certain services in an emergency department of a hospital or an independent freestanding emergency department. It also includes post-stabilization services, unless all of the following conditions are met:

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

The interim final rule also defines "emergency medical condition" to be a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson with an average knowledge of health and medicine could reasonably expect to either (1) place their health in serious jeopardy, (2) seriously impair bodily functions, or (3) cause serious dysfunction to any bodily organ or part. The definition includes both mental health and substance use disorders. Plans must determine whether the standard has been met with a focus on the presenting symptoms, without imposing a time limit between the onset of symptoms and presentation for emergency care, and without restricting coverage to instances of a "sudden onset" of the condition.

Determining Reimbursement Rates for OON Providers

The interim final rule provides that consumer cost-sharing amounts for emergency services provided by out-of-network emergency facilities and out-of-network providers, and certain non-emergency services furnished by out-of-network providers at certain in-network facilities, must be calculated based on one of the following amounts:

- An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act.
- If there is no such applicable All-Payer Model Agreement, an amount determined under a specified state law.
- If there is no such applicable All-Payer Model Agreement or specified state law, an amount agreed upon by the plan or issuer and the provider or facility.
- If none of the three conditions above apply, an amount determined by an independent dispute resolution (IDR) entity.

Similarly, cost-sharing amounts for air ambulance services provided by out-of-network providers must be calculated using the lesser of the billed charge or the plan's or issuer's qualifying payment amount, and the cost sharing requirement must be the same as if services were provided by an in-network air ambulance provider.

Limited Consent for Out-of-Network Rates

In limited cases, the interim final rule allows a provider or facility to provide notice to a patient regarding potential out-of-network care and obtain the individual's consent for that out-of-network care and extra costs. However, this exception does not apply to ancillary services, which include items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology. It also does not apply to items and services provided by assistant surgeons, hospitalists, and intensivists; diagnostic services, including radiology and laboratory services; and items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at the facility. Finally, the notice and consent exception does not apply to items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished for which a nonparticipating provider satisfied the notice and consent criteria.

Notice to Consumers

The interim final rule also requires certain health care providers and facilities to make publicly available, post on a public website, and provide to individuals a one-page notice about:

- The requirements and prohibitions applicable to the provider or facility under Public Health Service Act sections 2799B-1 and 2799B-2 and their implementing regulations.
- Any applicable state balance billing limitations or prohibitions.
- How to contact appropriate state and federal agencies if someone believes the provider or facility has violated the requirements described in the notice.

Effective Dates

As mentioned above, the interim final rule is generally applicable to group health plans and health insurance issuers for plan and policy years beginning on or after January 1, 2022. The regulations that apply to health care providers, facilities, and providers of air ambulance services are applicable beginning on January 1, 2022.

The following links will be helpful to those seeking more information:

- Interim Final Rule and Comment Period: https://www.cms.gov/files/document/cms-9909-ifc-surprise-billing-disclaimer-50.pdf

- CMS Fact Sheets: https://www.cms.gov/newsroom/fact-sheets/requirements-related-surprise-billing-part-i-interim-final-rule-comment-period and https://www.cms.gov/newsroom/fact-sheets/what-you-need-know-about-biden-harris-administrations-actions-prevent-surprise-billing

NEW GUIDANCE ON TRANSPARENCY REQUIREMENTS FOR HEALTH PLANS

- FAQs issued to clarify guidance and delaying the enforcement of many of the transparency rules
- The Departments have delayed the enforcement of the provision requiring the publication of three machine-readable files
- The Departments will not issue regulations in time to implement the good faith estimate or Advanced Explanation of Benefits requirements of the CAA

In the face of mounting concern regarding confusing overlapping mandates and looming deadlines, the three federal departments charged with enforcing the various group health transparency mandates — The Department of Labor, the Department of Health and Human Services, and the Treasury (together, the Departments) — have issued FAQ guidance acknowledging the confusion, clarifying some guidance, and delaying the enforcement of many of the transparency rules scheduled to go into effect at the beginning of 2022.

As detailed in our August 4, 2021 briefing, New Transparency Requirements for Health Plans, both regulatory action taken under the ACA (the Transparency in Coverage final rule, or TiC final rule) and statutory changes enacted as part of the budget process (the Consolidated Appropriations Act, 2021 or CAA, which includes the No Surprises Act) are set to require group health plans and carriers to enact a variety of measures intended to give plan members and the public more information regarding the price of health care services and prescription drugs. On August 20, 2021, the Departments issued FAQs which addressed the following issues.

- The passage of CAA significantly changed the regulatory landscape after the TiC final rule was adopted and, many stakeholders have expressed concern about potentially duplicative and overlapping reporting requirements, especially for prescription drugs. Therefore, the Departments have delayed the enforcement of the provision requiring the publication of three machine-readable files.

