Welcome to the NCBGH 2022 Fall Forum!

Platinum Sponsor

Gold Sponsors

Cigna®

GRAIL

ABOUT NCBGH

Mission and Charter

North Carolina Business Group on Health is a 501c(6) trade association which acts as advocacy group of employers who use their collective voice to influence decisions that impact the quality and cost of healthcare delivery systems. We will accomplish our mission and foster North Carolina's economic development in the following ways:

- **Advocate** – Create a business community with a shared vision and message on matters of healthcare policy, regulation, and legislation based on sound fiscal principles and quality standards.

- **Innovate** – Seek creative, common sense solutions to improve the overall cost and quality of our healthcare delivery system.

- **Educate** – Promote health and wellness education. Advocate for provider performance disclosure of both quality and outcomes to help employees become better consumers of healthcare services.

NCBGH Initiatives

- **Routine Screenings**
  - My-Health-NC.com
    - Quick resource for preventive screening and vaccination information
    - Links to help find doctor for all major carriers and Community Health Centers
  - Billboards courtesy of NC Medical Society

- **Hospital Transparency**
  - Roundtable
  - Playbook

- **Oncology Roundtable**
  - Resources at NCBGH.org

- **Culture of Wellness Award**
  - 2022 Winners: Alex Lee, Inc., and Cleveland County Government
  - 2023 (2nd Annual) applications open January 2nd

- **Coming:** *Prescriptive Digital Therapeutics (PDTs) Learning Collaborative*

Legal Upate

Scott Segal, J.D.

ERISA and Employee Benefits Council
USI Insurance Services

Benefits Compliance 2022
Where Are We Now?

October 7, 2022

Scott Segal, USI ERISA & Employee Benefits Counsel

© 2022 USI Insurance Services. All rights reserved.

Today's Agenda

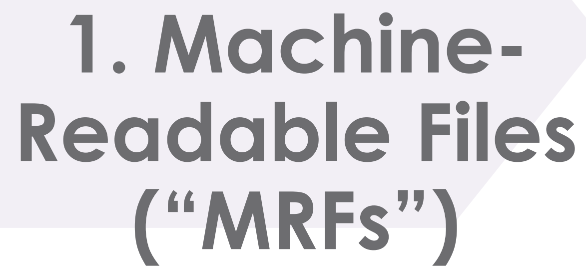
- Transparency Requirements
- Consumer Protections
- Mental Health Parity Initiatives
- COVID-19 Rules
- Post Dobbs
- Other Notable Updates
- Preparing for 2023

© 2022 USI Insurance Services. All rights reserved.

Transparency In Coverage ("TiC")

© 2022 USI Insurance Services. All rights reserved.

Two Requirements



© 2022 USI Insurance Services. All rights reserved.

Posting Machine-Readable Files

Non-grandfathered group health plans and carriers must publish machine-readable files ("MRFs")

Disclosure of the In-Network Rate File and Allowed Amount file due by:

- **July 1, 2022** – for plan years that began between Jan. 1, 2022 – July 1, 2022
- For other plan years, plan year start month

Files must be updated monthly

Posting prescription drug file delayed pending guidance

In-Network Rate File

- Negotiated rates for all covered items and services between the plan or carrier and in-network providers

Allowed Amount File

- Allowed amount paid to, and billed charges from, OON providers for all covered services within a 90-day period

Prescription Drug File (*delayed*)

- Negotiated rates and historical net prices for covered prescription drugs

© 2022 USI Insurance Services. All rights reserved.

Posting Machine-Readable Files (cont.)

- MRFs must be posted to an internet website that is accessible to the public free of charge
  - No user account, password or other credentials
  - Posting to an intranet page or specific portal is not sufficient
- A lot of confusion around the posting requirement – who is responsible?

Fully Insured	Self-Funded
• Carrier is responsible • Employers can rely on the carrier to post this information if there is a written agreement between the plan and carrier • If no written agreement – employers should post link to MRFs on the employer's public facing website	• Employers may contract with their TPA to create and publicly post the plan's MRFs – plan remains liable • Best practice, if TPA posts the files on behalf of the plan, consider adding a link to the MRFs on the plans (or employer's) public facing website

© 2022 USI Insurance Services. All rights reserved.

Price Transparency and Comparison Tools

- Applies to all group health plans (including grandfathered plans)
- Plans must provide covered members a disclosure of cost sharing information in advance of receiving care through an internet-based self-service tool, in paper form or by telephone
  - Provided in advance of medical treatment (not after)
  - Must be provided in "plain language" – manner calculated to be understood by the average participant
- Initial compliance with respect to 500 identified items and services beginning with the first plan year on or after January 1, 2023
  - Full compliance (all items and services) required beginning with the first plan year on or after January 1, 2024

© 2022 USI Insurance Services. All rights reserved.

Content Requirement

Estimated cost sharing	Estimate of member's cost sharing at time request is made
Accumulated amounts	Accumulated amounts of the member's cost sharing already incurred
In-network negotiated rates	Amount the plan pays in-network provider for the items or service
OON allowed amounts	Maximum allowed amount that could be paid for the items or service out-of-network
Bundled payment arrangements (if applicable)	Cost-sharing for each item or service within the bundled arrangement
Coverage prerequisites	Any requirements (e.g., prior authorization, step-therapy) to satisfy before member receives item or service
Disclosure	Disclosure of certain key terms and other information – draft model notice available

© 2022 USI Insurance Services. All rights reserved.

Price Transparency and Comparison Tools (cont.)

Who is responsible?

Fully Insured	Self-Funded
• Carrier is responsible • Employers can rely on the carrier to provide these tools if there is a written agreement between the plan and carrier	• Employers may contract with their TPA to provide these tools (most do) – plan remains liable

© 2022 USI Insurance Services. All rights reserved.

Good Faith Compliance – Safe Harbor

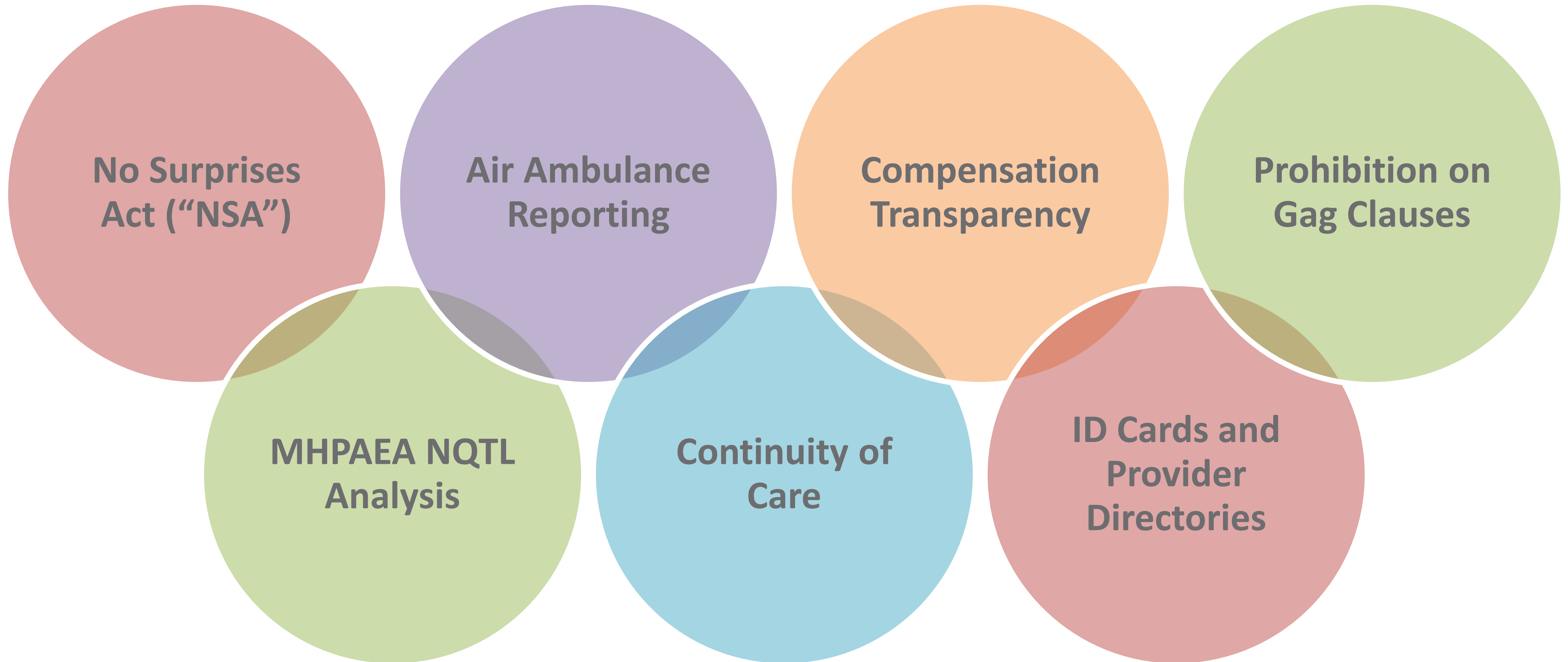
- For both TiC requirements, rules provide for good faith compliance
- A plan or carrier will not fail to comply with these requirements when, acting in good faith and with reasonable diligence:
  - an error or omission in the required disclosure is made, provided the information is corrected as soon as practicable
  - the internet website hosting the MRF files is temporarily inaccessible, provided that the plan or carrier makes the information available as soon as practicable
- Further, when information must be obtained from a third party, the plan or carrier will not fail to comply with this requirement because it relied in good faith on the information provided by the third party, unless it is known (or reasonably should have known) the information is incomplete or inaccurate

© 2022 USI Insurance Services. All rights reserved.

CAA Requirements

© 2022 USI Insurance Services. All rights reserved.

CAA Requirements – Currently In Effect



© 2022 USI Insurance Services. All rights reserved.

NSA – Overview

- Effective first plan year on or after January 1, 2022
- Applies to all group health plans
- Self-funded plans are subject to the NSA and responsible for compliance (TPA assistance needed)
  - Where allowed, may "opt in" to an available state program with additional consumer protections and
- Fully insured plans are subject to the NSA unless state law or the All-Payer Model Agreement ("APMA") applies
  - Carrier responsible for compliance for fully insured plans

© 2022 USI Insurance Services. All rights reserved.

NSA – Claims Protected

OON emergency services

Non-emergency services furnished by an OON provider in an in-network facility

OON air ambulance services

- These services must be provided to the member:
  - Without cost-sharing greater than what applies when provided in-network
  - By calculating the cost-sharing based on the “recognized amount” for such services
  - By counting any cost-sharing toward the in-network deductible and/or out-of-pocket maximum (“OOPM”)
- Provider may not bill the member more than cost-sharing amount (no “balance billing”)

© 2022 USI Insurance Services. All rights reserved.

NSA – Notice and Consent Exception

- OON provider furnishing non-emergency, *non-ancillary services* to the member may be able to balance bill the member when:
  - the provider gives the patient advance oral and written notice (in an approved form, manner and timing); and
  - The patient provides written and signed consent
- Exception cannot be used for ancillary services, which include items and services:
  - related to emergency medicine, anesthesiology, pathology, radiology, and neonatology
  - provided by assistant surgeons, hospitalists, and intensivists;
  - that are diagnostic services, including radiology and laboratory services
  - provided by an OON provider, only if there is no in-network provider who can furnish such item or service at such facility

© 2022 USI Insurance Services. All rights reserved.

NSA – IDR Process

- The NSA provides an Independent Dispute Resolution (“IDR”) process for resolving payer-provider payment disputes using negotiation and arbitration
- Process will likely be handled between the provider and the claims administrator (e.g., carrier or TPA)
  - Self-funded plans may see an additional administrative charge or other fees assessed to support NSA compliance
  - Should be addressed in administrative agreements

Federal IDR Process Guidance for Disputing Parties (April 2022)

© 2022 USI Insurance Services. All rights reserved.

NSA – Notice

- Group health plans (and carriers) must provide a notice of the protections under the NSA and:
  - post it to a public website of the plan/carrier, and
  - include it on each EOB for an item or service with respect to which the NSA applies
- If a state balance billing law applies, state information must be included in the notice

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

[*Insert plain language summary of any applicable state balance billing laws or requirements OR state-developed model language as appropriate*]

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

© 2022 USI Insurance Services. All rights reserved.

Air Ambulance Reporting

- Plans and carriers must submit data regarding air ambulance services to HHS on a calendar year basis for two years
- Must be submitted within 90 days of the end of the calendar year (regardless of plan year)
  - For CY 2022, submit by March 31, 2023
  - For CY 2023, submit by March 31, 2024
- Pending guidance

© 2022 USI Insurance Services. All rights reserved.

Continuity of Care

Effective for PY's beginning on or after January 1, 2022, all group health plans and carriers must:

- Timely provide notice to the covered *continuing care patient* of the termination of the provider/facility;
- Allow the individual an opportunity to elect transitional care; and
- If the individual elects transitional care, provide benefits under the same terms and condition as would have applies had the contract not terminated for up to 90 days

Good faith compliance pending issuance of further guidance

Continuing care patient is an individual who is, with respect to the provider or facility:

- undergoing a course of treatment for a serious and complex condition
- undergoing a course of institutional or inpatient care
- scheduled to undergo nonelective surgery (including postoperative care)
- is pregnant and undergoing a course of treatment for the pregnancy
- is or was determined to be terminally ill and receiving treatment for such illness

© 2022 USI Insurance Services. All rights reserved.

Continuity of Care (cont.)

Requirement to provide notice and transitional care applies when:

- The contractual relationship between plan and provider/facility is terminated
- Benefits provided by the plan with respect to the provider/facility are terminated because of a change in the terms of participation of the provider/facility in the plan
- Contract between group health plan and a carrier offering coverage in connection with the plan is terminated resulting in a loss of benefits provided under the plan with respect to such provider/facility

Appears to apply if you move to a new network at renewal where the provider or facility is not "in-network"

© 2022 USI Insurance Services. All rights reserved.

Compensation Transparency

- Fiduciaries of ERISA covered group health plans must have a written contract with “brokers” and “consultants” that provides disclosure of specific compensation information
  - Services provided to the plan
  - Direct, indirect compensation ($ amounts, percentage, range okay)
  - Transaction based compensation
  - Compensation in connection with termination
- Effective for contracts entered, extended or renewed on or after December 27, 2021
  - If there is a Broker of Record letter – disclosure must be provided to the plan prior to carrier submission
- A group health plan includes:
  - Major medical, dental and vision
  - Certain tax favored plans (e.g., health FSA, HRA, ICHRA)
  - EAPs, wellness program, DM, telehealth, onsite clinics

© 2022 USI Insurance Services. All rights reserved.