- The price comparison methods required by the CAA are largely duplicative of the internet-based self-service tool requirements of the TiC final rule. Therefore, the Departments will defer enforcement of the CAA requirement that a plan or issuer make a price comparison tool to bring it into alignment with the similar TiC rule.

- The Departments will not issue regulations in time to implement the good faith estimate or Advanced Explanation of Benefits requirements of the CAA. Enforcement of those provisions will be delayed.

- While grandfathered plans are not subject to the TiC final rule, the Departments confirmed that they are subject to the transparency provisions in the CAA.

- Pending issuance of regulations regarding the ID card requirements, plans should make good faith efforts to comply.

In light of these outstanding issues, the Departments have delayed enforcement of the following:

Requirement	Original Effective Date	Enforcement Date
Machine-readable files — medical (TiC)	1/1/22	7/1/22
Machine-readable files — pharmacy (TiC)	1/1/22	TBD pending further regulatory action
Price-comparison tools (CAA)	Plan years beginning on or after 1/1/22	Plan years beginning on or after 1/1/23
Pharmacy benefit and price information reporting (CAA)	12/27/21	12/27/22
Good Faith Estimate of cost and Advanced EOB (CAA)	Plan years beginning on or after 1/1/22	TBD pending further regulatory action

The FAQs did not delay the following deadlines for transparency provisions:

Requirement	Effective Date
ID cards — cost sharing and contact information (CAA)	Plan years beginning on or after 1/1/22
Provider Directory information	Plan years beginning on or after 1/1/22
Price comparison tools — 500 items and services (TiC)	1/1/23
Price comparison tools — all items and services	1/1/24

AB 845: COVID-19 PRESUMPTION FOR DISABILITY RETIREMENT

- AB 845 temporarily expands eligibility for a disability retirement under the retirement systems governed by the California Public Employees' Pension Reform Act of 2013 (PEPRA)

On July 23, 2021, Governor Gavin Newsom signed into law AB 845 (Chapter 122, Statutes of 2021), a bill that will temporarily create a rebuttable presumption with regard to disability retirement due to COVID-19 that applies to members of public retirement systems in California.

Under California's public retirement systems, a disability retirement is available regardless of the member's age when the member suffers an injury that arouse out of or during the normal course and performance of job duties and the injury is such that the member can no longer perform their job duties. This bill expands eligibility for a disability retirement under the retirement systems governed by the California Public Employees' Pension Reform Act of 2013 (PEPRA) by adding COVID-19 as a factor for two specified groups of public employees:

1. Active firefighting members, peace officers, employees providing direct patient care in health facilities and providers of in-home support services (as defined by Labor Code § 3212.87); and

2. Any public employees who test positive for COVID-19 during an outbreak at their place of employment (as defined by Labor Code § 3212.88).

For a worker in the above categories who retires for disability on the basis of a COVID-19 related illness, there will be a presumption that the disability arose out of or in the course of the worker's employment. The presumption can be rebutted by the employer if there is evidence that the worker may have more likely contracted the virus outside the workplace. This provision goes into effect on January 1, 2022 and will remain in effect until January 1, 2023.

ADDITIONAL IRS Q&AS ON AMERICAN RESCUE PLAN'S COBRA SUBSIDY

- Even if state-mandated continuation coverage would require an assistance-eligible individual to pay premiums directly to the insurer after the period of federal COBRA coverage ends, the insurer is not entitled to claim the premium assistance credit, the common law employer is.
- Although all members of a controlled group are treated as a single employer for employee benefit purposes, each member is a separate common law employer for employment tax purposes.

On July 26, 2021, the IRS issued Notice 2021-46, providing additional guidance on the application of the American Rescue Plan Act (ARPA) subsidy for continuation health coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) in the form of 11 questions and answers.

The Notice expands on prior guidance issued on May 18, 2021.

BACKGROUND

The ARPA subsidy covers 100% of COBRA and state mini-COBRA premiums from April 1–Sept. 30, 2021, for certain assistance-eligible individuals whose work hours were reduced or whose employment was involuntarily terminated. The subsidy is funded via a tax credit provided to employers, insurers or group health plans, according to the terms of the statute.

Q&A TOPICS

The questions addressed include:

- Subsidy availability to individuals eligible for an extension who had not elected it;
- Whether subsidies for vision or dental-only coverage ends due to eligibility for other coverage that does not include vision or dental benefits;
- Subsidy availability under a state statute that limits continuation coverage to government employees;
- Whether employers may claim the tax credit if the Small Business Health Options Program (SHOP) Exchange requires employers to pay COBRA premiums; and
- Which party may claim the tax credit in situations involving parties other than an insurer or former common law employer providing the COBRA coverage.