Provider Directories and ID Cards

- Effective for plan years beginning on or after January 1, 2022
- Good faith compliance pending issuance of further guidance
- **Provider Directories.** Plans must:
  - Update and verify the accuracy of provider directory information (every 90 days)
  - Establish a protocol for responding to requests by telephone and email from a member about a provider's network participation status
  - If inaccurate information reflects that a provider or facility was a participating provider is relied upon by a participant or beneficiary, the plan must treat as "in-network"
- **ID Cards.** Plans must include in clear writing, on any physical or electronic plan or insurance identification (ID) card issued to participants and beneficiaries, any applicable deductibles, any applicable out-of-pocket maximum limitations, and a telephone number and website address for individuals to seek consumer assistance

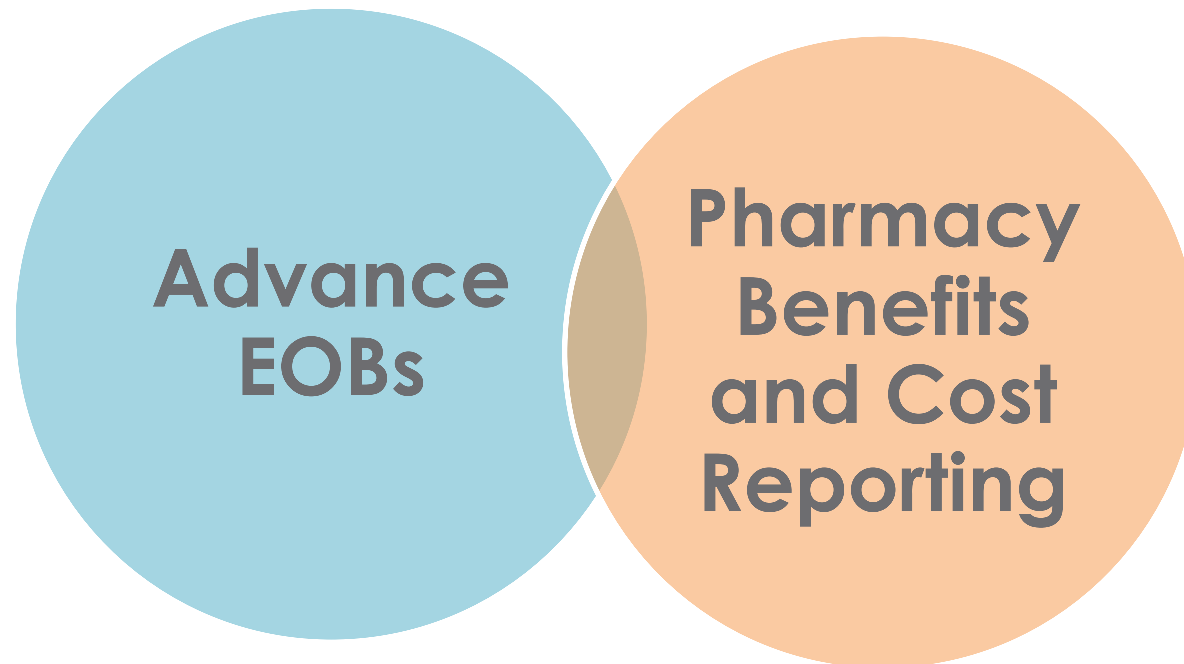
© 2022 USI Insurance Services. All rights reserved.

Prohibition on Gag Clauses

- Plans and carriers may not enter into an agreement with a provider, network, TPA or other service provider offering access to a network of providers that directly (or indirectly) restricts the plan from:
  - providing provider-specific cost or quality of care information or data;
  - electronically accessing de-identified claims and encounter data for each participant or beneficiary; and
  - sharing such information, consistent with applicable privacy regulations
- An attestation of compliance must be filed annually – further guidance expected with a compliance date in 2022 anticipated
- Good faith compliance pending issuance of further guidance
- Applies to all group health plans

© 2022 USI Insurance Services. All rights reserved.

CAA Requirements – Coming Soon



© 2022 USI Insurance Services. All rights reserved.

Advance EOBs

When items or services are scheduled providers will be required to provide a Good Faith Estimate ("GFE") of the expected charges for the items and services to the group health plan

The plan, after receiving a GFE, will need to send the member an Advance EOB

Not currently enforced – pending guidance

- Future guidance will include a prospective date for plans to comply

- The Advance EOB must include:
  - the network status of the provider or facility;
  - the contracted rate of the item or service;
  - the good faith estimate received from the provider;
  - a good faith estimate of the amount the plan is responsible for paying for the item or service and the amount of any cost-sharing the individual will be responsible for paying; and
  - disclaimers explaining whether the item or service is subject to any medical management techniques

© 2022 USI Insurance Services. All rights reserved.

Sec. 204 Pharmacy Reporting

- Under CAA 2021 (Sec. 204), group health plans and insurers will be required to annually report on their pharmacy benefits and costs to IRS, DOL, HHS
  - Report will be submitted through CMS
- Reported on a CY (not PY) basis
- Timing
  - CY 2020 and 2021 information must be submitted by December 27, 2022;
  - CY 2022 information by June 1, 2023;
  - CY 2023 information by June 1, 2024; etc.
- Employer may enter into agreement with carrier (insured) or TPA (self-funded) to submit reporting on behalf of the plan ("reporting entity")
  - Multiple reporting entities permitted (e.g., TPA and PBM)
  - For example, a self-funded group health plan may contract with a TPA to submit the Spending by Category data file and separately contract with a PBM to submit the Top 50 Most Costly Drugs file

© 2022 USI Insurance Services. All rights reserved.

Sec. 204 Pharmacy Reporting – What's Reported

- Number of enrollees
- States in which the plan is offered
- 50 most common brand prescription drugs dispensed
- 50 most costly drugs by total annual spending
- 50 drugs with the greatest year-over-year cost increase for the plan
- Total spending by the plan broken down by:
  - Types of cost (e.g., hospital, primary care, specialty care, provider and clinical service costs, prescription drugs, wellness) and
  - Plan and enrollee spending on prescription drugs
- Average monthly premiums paid by the employer and the enrollees
- Impact on premiums and out-of-pocket costs associated with rebates, fees or other payments by drug manufacturers to the plan or the plan's administrators, and certain specifics about those rebates/payments

© 2022 USI Insurance Services. All rights reserved.

Information to be Reported

I114 | Client/PBM responsible

Carrier/TPA Responses - CAA Section 204 Pharmacy Reporting Specifics

Plan lists P1 (Individual and Student Market Plan List) and P3 (FEHB Plan List) are not included in this chart as they are not applicable to employer group health plans.

TPA/PBM		Plan Design			P2	D1	D2	D3	D4	D5	D6	D7	D8
TPA/PBM	**Notes (regarding questions/confirming answer, etc.)**	**FI/SF**	**PBM**	**Integrated/ Carve-out Rx or Stop Loss**	**Group Health Plan List**	**Premium and Life Years**	**Spending by Category**	**Top 50 Most Request Brand Drugs**	**Top 50 Most Costly Drugs**	**Top 50 Drugs by Spending Increase**	**Rx Totals**	**Rx Rebates by Therapeutic Class**	**Rx Rebates for the Top 25 Drugs**
Aetna/ Meritain		SF	CVSC	Integrated Rx	Aetna/ Meritain will submit	Aetna/ Meritain will submit	Aetna/ Meritain will submit	Aetna/ Meritain will submit	Aetna/ Meritain will submit	Aetna/ Meritain will submit	Aetna/ Meritain will submit	Aetna/ Meritain will submit	Aetna/ Meritain will submit
Aetna/ Meritain		SF		Carve-out Rx	Aetna/ Meritain will submit	Aetna/ Meritain will submit	Aetna/ Meritain will submit	Client/PBM responsible	Client/PBM responsible	Client/PBM responsible	Client/PBM responsible	Client/PBM responsible	Client/PBM responsible
Allied		SF		Integrated Rx	Allied will submit	Allied will submit	Allied will submit	Allied will submit	Allied will submit	Allied will submit	Allied will submit	Allied will submit	Allied will submit
Allied	Confirming how Aetna/Meritain will handle SF groups with carve-out Rx	SF		Carve-out Rx				Client/PBM responsible	Client/PBM responsible	Client/PBM responsible	Client/PBM responsible	Client/PBM responsible	Client/PBM responsible
Anthem		FI	Ingenio-Rx	Integrated Rx	Anthem will submit	Anthem will submit	Anthem will submit	Anthem will submit	Anthem will submit	Anthem will submit	Anthem will submit	Anthem will submit	Anthem will submit
Anthem	Confirming how Anthem will handle SF groups with integrated Rx but carve-out stop loss	SF	Ingenio-Rx	Integrated Rx	Anthem will submit	Anthem will submit	Anthem will submit	Anthem will submit	Anthem will submit	Anthem will submit	Anthem will submit	Anthem will submit	Anthem will submit
Anthem	Confirming how Anthem will handle SF gr[illegible]s with carve-out Rx (and carveou[illegible]op loss)	SF		Carve-out Rx				Client/PBM responsible	Client/PBM responsible	Client/PBM responsible	Client/PBM responsible	Client/PBM responsible	Client/PBM responsible
Bas Health		SF		Integrated Rx									
Bas Health	Confirming h[illegible] Bas Health will handle SF gr[illegible]s with carve-out Rx	SF		Carve-out Rx									
BCBS AL		FI	Prime Therapeutics	Integrated Rx	BCBS AL will submit	BCBS AL will submit	BCBS AL will submit	BCBS AL will submit	BCBS AL will submit	BCBS AL will submit	BCBS AL will submit	BCBS AL will submit	BCBS AL will submit

RxDC Specifics by Vendor | RxDC Snapshot - Who will submit | Info clients may need to provi | P2 Group Health Plan List | D1 Premium and Life Years ...

© 2022 USI Insurance Services. All rights reserved.

Who will generally submit the RxDC reports

Generalizations – Note exceptions*	P2 Plan List	D1 Premium and Life Years	D2 Spending by Category	D3 – D8 Rx Files	Employer Responsibility
Fully Insured	Carrier will submit file	Carrier will submit file	Carrier will submit file	Carrier will submit files	· Provide any information requested by carrier · Verify carrier will submit all files
Self-Funded w Integrated Rx	TPA will submit file Note – if employer is responsible for any data files, employer must submit P2 with the data file(s)	TPA will submit file Note: several Blues TPAs*and UHC Key Accounts (not UMR) indicate they will provide D1 to employer for submission because they don't have all info in their systems	TPA will submit file	TPA will submit files	· Provide any information requested by TPA · Verify TPA will submit D1 and D2 or if employer must submit D1 · Verify TPA will submit D3-D8
Self-Funded w Rx Carve-Out	TPA will submit file Note - if employer is responsible for any data files, employer must submit P2 with the data file(s)	TPA will submit file Note: several Blues TPAs* and UHC Key Accounts (not UMR) indicate they will provide D1 to employer for submission because they don't have all info in their systems	TPA will submit file	PBM* will submit files or provide to employer for submission PBMs may be charging for this reporting, whether submitting for the employer or providing files to employer for submission	· Provide any information requested by TPA · Verify TPA will submit D1 and D2 or if employer must submit D1 · Provide any information requested by PBM · Verify PBM will submit D3-D8 or if employer must submit
Self-Funded w Stop-Loss Carve-Out	TPA will submit file Note – if employer is responsible for any data files, employer must submit P2 with the data file(s)	TPA will submit file Note: a few TPAs* state they will provide D1 to employer for submission because they don't have stop-loss premium if stop-loss is carved out	TPA will submit file	See above regarding self-funded with or without Rx carve-out for handling of Rx files D3-D8	· Provide any information requested by TPA · Verify TPA will submit D1 and D2 or if employer must submit D1 · See above regarding self-funded with or without Rx carve-out

© 2022 USI Insurance Services. All rights reserved.

Mental Health Parity and Addiction Equity Act

© 2022 USI Insurance Services. All rights reserved.

Mental Health Parity & Addiction Equity Act (MHPAEA)

- Generally, requires group health plans that provide coverage for Mental Health and Substance Use Disorder (MH/SUD) benefits to ensure the financial requirements and any treatment limitations (quantitative and non-quantitative) imposed on MH/SUD benefits are not more restrictive than other medical/surgical benefits
- Applies to:
  - Self-funded group health plans that offer any mental health or substance use disorder benefits where the employer has more than 50 employees
  - Fully insured group health plans
- A comparative analysis requirement for non-quantitative treatment limitations took effect February 10, 2021
- Enforcement priority of the DOL and Biden administration

© 2022 USI Insurance Services. All rights reserved.

MHPAEA – Comparative Analysis Requirement

- A group health plan or carrier must perform and document comparative analyses of the design and application of *NQTLs**
- Must provide upon request of federal or state agency, participants, beneficiaries and authorized representative
- Self-funded plans and/or carveout arrangements (i.e., PBM carveout) will need to work with TPAs to determine capabilities for providing a comparative analysis
- Updated DOL self-compliance tool and additional guidance expected in 2022

**NQTLs* are *nonquantitative treatment limitations* – limits on the scope or duration of treatment that are not expressed numerically such as medical management techniques like prior authorization. Note, MHPAEA also requires parity with respect to quantitative treatment limits (e.g., day visits) and financial requirements (e.g., copays, deductibles)

© 2022 USI Insurance Services. All rights reserved.

MHPAEA Comparative Analysis – Rocky Road

- In its first report to Congress that included information on the comparative analysis, the DOL indicated NONE of the analyses contained sufficient information upon receipt

- Once the DOL received enough information from plans, the DOL found parity violations that included the following NQTLs
  - Limits or exclusions on applied behavior analysis therapy (“ABA therapy”) or other services to treat autism disorder
  - Billing requirements – licensed MH/SUD providers can bill the plan only through specific types of providers
  - Limitation or exclusion of medication-assisted treatment for opioid use disorder
  - Preauthorization or precertification
  - Maximum allowable charge and reference-based pricing
  - Age, scope, or duration limits

© 2022 USI Insurance Services. All rights reserved.

MHPAEA Comparative Analysis – Rocky Road (cont.)

- The DOL worked with plans and carriers who had parity issues on the following resolution:
  - Removal of a specific NQTL limiting MH/SUD benefits, including changes to plan document language and changes to claims processing procedures
  - Addition of coverage for MH/SUD benefits previously excluded
  - Reduction of scope of an NQTL imposed on MH/SUD benefits; and
  - Notice to participants and beneficiaries of a change in plan terms

- DOL is expected to issue updated guidance on this topic in summer 2022

- Big focus area for DOL right now appears to be:
  - Limits/exclusions on ABA therapy
  - Limits/exclusions on residential treatment for eating disorders

© 2022 USI Insurance Services. All rights reserved.

COVID-19 Benefit Plan Design

© 2022 USI Insurance Services. All rights reserved.

Emergency Period and Outbreak Period

- **Emergency Period**
  - HHS announced a Public Health Emergency Period beginning January 27, 2020, due to the COVID-19 pandemic
  - Currently set to expire **October 13, 2022**, unless extended or shortened by HHS
- **Outbreak Period**
  - The Outbreak Period started on March 1, 2020
  - The end date is applied on a participant-by-participant basis and is the earlier of 1) one year after the date the participant was eligible for relief and 2) 60 days after the announced end of the National Emergency*

* For purposes of the Outbreak Period, on March 13, 2020, President Trump, in Proclamation 9994, declared a national emergency concerning the COVID-19 pandemic, effective beginning March 1, 2020. A national emergency generally extends for one year. On February 24, 2021, President Biden issued a Notice continuing the national emergency beyond March 1, 2021, for an effective extension to February 28, 2022. On February 18, 2022, President Biden issued a Notice continuing the National Emergency beyond March 1, 2022, for an effective extension to February 28, 2023 (unless an earlier termination is announced). The announced end date of the National Emergency may not be the same date as the end of the Public Health Emergency period announced by HHS.

© 2022 USI Insurance Services. All rights reserved.

HHS Emergency Period

COVID-19 Emergency Period through **July 15, 2022** (unless extended or shortened by HHS)

For the duration of the Emergency Period:

- Plans must cover COVID-19 tests with a doctor's order (and expanded OTC testing) and vaccines
- EAPs will not lose excepted status because medical benefits for COVID-19 testing or diagnosis are offered
- For plan years that begin before the end of the emergency period, telehealth may be provided by large employers to employees who are not eligible for other group health plan coverage offered by the employer
- SBC 60-day notice relaxed
- No loss of grandfathered status for COVID-19 benefit enhancements (then removal after end of emergency period)

© 2022 USI Insurance Services. All rights reserved.

Required Deadline Extensions

Deadlines are suspended from March 1, 2020, until the earlier of:
1) one year from the date an individual is first eligible for relief, or 2) the end of the Outbreak Period

	Plans Affected	What's Extended
Special enrollment rights	Medical Only	✓ Date to exercise a special enrollment right (30 days for loss of eligibility or acquisition of a dependent, 60 days for Medicaid/CHIPRA eligibility or premium assistance)
COBRA	Medical, Dental, Vision, Health FSA, EAPs, Onsite Clinics	✓ Date for the plan to provide COBRA election notice ✓ 60-day election period ✓ Due date for timely COBRA premium payments ✓ Due date to notify of a qualifying event or disability determination
Claims for benefits	All ERISA covered benefits	✓ Date to file a benefit claim
Appeals of denied claims	All ERISA covered benefits	✓ Date to file an appeal of an Adverse Benefit Determination ("ABD")
External review	Non-grandfathered medical plans	✓ Date to request an external review after receipt of an ABD ✓ Date to file information to perfect a request for external review

Coordination with COBRA vendors and carriers (including stop loss) will be important as the end of the deadline period approaches for each individual. In some cases (COBRA, birth/adoption, claims), retroactive coverage may be required.

© 2022 USI Insurance Services. All rights reserved.

COVID-19 Checklist

- ❑ Ensure coverage requirements follow ongoing COVID-19 requirements (e.g., testing)
- ❑ While the Outbreak Period runs, new COBRA events, special enrollment rights and claims all have the additional deadline relief
- ❑ Important to confirm and discuss with services providers – especially if you are making changes (e.g., COBRA, health FSA, stop loss)
- ❑ Await further guidance as the pandemic moves into the endemic phase and at what point some of these plan design requirements may change or be lifted

© 2022 USI Insurance Services. All rights reserved.

Post-*Dobbs* Considerations

© 2022 USI Insurance Services. All rights reserved.

Key Details

- On June 24, 2022, the U. S. Supreme Court ruled in *Dobbs v. Jackson Women's Health Organization* the right to decide whether to permit abortions falls to the states – overturning *Roe v. Wade*
- Many employers are looking for ways to preserve access to abortion services
  - There are health plan and other compliance issues to consider
  - Employers should proceed with the support of legal counsel
- Information in this area is changing as guidance develops from the courts, states, and federal government

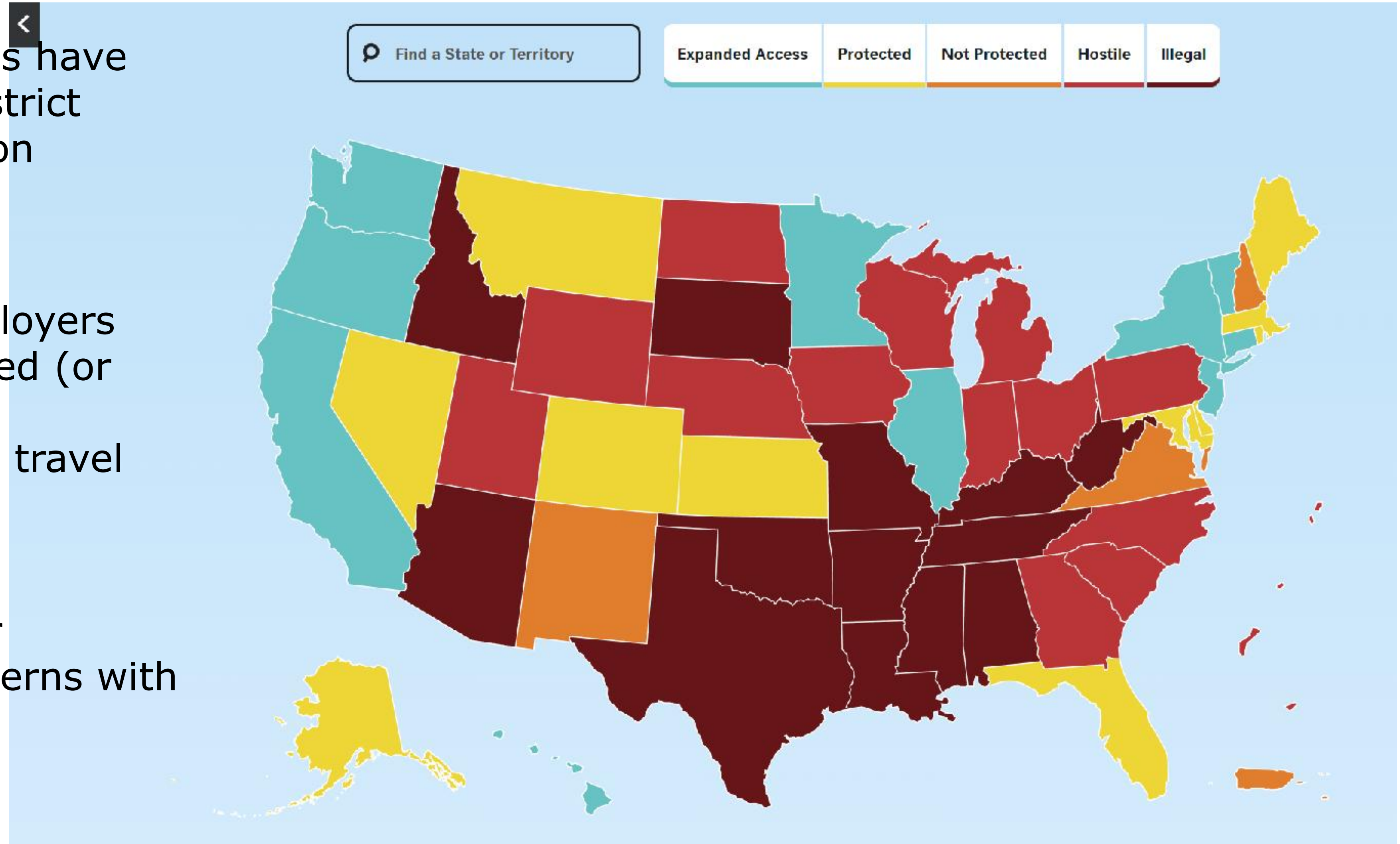
© 2022 USI Insurance Services. All rights reserved.

Current Status of Access in the USA

- At least 26 states have prohibited or restrict access to abortion services.

- Some large employers have implemented (or have discussed implementing) a travel benefit.

- ERISA and other compliance concerns with any program.



© 2022 USI Insurance Services. All rights reserved.

ERISA Preemption

- ERISA preempts state laws that relate to employee benefit plans (e.g., a medical plan)
  - State civil laws, like those in TX and OK, may be preempted by ERISA because the state law relates to the payment of benefits in an ERISA plan
    - This is likely an area where we will see legal challenges and litigation
- ERISA does not preempt:
  - State insurance laws
  - "Generally applicable" state criminal laws
    - Texas Republicans have indicated they are looking to add criminal liability to get at self-funded plans (See letter from Freedom Caucus to Sidley Austin, July 8, 2022)
  - State civil laws where the state is exercising its general police powers (e.g., public safety)

© 2022 USI Insurance Services. All rights reserved.

Health Plan Compliance Issues

Plan Design

- Self-funded ERISA plans generally have the flexibility to expand access to reproductive services. State laws govern fully insured plans, and in some states, services may be limited or restricted
  - Understand whether your TPA can administer the travel benefit and any additional costs with expanding the coverage
- Plan materials should be updated to reflect the new benefits, eligibility, and the process for claims reimbursement
  - Provide notice of the benefit plan change to plan participants as soon as practicable
- Eligibility may need to be limited to those covered by the group health plan due to ACA concerns

© 2022 USI Insurance Services. All rights reserved.

Health Plan Compliance Issues (cont.)

Plan Design (cont.)

Prescription drug coverage

- Non-grandfathered plans must cover ACA mandated preventive care in-network without cost sharing, which includes access to FDA-approved contraceptive methods, including birth control pills, implanted devices, and emergency contraception
- Many states that restrict access to abortion services prohibit the use of telehealth or mail-order prescription for medication abortion
- Through Executive Order, HHS has been directed to take additional action to protect and expand access to approved medication abortion
  - Legal challenges between the states and federal government are expected

© 2022 USI Insurance Services. All rights reserved.

Health Plan Compliance Issues (cont.)

Health Reimbursement Account (“HRA”)

- If offering the benefits through an HRA, must be integrated with other major medical coverage (cannot be offered on a stand-alone basis)
- Excepted benefit HRA may be an option, but reimbursement amount is limited ($1,800 in 2022)

HDHPs and HSAs

- First dollar travel medical benefits may be disqualifying coverage for purposes of HSA contributions if provided before the satisfaction of the minimum deductible for a qualified HDHP

Mental Health Parity and Addiction Equity Act (“MHPAEA”)

- There may be a MHPAEA issue if travel benefits are not available for mental health and substance use disorder benefits
- Consider providing coverage for all medical care (including mental health and substance use disorder benefits) that cannot be accessed within a certain radius

© 2022 USI Insurance Services. All rights reserved.

Health Plan Compliance Issues (cont.)

Privacy

- HIPAA privacy rules should protect the covered individuals protected health information ("PHI") that would be housed by the group health plan (covered entity). PHI cannot be used or disclosed without an individual's signed authorization except in limited circumstances
- Privacy rule permits (but does not require) disclosure with respect to certain law enforcement activities. Disclosure is not permissible without court order.
  - It is uncertain how this may be applied in the context of states seeking to enforce state laws prohibiting or limiting abortion services

© 2022 USI Insurance Services. All rights reserved.

Employer Next Steps

Employers should:

- Review potential legal issues with counsel both under the group health plan as well as in connection with their general business operations before implementing these programs to understand the potential legal risks and obligations
- Consider non-legal/business issues
  - States may be unwilling to contract with businesses who provide these benefits
- Continue to monitor developments in this space and determine what (if any) changes in the group health plan should be considered

© 2022 USI Insurance Services. All rights reserved.

Other Notable Developments

© 2022 USI Insurance Services. All rights reserved.

HDHP Telehealth Relief Expanded

- CARES Act relief allowing first dollar telehealth or other remote care services to be provided without jeopardizing an individual's ability to contribute to an HSA expires for the first plan year that begins on or after January 1, 2022
- CAA-22 provides a temporary extension of the relief from April 1, 2022, through December 31, 2022
  - Free telehealth or other remote care services provided during this timeframe and prior to satisfaction of the minimum HDHP deductible will not jeopardize an individual's HSA eligibility
  - Relief is permissive (not mandatory)
- Creates some administrative complexities

© 2022 USI Insurance Services. All rights reserved.

Section 1557 Nondiscrimination Rules

HHS proposed rule to expand the interpretation and application of ACA Section 1557 to include

- Reinstatement of protections on the basis of gender identity
- Expansion of who is subject to Section 1557
- Reinstating certain notice requirements

Section 1557 prohibits discrimination in certain health care programs and activities on the basis of race, color, national origin, sex, age, or disability

- Proposed Rule would be effective date 60 days after publication in the Federal Register of the Final Rule.

© 2022 USI Insurance Services. All rights reserved.

Section 1557 Nondiscrimination Rules

Reinstates the scope of Section 1557 to cover HHS' health programs and activities

- Generally, applies to every health program that receives federal financial assistance, directly or indirectly, from HHS
- Clarifies the application of Section 1557 nondiscrimination requirements to health insurance issuers that receive federal financial assistance.
- The proposed rule would not apply Section 1557 to an employer's employment practices, but Office of Civil Rights (OCR) can refer complaints to EEOC/DOJ for possible violations
- Reinstates definition of discrimination to include pregnancy termination

© 2022 USI Insurance Services. All rights reserved.

Proposed Rule to Fix the Family Glitch

Proposed rule would expand availability of premium tax credits ("PTCs") in the Marketplace for family members of employees with employer provided coverage (likely effective beginning January 1, 2023)

Family members may access PTCs if the cost for the employee to cover the employee and family members is more than 9.5%* of household income

- May also access PTCs if the coverage offered to family members does not meet minimum value

*9.5% is the original threshold – it has been adjusted for inflation

- Impact to employer sponsored plans
  - Does not affect affordability for purposes of the employer mandate
    - Whether coverage is affordable is based on the cost of self-only coverage in the lowest-cost plan that provides minimum value
  - Employers may see employees more closely evaluate options for family members in the Marketplace – migrate from the employer plan
  - Changes to the Form 1095-C

© 2022 USI Insurance Services. All rights reserved.

Wrap Up

© 2022 USI Insurance Services. All rights reserved.

Upcoming Deadlines and Next Steps

- Ensure MRFs are posted to a public website
- Prepare for compliance with member disclosure of TiC price comparison tools
- Monitor ongoing compliance with CAA provisions already in effect and await guidance on those that are delayed
  - By December 27, 2022 – coordinate/confirm with TPAs/PBM to have CAA 204 pharmacy reporting submitted to HHS
  - Continuity of care requirements if provider network is changing
  - By March 1, 2023 – furnish first air ambulance reports (likely in coordination with carrier/TPA)
- Continue coverage and Outbreak Period compliance associated with the COVID-19 pandemic

© 2022 USI Insurance Services. All rights reserved.

QUESTIONS?

© 2022 USI Insurance Services. All rights reserved.

Scott D Segal

ERISA & EB Counsel

USI Southeast

The information in this presentation was current as of October 7, 2022.

CONFIDENTIAL AND PROPRIETARY: This presentation contains confidential & proprietary information of USI Insurance Services and may not be copied, reproduced, and/or transmitted without the express written consent of USI. The information contained herein is for general information purposes only and should not be considered legal, tax, or accounting advice. Any estimates are illustrative given data limitation, may not be cumulative, and are subject to change based on carrier underwriting.

© 2022 USI Insurance Services. All rights reserved.

Transparency in Pharmaceuticals

Moderator

Rochelle Henderson,
Vice President – Research
National Pharmaceutical Council

Panelists

- ➢ *Jim Curotto, VP of Integrated Account Management, Merck*
- ➢ *Dwight Davis, Senior Benefits Consultant, PSG*
- ➢ *Kim Davis, Sr. Director HR Operations, Compensation & Benefits, Alex Lee, Inc.*
- ➢ *Cory Super, Vice President of Sales, Navitus Health Solutions*

Hospital Transparency

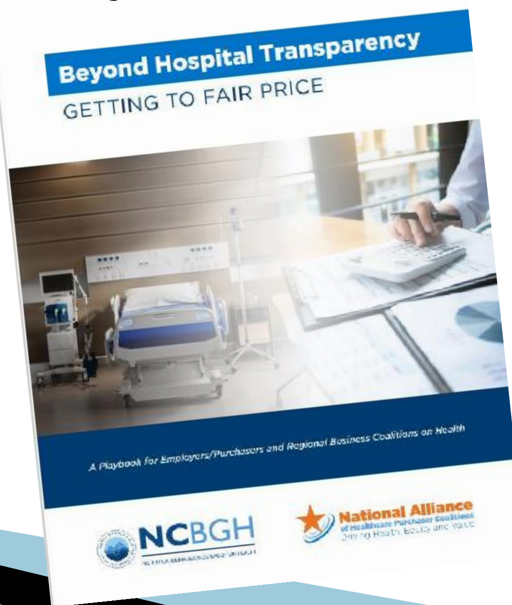
New Data and Tools for Employers

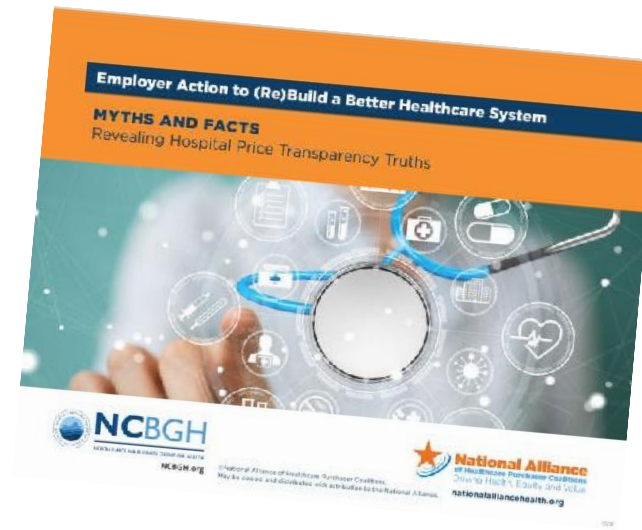
- National Alliance Employer Roundtables & Playbook
- RAND National Hospital Price Transparency Study
- National Academy for State Health Policy
- Turquoise Health
- Quantros / Healthcare Bluebook
- Centers for Medicare and Medicaid Services
- Leapfrog Hospital Safety Grades

Employer Roundtable

- Employer Roundtable on Hospital Transparency held in early August
  - Thanks to: City of Charlotte, Bernhardt Furniture, Volvo Group, Duke University, Alex Lee, Charlotte Pipe, Autobell, The Fresh Market, NC State Health Plan

- “Playbook” and “Myths & Facts” developed through National Alliance





Hospital Price Increases Have Outpaced Every Major Segment of the Economy

Selected Consumer Goods & Services, Wages (January 1998 to December 2018)

250%
200%
150%
100%
50%
0
-50%
-100%

MORE EXPENSIVE

MORE AFFORDABLE

1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018

Hospital Services
College Tuition & Fees
College Textbooks
Child Care & Nursery School
Medical Care Services
Average Hourly Earnings
Housing
Food & Beverages
CPI for All Items
New cars
Household Furnishings
Apparel
Wireless Telephone Services
Computer Software
Toys
Televisions

Article & Sources:
https://howmuch.net/articles/price-changes-in-usa-in-past-20-years
CPI and other price indices - Bureau of Labor Statistics - https://data.bls.gov/PDQWeb/cu
Average hourly earnings - Bureau of Labor Statistics - https://data.bls.gov/timeseries/CES0500000008

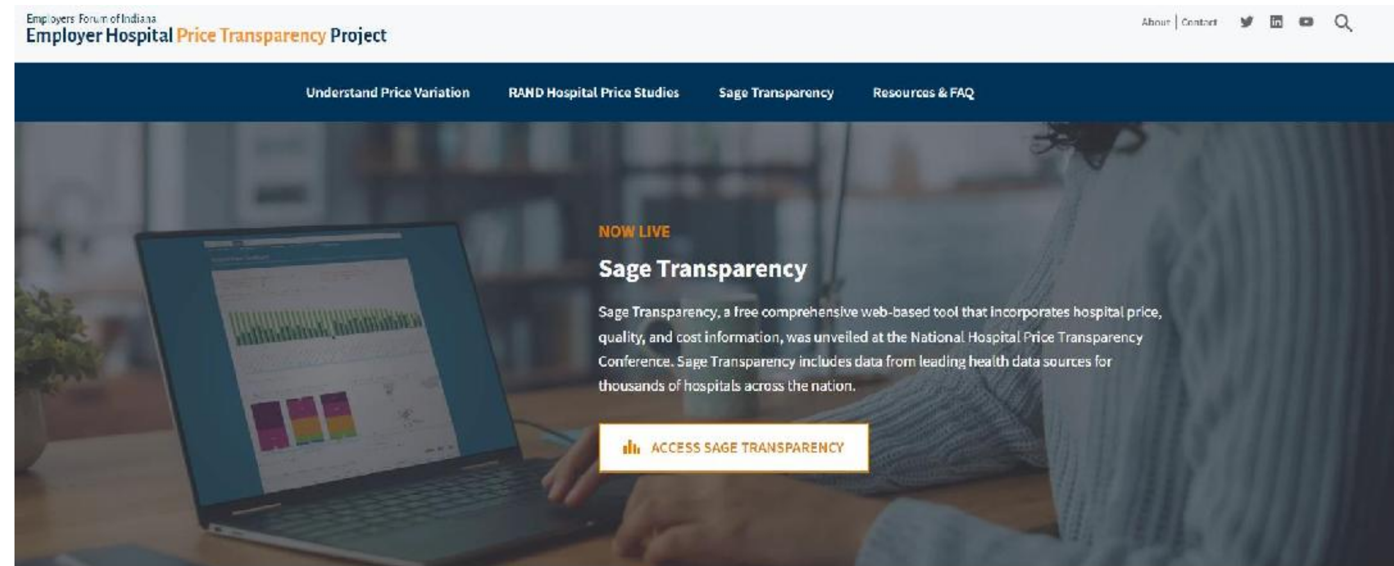
howmuch.net

Source: ncci.com/Articles/Pages/II_Insights_QEB_Impact-of-Hospital-Consolidation-on-Medical-Costs.aspx

Employer Hospital Price Transparency Project

employerptp.org

“Sage Transparency Tool”



(With acknowledgement and thanks to our “sister” coalition, Employers’ Forum of Indiana)

Rand 4.0

Based on $1.3 billion employers paid in NC claims in 2020

North Carolina Average Amount Paid by Employer-Sponsored Health Plans in 2020
as Percent of Medicare Allowed Amount

	Total Inpatient and Outpatient	Inpatient Services	Outpatient Services
Average	266%	211%	331%
Range	121% - 452%	82% - 328%	126% - 525%

Quality among North Carolina hospitals is not correlated with price.

Prices employers paid at hospitals in the Charlotte region varied from 250% to 427% of Medicare.

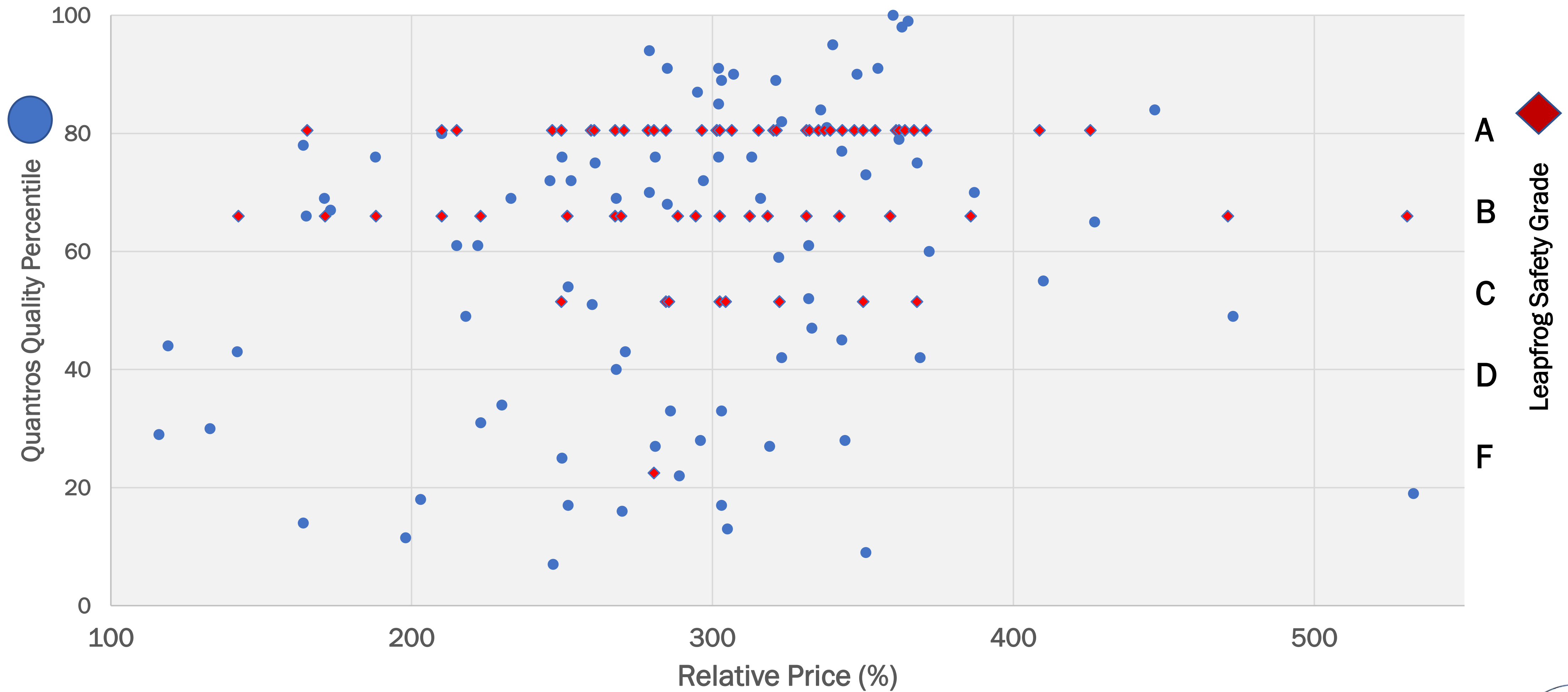
2 STARS
3 STARS
4 STARS
5 STARS

TOTAL FACILITY PRICES AS % OF MEDICARE

450
400
350
300
250
200
150
100
50
0

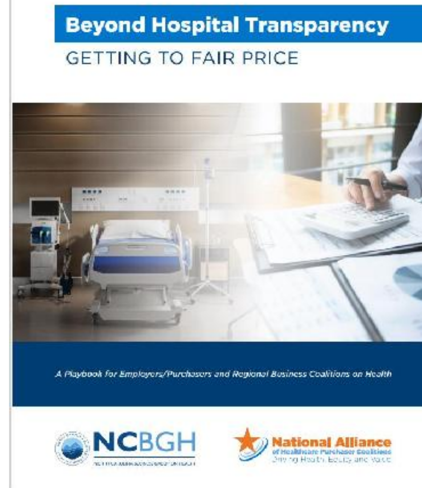
Davis Regional
Lake Norman Regional
Caromont Regional
Atrium Health Union
Iredell Memorial
Novant Health Rowan
Novant Health Presbyterian
Novant Health Huntersville
Carolinas Medical Ctr-Northeast
Atrium Health Lincoln
Novant Health Matthews
Carolinas Medical Ctr-Pineville
Atrium Health University City

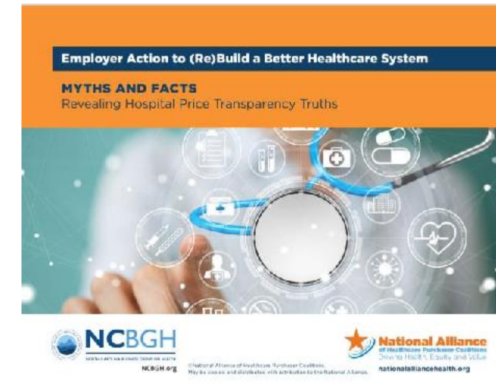
Price Does Not Correlate to Quality & Safety at North Carolina Hospitals



Hospital Transparency – What's Next

- Review Playbook





- Watch for email on further ways to get involved through NCBGH

- After lunch session: Strategies employers can take utilizing data

Innovation in Employer Health/Wellness Benefits *Quick Rounds*

Format

Each speaker will have *only* 5 minutes to convey their innovative product/service

(We don't have a "stage hook",

so instead, microphone will cut off when time runs out!

Innovator #1: Progyny

NCBGH

NORTH CAROLINA BUSINESS GROUP ON HEALTH

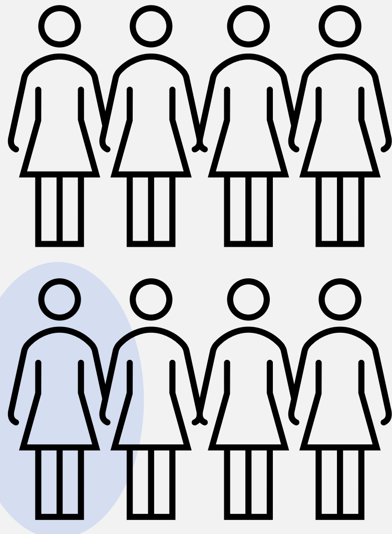
Wendy Wright

VP Business Development

progyny

Smarter Fertility Benefits

The need for a fertility benefit is urgent



Impacts 1 in 8 people…

1 in 4	Arthritis
1 in 7	Chronic kidney disease
1 in 8	**Infertility**
1 in 11	Diabetes
1 in 13	Asthma
1 in 20	Depression
1 in 230	Cancer

…more than diabetes, asthma, depression, cancer

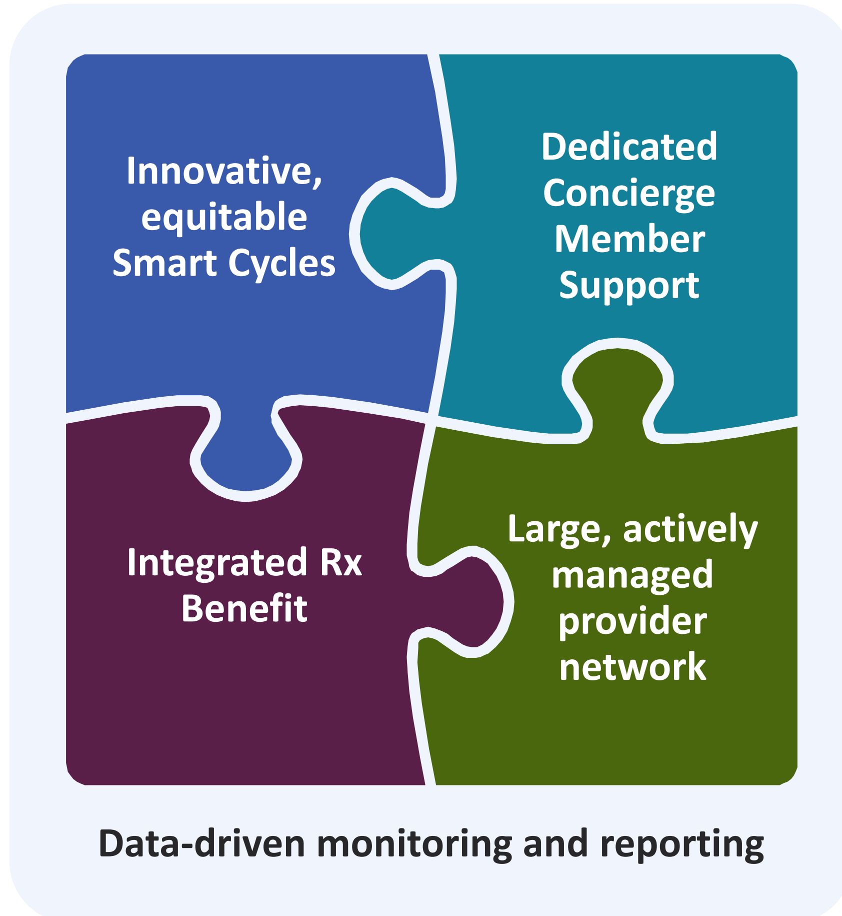
- **Starting to have families later** when it's harder to have a baby
- **Diverse paths** to parenthood
- **Egg quality and quantity** declines with age
- **Male infertility** accounts for 1/3 of cases
- **Black women are 2x as likely to experience infertility** yet half as likely to seek treatment
- **Economic impact:** $33.7 billion due to multiples; $5.7 billion due to lost productivity

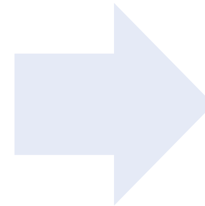
1. Technavio Market Research, March 2017; Harris Williams & Co. Fertility Market Overview 2015; CDC Data, Statistics and Surveillance, retrieved December 2017. | 2. Birth of the Biological Clock, https://www.st-andrews.ac.uk/news/archive/2010/title,46684,en.php ; Maternal age and fetal loss: population-based register linkage study. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC27416/ | 3. Lemos, E. V., Zhang, D., Voorhis, B. J., & Hu, X. H. (2013). Healthcare expenses associated with multiple vs singleton pregnancies in the United States. American Journal of Obstetrics and Gynecology, 209(6). doi:10.1016/j.ajog.2013.10.005, adjusted for medical inflation; https://www.ncbi.nlm.nih.gov/books/NBK11358.; EMD Serono, Employers and Evidence Based Infertility Benefits http://resolve.org/wp-content/uploads/2017/09/employers-and-evidence-based-infertility-benefits.pdf

PROPRIETARY & CONFIDENTIAL | NOT FOR DISTRIBUTION

Progyny: A more efficient fertility benefit delivering superior outcomes

Progyny's Fertility and Family Building Benefit





Superior clinical outcomes

- More live births
- Faster time to pregnancy
- Fewer miscarriages
- Fewer twins and triplets
- Better supported employees, high employee satisfaction

Increased claims stability, cost-savings

- Multiples and high-risk maternity/NICU cost avoidance
- Medical and pharmacy savings

Thank you!

Innovator #2: Grail

GRAIL

NCBGH
NORTH CAROLINA BUSINESS GROUP ON HEALTH

Galleri, Multi-Cancer Early Detection

Mark Russo
Director, Employer Partnerships

mrusso@grailbio.com
919-624-1906

October 2022

Beating cancer starts with **knowing you have it**

Galleri®

#1

Cancer is now one of the largest healthcare spend categories for employers[1]

(And growing at a rate of 2x than that of other healthcare expenses)

1 2020 National Business Group on Health "Large Employers' Health Care Strategy and Plan Design Survey"
2 Nobel et al. Cancer and the Workplace: The Employer Perspective. (2015). https://nebgh.org/wp-content/uploads/2015/10/CancerWorkplace_FINAL.pdf

29%

Percentage of deaths due to cancers with available screening modalities

64%

Decreased adherence to single cancer screenings[1]

1 https://ehrn.org/delayed-cancer-screenings-a-second-look/ 2https://www.washingtonpost.com/health/2020/06/18/nations-cancer-chief-warns-delays-cancer-care-are-likely-result-thousands-extra-deaths-coming-years

1 in 3

People will be diagnosed with cancer in their lifetime

Based on 5-year cancer-specific survival rates. Source: Surveillance, Epidemiology, and End Results (SEER) Program (www.seer.cancer.gov) SEER*Stat Database: Incidence - SEER 18 Regs Research Data, Nov 2018 Sub. Includes persons aged 50-79 diagnosed 2006-2015. "Early/Localized" includes invasive localized tumors that have not spread beyond organ of origin, "Late/Metastasized" includes invasive cancers that have metastasized beyond the organ of origin to other parts of the body.

89%

Survival rate when diagnosed early

Based on 5-year cancer-specific survival rates. Source: Surveillance, Epidemiology, and End Results (SEER) Program (www.seer.cancer.gov) SEER*Stat Database: Incidence - SEER 18 Regs Research Data, Nov 2018 Sub. Includes persons aged 50-79 diagnosed 2006-2015. "Early/Localized" includes invasive localized tumors that have not spread beyond organ of origin, "Late/Metastasized" includes invasive cancers that have metastasized beyond the organ of origin to other parts of the body.

Introducing Galleri™

Multi-Cancer Early Detection Test

Galleri is clinically proven to **detect >50 cancers through a simple blood draw.**

When cancer was detected, **Galleri identifies the location of the cancer with high accuracy**, helping inform next steps to diagnosis.

Liu MC et al, Ann Oncol. 2020;31(6):745-759. DOI:10.1016/j.annonc.2020.02.011.

GRAIL'S MISSION:

Detect cancer early, when it can be cured.

Mark Russo
Director, Employer Partnerships
919-624-1906
mrusso@grailbio.com
www.galleri.com

Innovator #3: Calibrate

Calibrate

Calibrate

WE'RE CHANGING THE WAY THE WORLD **TREATS WEIGHT**

Confidential and proprietary of Calibrate Health, Inc. All rights reserved.

EXECUTIVE SUMMARY

CALIBRATE IS THE LEADING METABOLIC HEALTH PLATFORM **ADDRESSING THE OBESITY CRISIS AND GLP-1 TIDAL WAVE FACING EMPLOYERS**

Launched - June 2020

$127.6M in investment

500+ employees

Exceptional results

- 20k+ members enrolled
- Full US provider coverage
- 15% average weight loss
- $15,000 savings opportunity per enrolled member

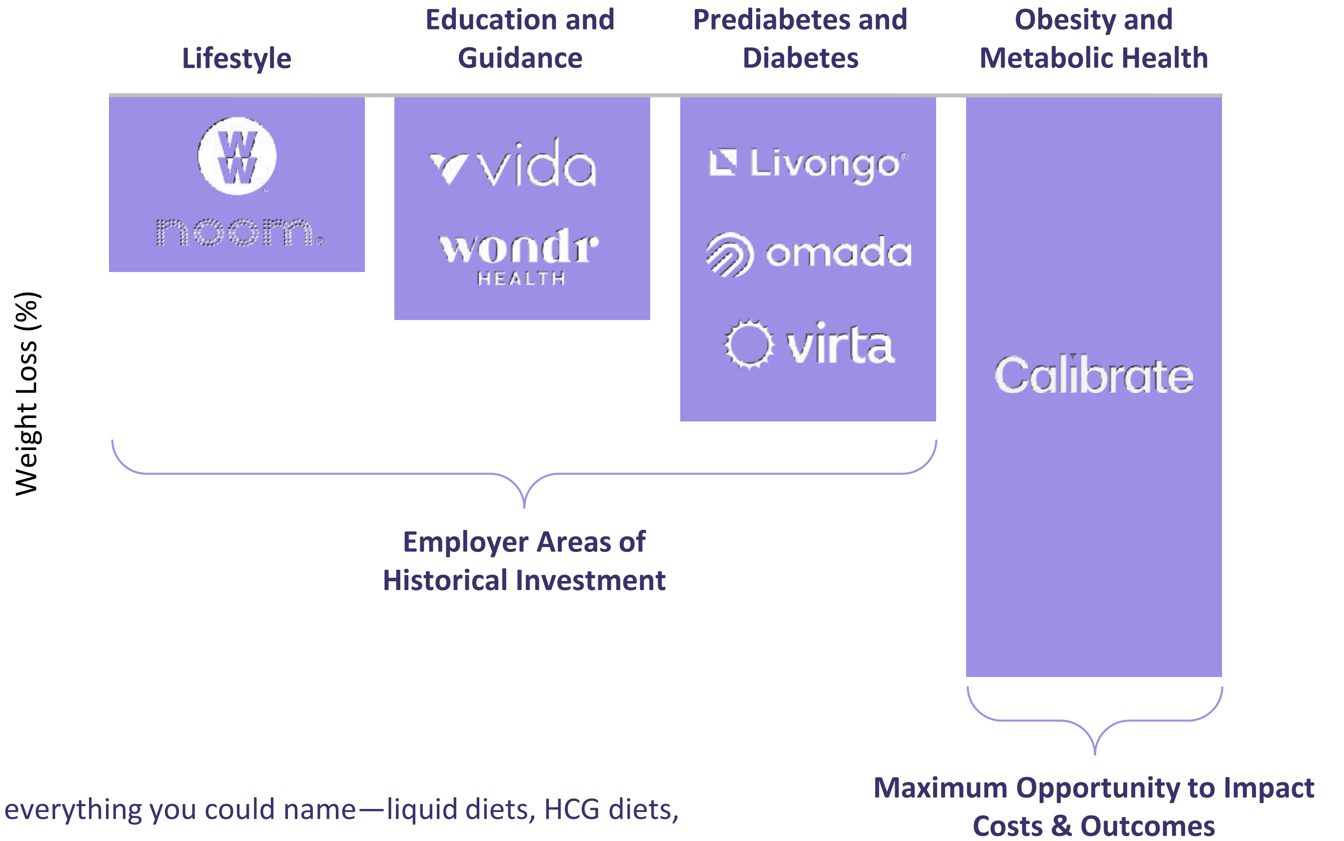
2021 Tech Pioneers nomination by the World Economic Forum as one of "the world's most promising start-up".

2022 Acknowledgement by Fast Company as an idea of innovation for the good of society and the planet.

Ali, Calibrate Member

Confidential and proprietary of Calibrate Health, Inc. All rights reserved.

WHERE ARE YOU INVESTING AS OBESITY INCREASINGLY IMPACTS YOUR BUSINESS?

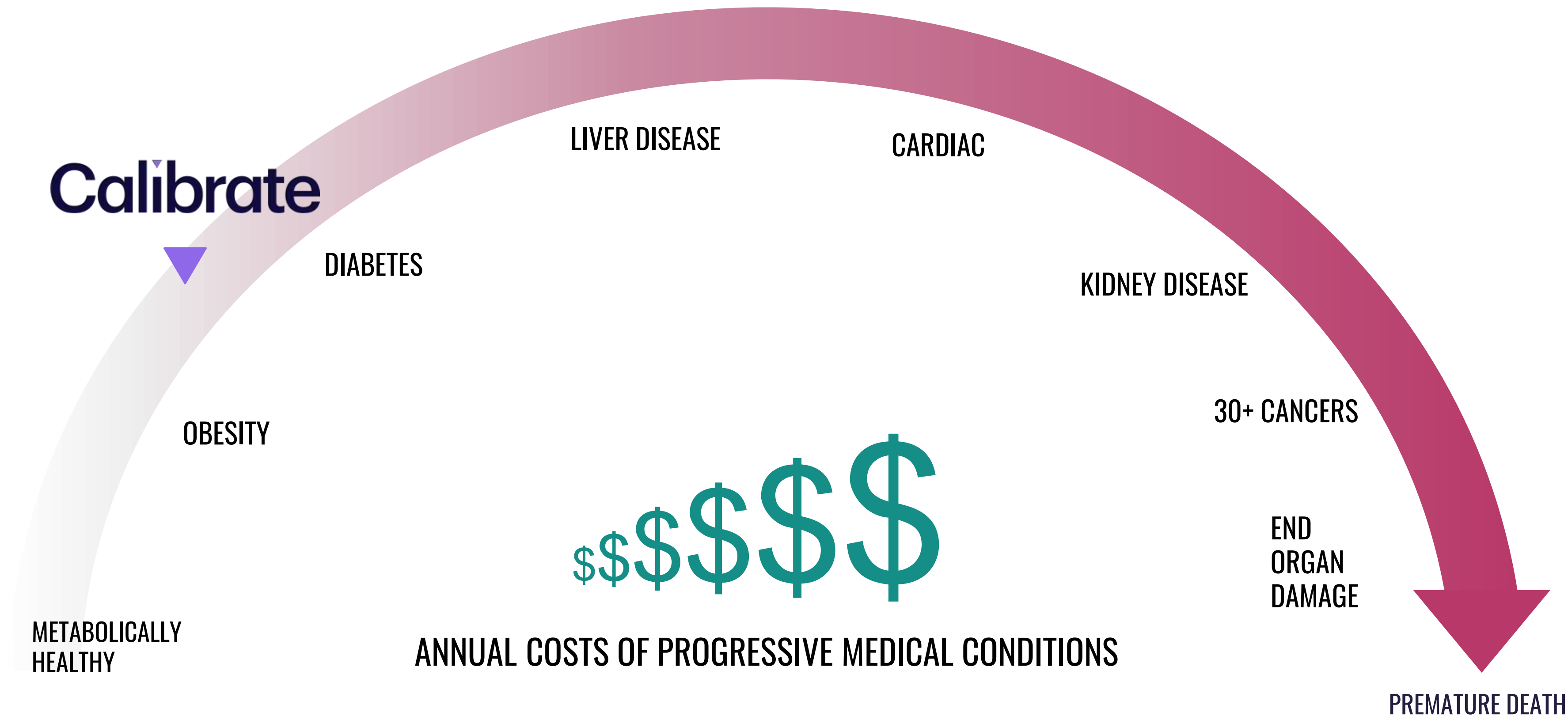


"I did everything you could name—liquid diets, HCG diets, Nutrisystem, Weight Watchers, Overeaters Anonymous— but nothing helped long-term."

Confidential and proprietary of Calibrate Health, Inc. All rights reserved.

OBESITY IS THE LARGEST CATEGORY OF CHRONIC DISEASE AND A SIGNIFICANT DRIVER OF HEALTHCARE COSTS

Addressing obesity is one of the most preventive investments you can make.



42%

OF POPULATION IMPACTED[1]

2x

HIGHER MEDICAL COSTS

[1] CDC. Adult obesity facts.

Confidential and proprietary of Calibrate Health, Inc. All rights reserved.

AN EFFECTIVE PLATFORM IS NEEDED **TO MANAGE THE IMMINENT GLP-1 TIDAL WAVE**

These new obesity medications cost over **$10,000 per year,** are already driving nearly **$1B of pharmacy costs**, and the **market for two medications alone is forecasted to 20x** in the next 5-10 years.

GLP-1s are rapidly becoming the standard of care with more medications on the way

novo nordisk®

Wegovy™ (semaglutide 2.4 mg), the first and only once-weekly GLP-1 therapy for weight management, approved in the US

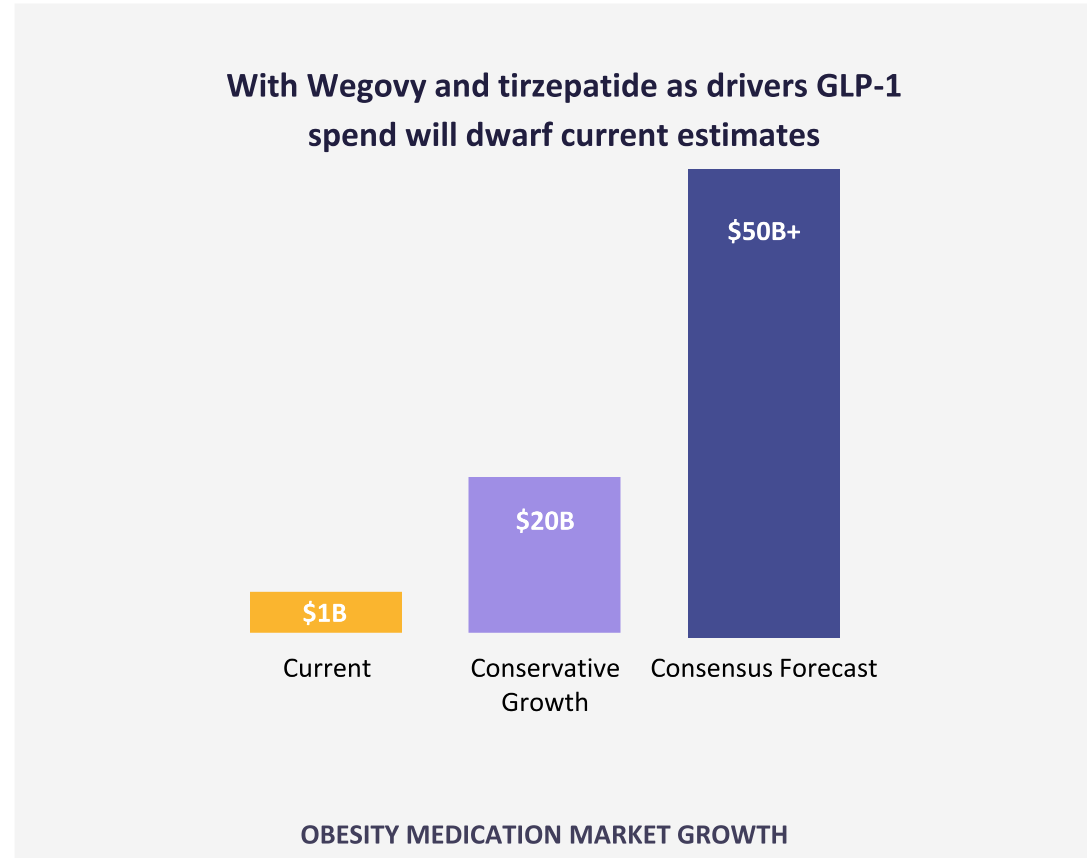
June 04, 2021 14:10 ET | Source: Novo Nordisk A

Cagrilintide plus semaglutide for obesity management

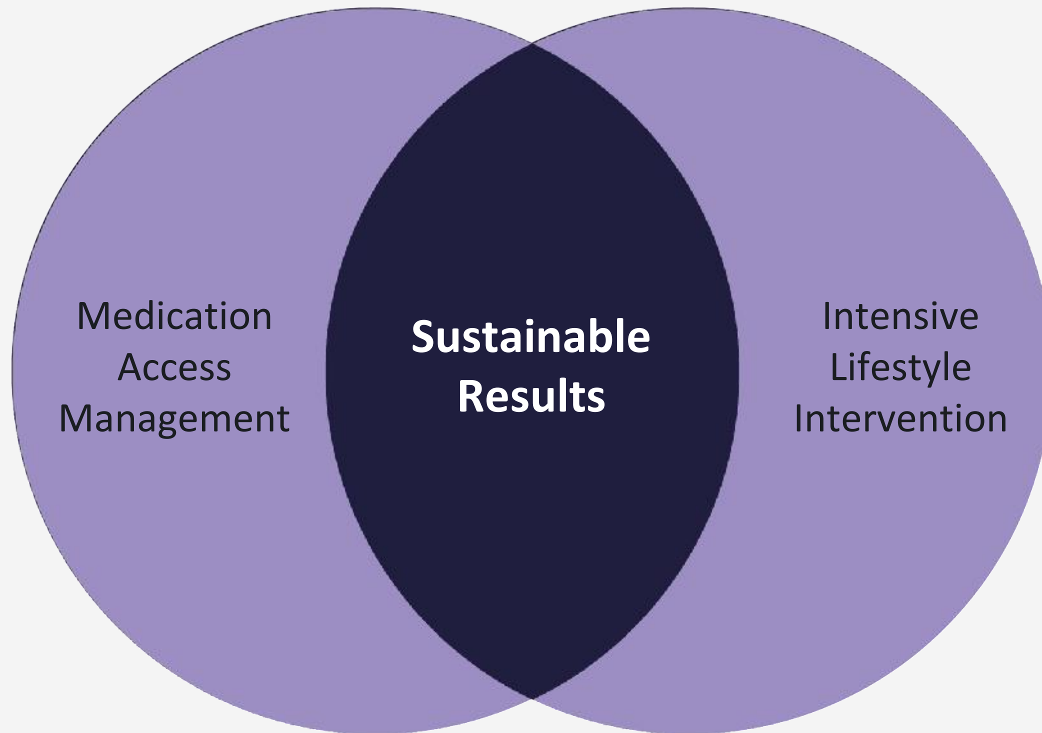
News Release

Lilly's tirzepatide delivered up to 22.5% weight loss in adults with obesity or overweight in SURMOUNT-1

April 28, 2022



Confidential and proprietary of Calibrate Health, Inc. All rights reserved.



CALIBRATE ADDRESSES THE OBESITY CRISIS FACING EMPLOYERS WHILE SIGNIFICANTLY REDUCING THE TOTAL COST OF CARE

Leading metabolic health platform that uniquely:

- Ensures the **right member,** receives the **right obesity medication,** for the **right length of time**.
- Provides the only purpose-built intensive lifestyle intervention—to **maintain long-term physiological changes** post medication use.
- Drives **significant, sustainable results** of ~15% average weight loss at 12 months.

Confidential and proprietary of Calibrate Health, Inc. All rights reserved

MEDICATION ACCESS MANAGEMENT ENSURES THE RIGHT MEMBER RECEIVES THE RIGHT OBESITY MEDICATION FOR THE RIGHT LENGTH OF TIME

Doctors guide and monitor members to manage side effects, titration, and eventual tapering off medication.

Medical Team prescribes clinically appropriate, lowest net cost obesity medication

- Lab values collected & reviewed
- Initial 30-minute consultation with a Calibrate Doctor

Pharmacy benefit coordination and prior authorization integration

- Rx sent to in-network pharmacy
- Calibrate can serve as a PA gate to ensure GLP-1 access is only available to enrolled members

Dose optimization, side-effect, and progress monitoring

- Titration up to therapeutic dose
- Medical reviews for member progress at 3, 6, 9, & 12 months

Medication tapering after a significant, sustained outcome

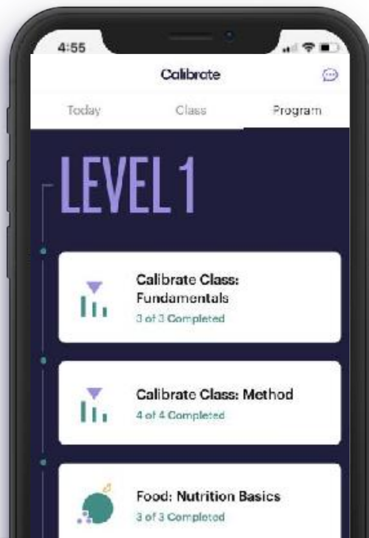
- Goal to taper members off medication between 12-18 months
- Calibrate program completion after 24 months of enrollment

Confidential and proprietary of Calibrate Health, Inc. All rights reserved.

OUR PURPOSE-BUILT INTENSIVE LIFESTYLE INTERVENTION CATALYZES PHYSIOLOGICAL CHANGES CRITICAL FOR SUSTAINED RESULTS

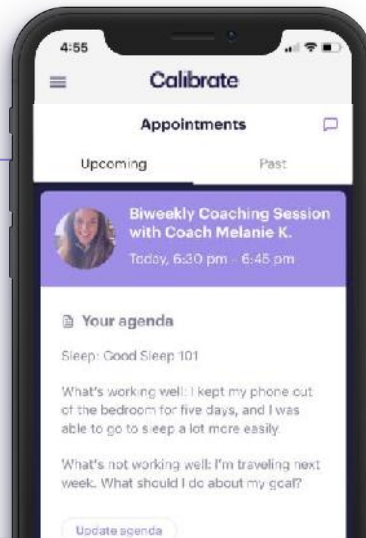
RESEARCH-BASED CURRICULUM

- Structured curriculum based on decades of research
- **Targeting physiological changes to sustain impact from GLP-1s** across food, sleep, exercise, and emotional health



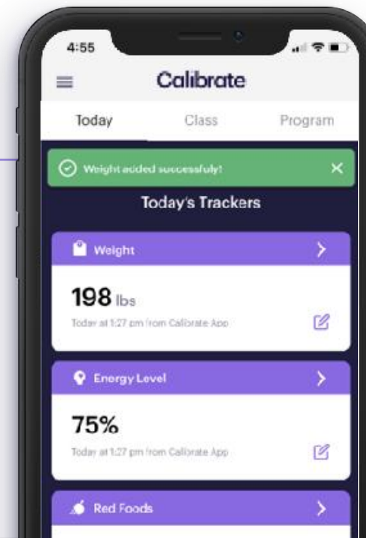
ACCOUNTABILITY COACHING

- Biweekly **face to face sessions** via digital technology
- Engaging content and structured plan + progress drive daily use
- Diverse hiring practices allow for tailored matching of coaches



HEALTH METRICS TRACKING

- Tracking creates sustainable habits and predicts success
- **Digital tracking** via app, connected scale, Apple Healthkit, Google Fit, and compatible wearables



COMMUNITY SUPPORT

- Member community and events to **drive long-term success**
- Provides accountability, social support, continuous learning, and inspiration

Confidential and proprietary of Calibrate Health, Inc. All rights reserved.

CALIBRATE DRIVES MEANINGFUL RESULTS

COST SAVINGS & VALUE

$12,000

Per Participant Cost Savings by Optimizing GLP-1 Utilization

$3,000+

Per Participant Annual Reduction in Medical Claims Spend[1]

MEASURABLE, SUSTAINED RESULTS

15%

Average Weight Reduction

75%

Of Members with Prediabetes Reduced A1c to Normal Levels

BELOVED MEMBER EXPERIENCE DRIVING RETENTION

4.9/5

240+ Google Review

20k+

Members Enrolled in 18 Months

[1]Data derived from Yuchen Ding, PhD. “Economic value of nonsurgical weight loss in adults with obesity”, JMCP.org, Jan 2021 (savings adjusted for inflation).

Confidential and proprietary of Calibrate Health, Inc. All rights reserved.

Calibrate Members

Innovator #4: Vera Health | Castlight

The Modern Healthcare Experience

North Carolina Business Group on Health

Innovator Session

October 7, 2022

Underlying market forces are shifting – putting even greater burden on the employees we all serve.

CRISIS OF AFFORDABILITY…

4 in 10 adults say they have **delayed needed medical care in the last year due to cost**[1]

1 in 3 adults say they or a family member have **skipped recommended medical treatment due to cost**[1]

1 in 4 adults have **not filled a prescription and/or skipped doses of medicine in the last year because of the cost**[1]

4 in 10 adults report having **debt due to medical or dental bills**[1]

…that is only going to get worse with consumers already struggling with inflation and medical inflation hasn't even kicked in yet[2]

BEHAVIORAL HEALTH CRISIS

2 in 5

adults report symptoms of anxiety or depression[3]

POINT SOLUTION FATIGUE

REGULATORY SHIFTS

force data transparency but don't ensure easy accessibility for patients and providers

1. *Kaiser Family Foundation*
2. *Medical Economics*
3. *Kaiser Family Foundation*

Care is not effectively meeting the needs of our people.

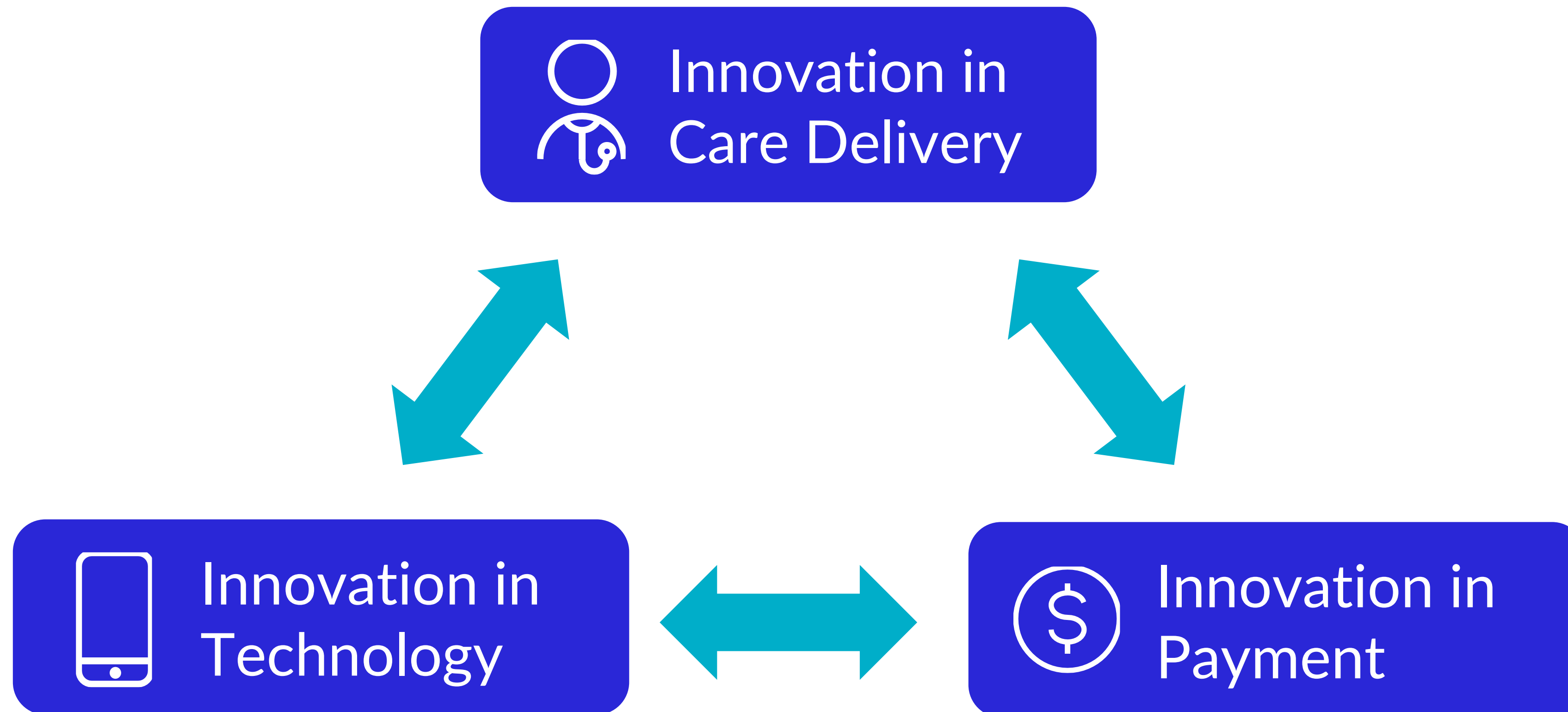
- Fragmented, (often) provider-centered care
- Long appointment wait times
- Transactional visits
- Gated experiences to control access and cost
- Lack of care coordination between visits
- No awareness of available health plan and employer benefit programs at point of care

25% of the adult population does not have a PCP

16 min median length of a PCP visit[1]

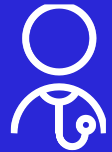
1. *Health Services Research: Time Allocation in Primary Care Office Visits*

Historical approaches have failed to unlock the outcomes for which employers, providers and patients are looking…



…because they did not take a systems-level approach to innovation.

System-level innovation requires ALL three levers of the system to operate differently



Innovation in Care Delivery

- Remake care team into the trusted source of care – replacing today's prevailing transactional model
- Reimagine how patients and providers relate to one another

Innovation in Technology

- Put data and insights into the hands of providers
- Enable true closed-loop coordination of primary care and downstream care
- Full view of member – their benefits, gaps in care, etc.
- Leverage technology to improve provider efficiency

Innovation in Payment

- Create a value-driven system that incentives the right behaviors for all stakeholders: payor, provider and patient
- Reshape the health network to effectively manage risk

The Modern Healthcare Experience

Innovation in Care Delivery

- **Patient-Centric:** Patients are heard, not herded
- **Guided:** Provider guided, not system gated

Innovation in Technology

- **Connected:** United, not divided, with less islands of care
- **Frictionless:** Convenient, not cumbersome
- **Data-Driven:** Referrals based on facts, not friendships

Innovation in Payment

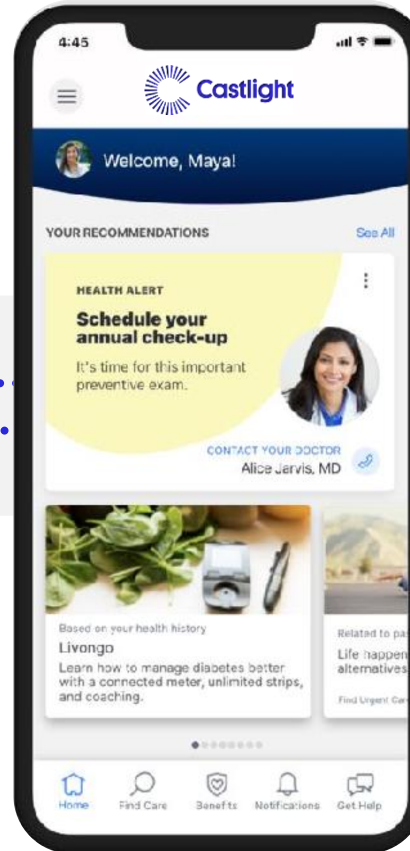
- **Affordable:** Providers paid on value, not volume, of care

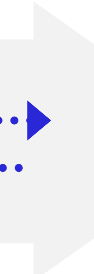
Appreciated: Employee benefits are a real benefit and become more worshiped, than wasted

apree health is creating the Modern Healthcare Experience and unlocking the promise of value-based care at scale

Single, digital front door offers a seamless platform for integrated and person-centered health and wellbeing navigation

Digital Front Door





+

Data-Enabled Care Team

Integrated primary care with wrap-around services to deliver a connected, guided, frictionless patient experience.

Personalized action plans for every member

Prevention & Wellbeing

- **Extended** wellness visits
- **Embedded** behavioral health
- **Personalized** health coaching
- **Additional services:** Immunizations, family planning, occupational health, sports physicals, and more

Disease & Care Management

- **Engagement** in condition-specific programs
- **Easy** access to Rx dispensaries & lab testing
- **Rx management** & adherence
- **Broad spectrum** of conditions covered*

Complex Care Navigation

- **Complex** and co-morbid disease management
- **Extended** care team
- **Benefits advocacy**, appointment scheduling
- **Referral** management to high-quality, cost-effective specialists

*ENT , Pulmonary, Cardiovascular, Neurologic, Diabetes, Genitourinary and Reproductive Care, Gastrointestinal, Musculoskeletal, Dermatologic, Psychiatric and Behavioral Health, Chronic Pain, Endocrine and Breast Related

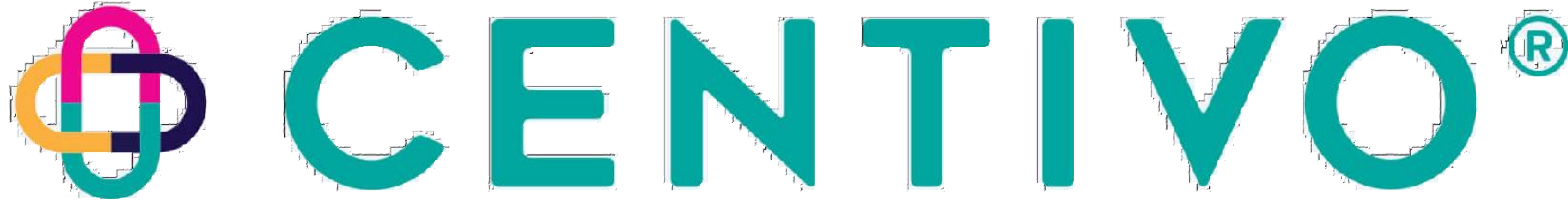
The Modern Healthcare Experience

Transforming how patients access care, how providers deliver care and how employers pay for care

Joe Dunlop
Sales Director
336.430-8924
jdunlop@castlighthealth.com

Castlight

Innovator #5: Centivo



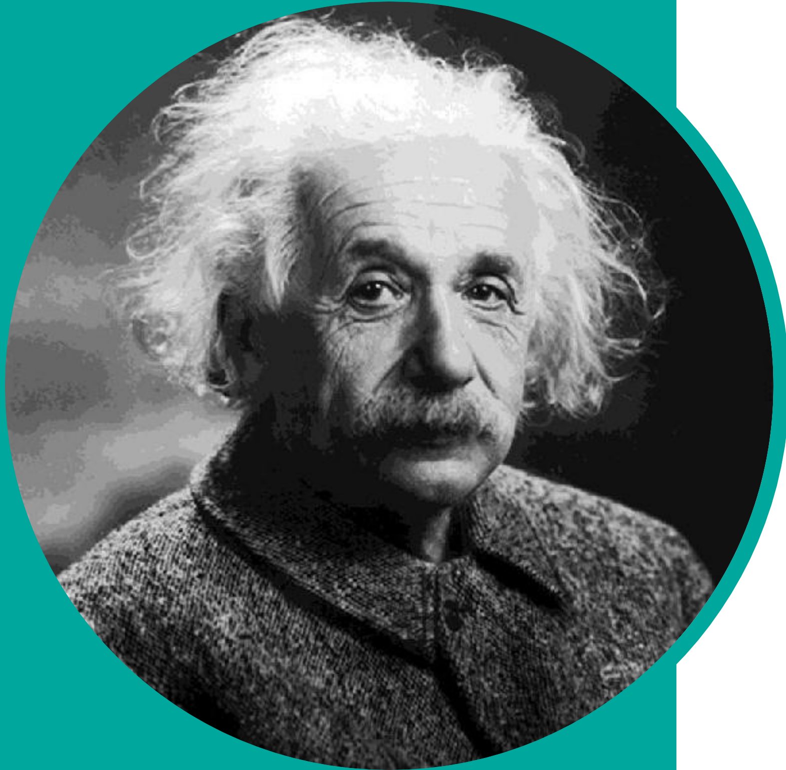
NORTH CAROLINA BUSINESS GROUP ON HEALTH

October 2022

Innovator Showcase:

North Carolina Business Group on Health

CENTIVO®



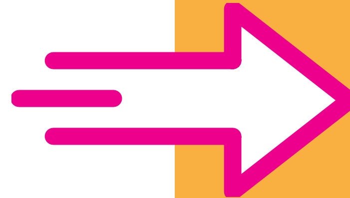
Insanity:

"Doing the same thing over and over again and expecting different results."

- Albert Einstein

The role of the traditional carrier

- **Scale hasn't controlled cost**
- **Not fully aligned to employer due to multiple lines of businesses**
- **Lack of transparency**
- **Legacy technologies** (both internal and member-facing)



Not getting the job done

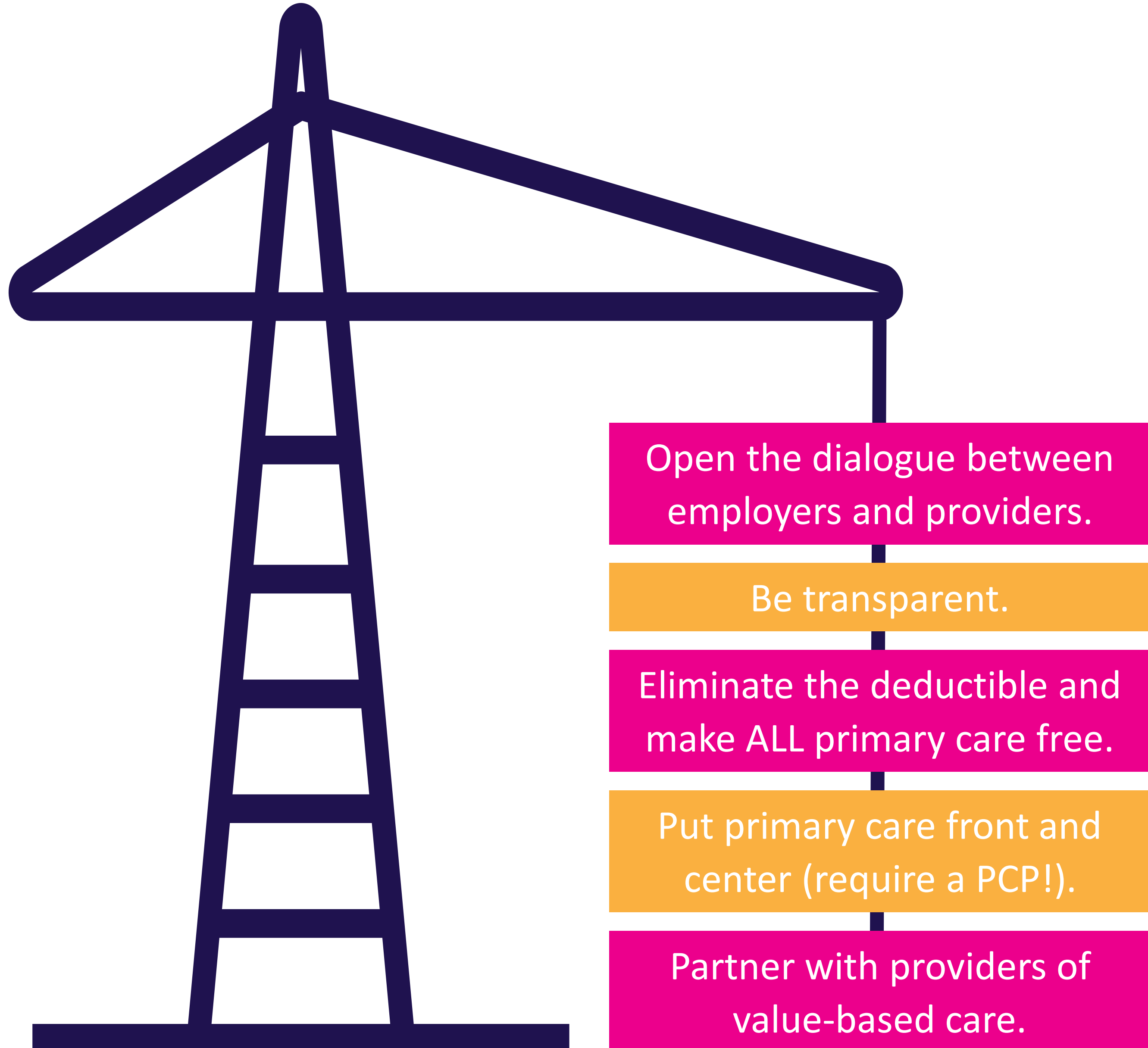
CENTIVO®

Making benefits a weapon in today's "War for Talent"

	HEALTHCARE MYTH	CENTIVO EVIDENCE
1	You can't enrich AV without increasing company costs	Shifting care from high-cost to high-value providers can **save up to 50%**
2	Scale drives the best discounts	Providers offer competitive rates to self-funded employers due to mutually aligned business goals AND total cost of care wins.
3	Employees want every provider in the network	~75% of people willing to trade network size and other plan features in exchange for a simple and affordable experience*

**Based on Centivo's 2021 Healthcare and Financial Sacrifices Survey of 805 adults with employer-based private health insurance*

Building a plan from the ground up



CENTIVO®

That was easy!
easy
MakeAGIF.com

THE SOLUTION:

A new type of health plan anchored around leading providers of value-based care

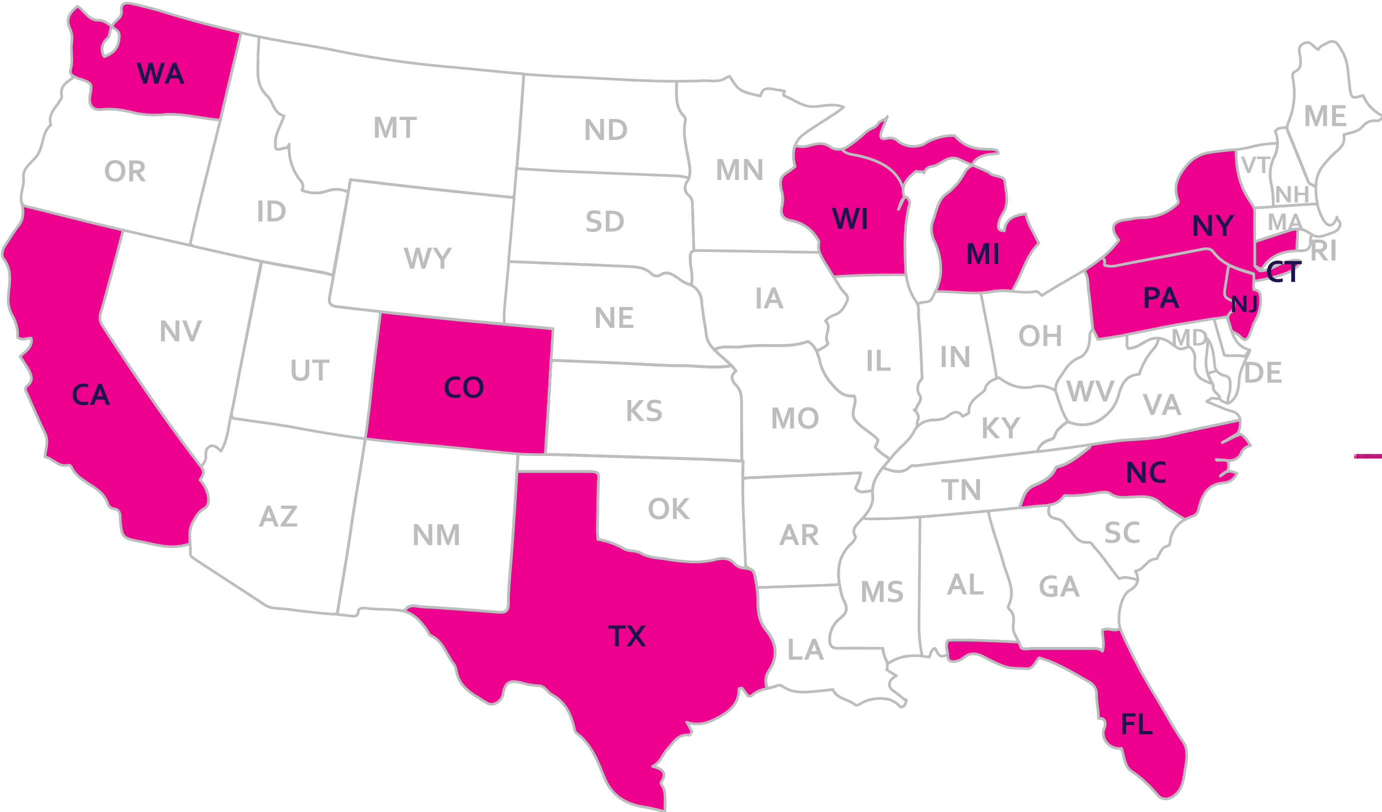
A "smart" health plan

Primary-care centered networks designed for affordability & quality

Simple, no deductible, copay only plan design

Member & provider tech to easily reinforce coordinated care

Our geographic footprint



N. CAROLINA

CENTIVO

Note: All service areas are geographically limited and do not cover the entire state. Consult your Centivo Account Executive for exact service area details.

The impact is substantial

Centivo book of business results

Affordability

Employer

Centivo costs compared to benchmark[1]

~27% savings

Employee

Centivo costs compared to traditional network plan[2]

Employees pay 58% less

Engagement

90% of members in a Centivo Partnership Plan designated a PCP

Of those members who designated a PCP 74% had a PCP visit in a rolling 12 months

vs.

55% of privately insured individuals report a regular, office-based source of care[3]

CENTIVO®

[1] Using the Milliman loosely managed plan as benchmark
[2] Based on Centivo Book of Business PMPY medical costs where a traditional plan refers to Cigna PPO or HDHP
[3] Medical Expenditure Panel Survey results referenced in Duke Margolis Integrated Pain Management PCC Whitepaper

How Centivo saves money

Care redirection

We identify the highest value integrated systems and develop a preferred network around them.

Unit cost savings

We negotiate better unit costs through a semi-exclusive relationship, and employ value-based contracts.

Better care supported via primary care model

- ↑ Primary & preventive care
- ↓ ER & urgent care
- ↓ Unnecessary specialist care
- → Shift from inpatient to outpatient: ambulatory for surgeries & imaging centers

Members get a simple, affordable experience

At the doctor

- Primary care team acts as a partner in care
- Great access to quality providers

&

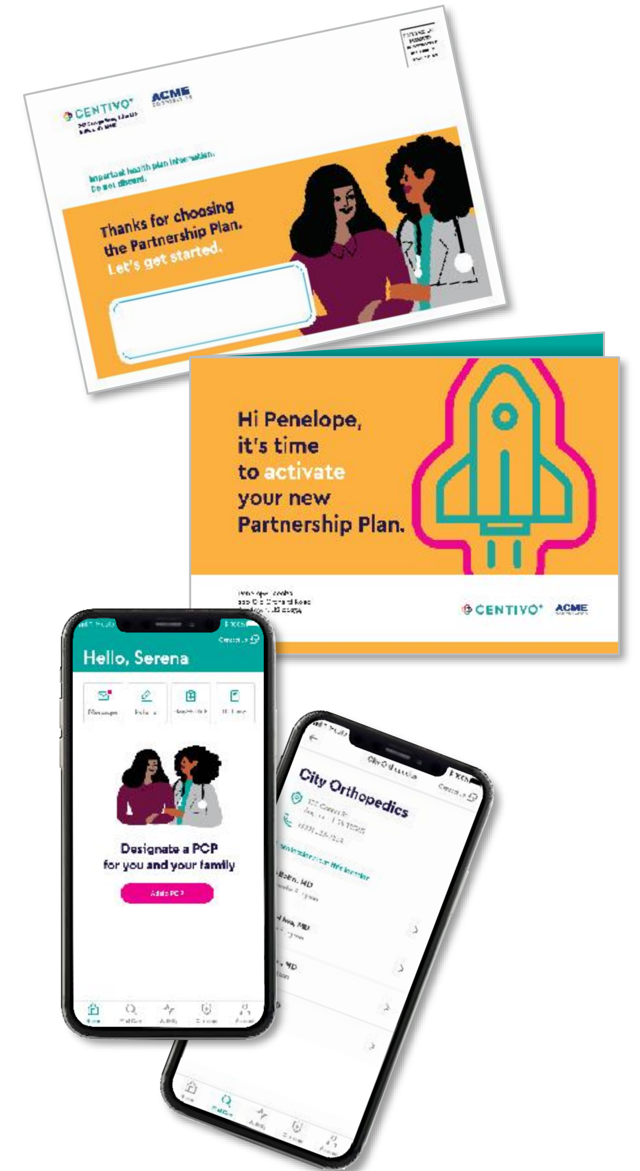
With the plan

- Clear communications
- Easy-to-use member app & portal
- Hands-on member service with no phone trees

&

Paying for care

- Affordable
  No deductible & Free primary care
- Predictable costs
  Copays for everything else



Innovator #6: Hydrogen Health

Hydrogen Health

Putting everyday health within reach.

Prepared for North Carolina Coalition on Health Care

October 7th, 2022

Hydrogen Health

We have a problem that can no longer be ignored

Life expectancy vs. health expenditure

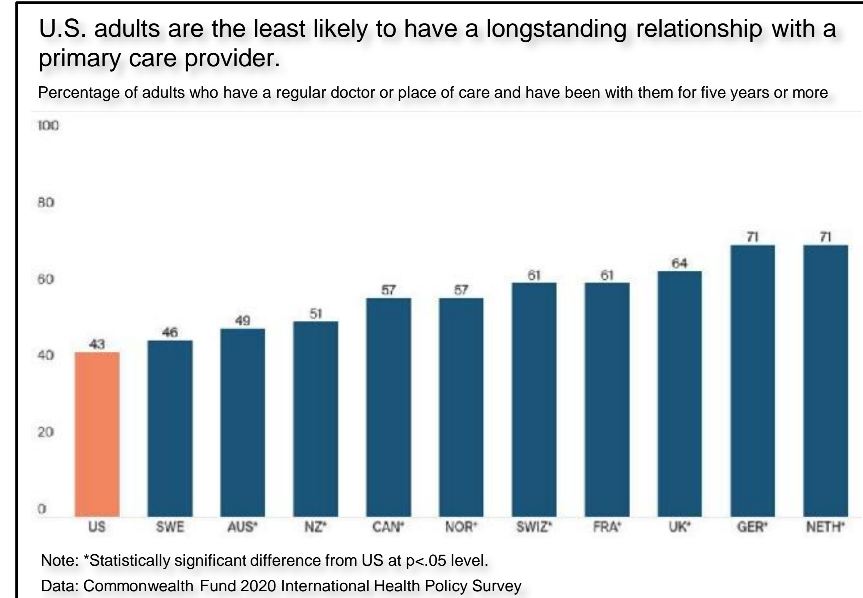
From 1970 to 2018

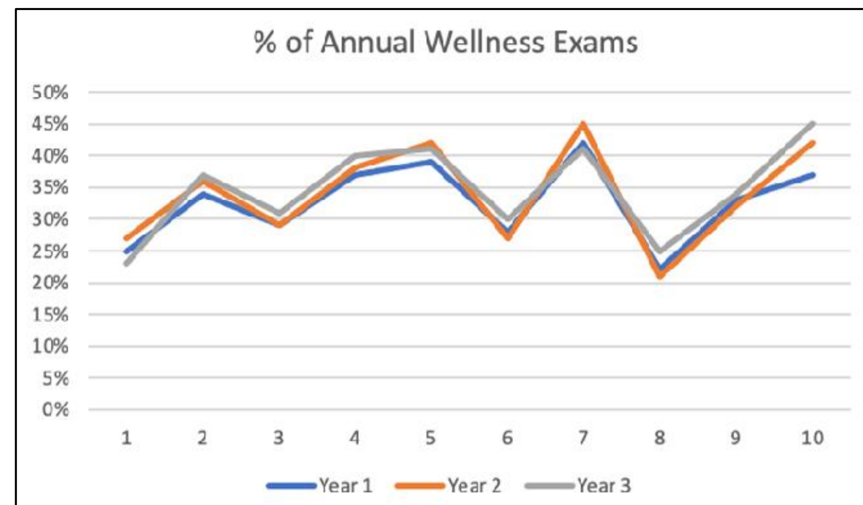
Life Expectancy

Health Expenditure per capita

adjusted for inflation and price differences between countries (PPP)

Japan, Switzerland, Spain, Italy, Israel, South Korea, Australia, France, Norway, Sweden, Ireland, New Zealand, Canada, Netherlands, Portugal, Finland, Austria, Belgium, UK, Germany, Denmark, USA





Hydrogen Health Data

Hydrogen Health

Problem at a more granular level?

- New AAMC report confirms growing physician shortage
- Access to primary care doctors takes up to 4–6 weeks

Results in:

- Loss of early detection for treatable serious health conditions
- Unnecessary large claims and increased treatment costs
- Loss of productivity and increase of work absenteeism

Many of the existing solutions do not provide follow-up care

- **Traditional telemedicine**

- **Onsite** biometrics

- At home testing with a singular clinical review
- Walk-in clinics with **no follow-up care**

Lack of basic prevention and ongoing follow up risks the health of your population

OUR SOLUTION:

A national prevention strategy

Our patients experience consistent, full-spectrum clinical care that fits their lives.

Wellness & Prevention That is Easy to Access	Virtual annual wellness exams with lab work.	*A scalable solution that is incredibly easy to access.*
Ongoing Health Care	Well care, chronic condition support, mental health care, and rapid prescription refills	*Safe and reliable personalized AI symptom checker.*
Sick Care	Primary and urgent care with referrals to specialists, as needed	Collaboration with: Mayo Clinic Platform_Discover

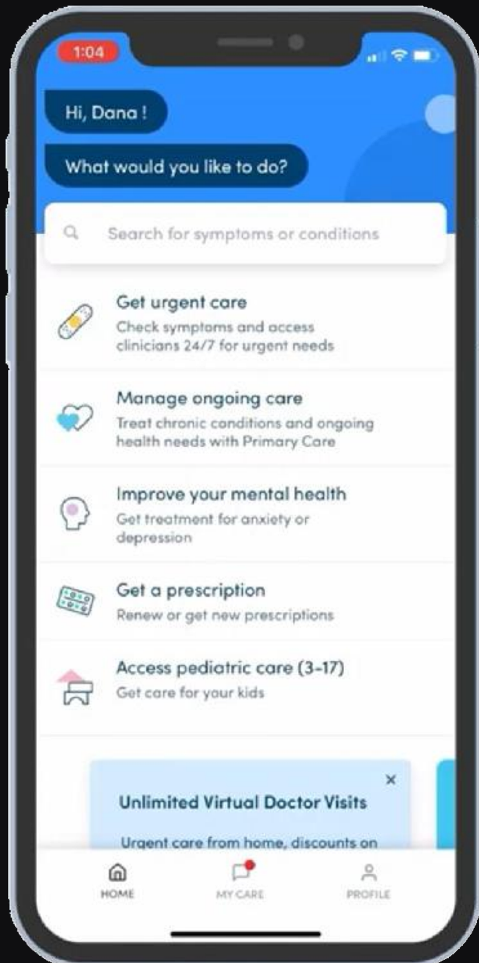
Typical telemedicine experience:
Occasional substitute for in-person visits.

Always on

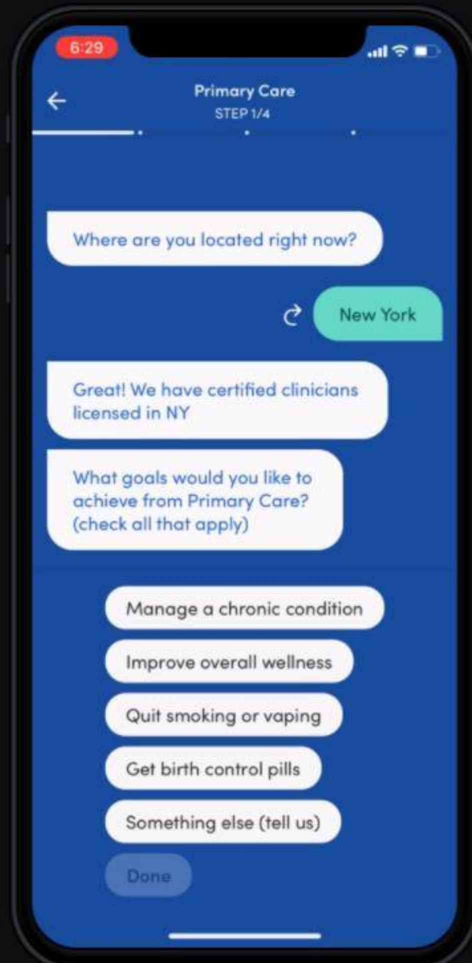
Simple access to all health needs including Annual Wellness Visit

Hydrogen Health

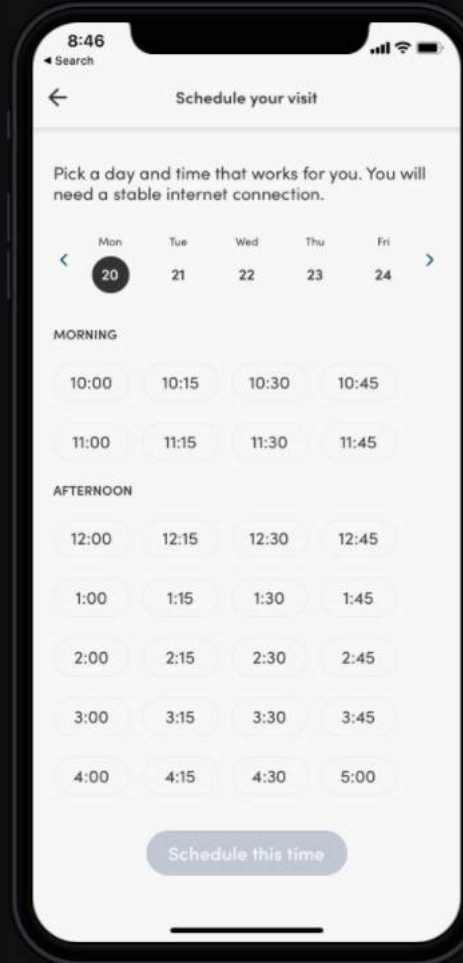
One click away from Always on care



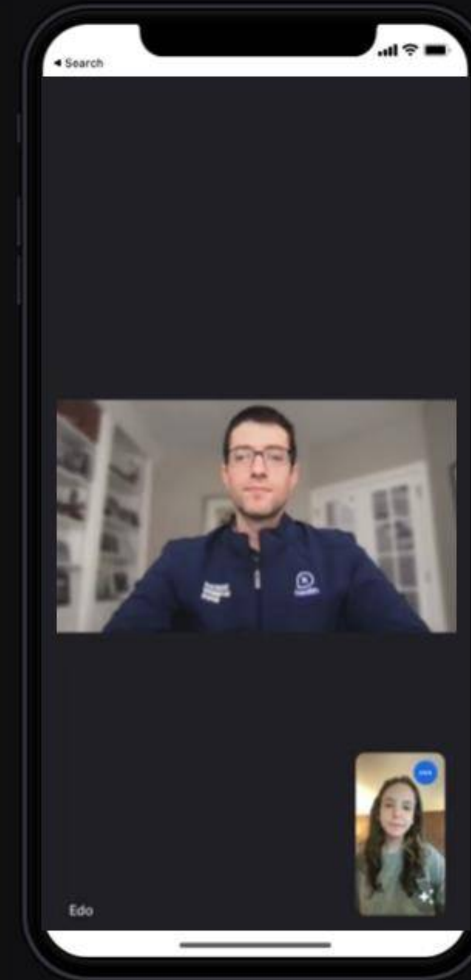
Member begins detailed medical intake in anticipation of wellness visit



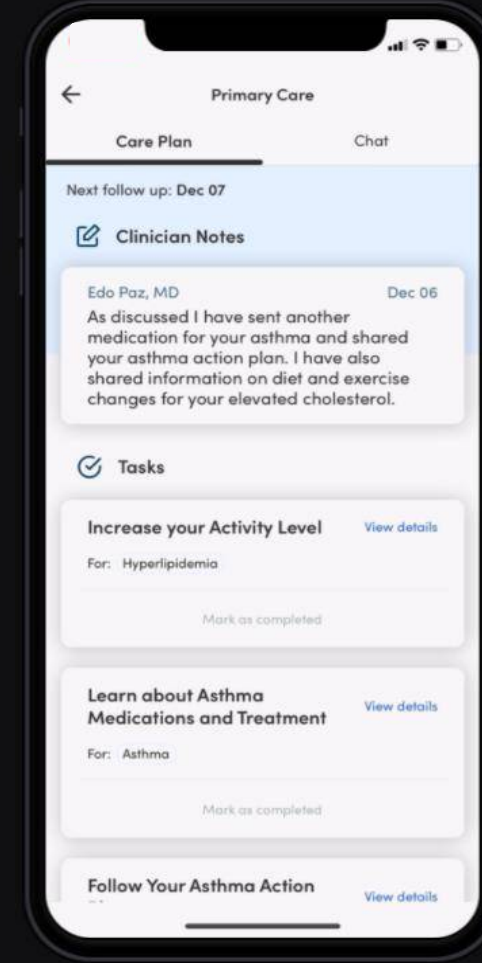
Accessibility in hours and days - not weeks



Virtual wellness visit when members want



Dynamic & personalized care plans – start to better health



Hydrogen Health

K Health launches hypertension treatment powered by Mayo Clinic Platform

Powered by

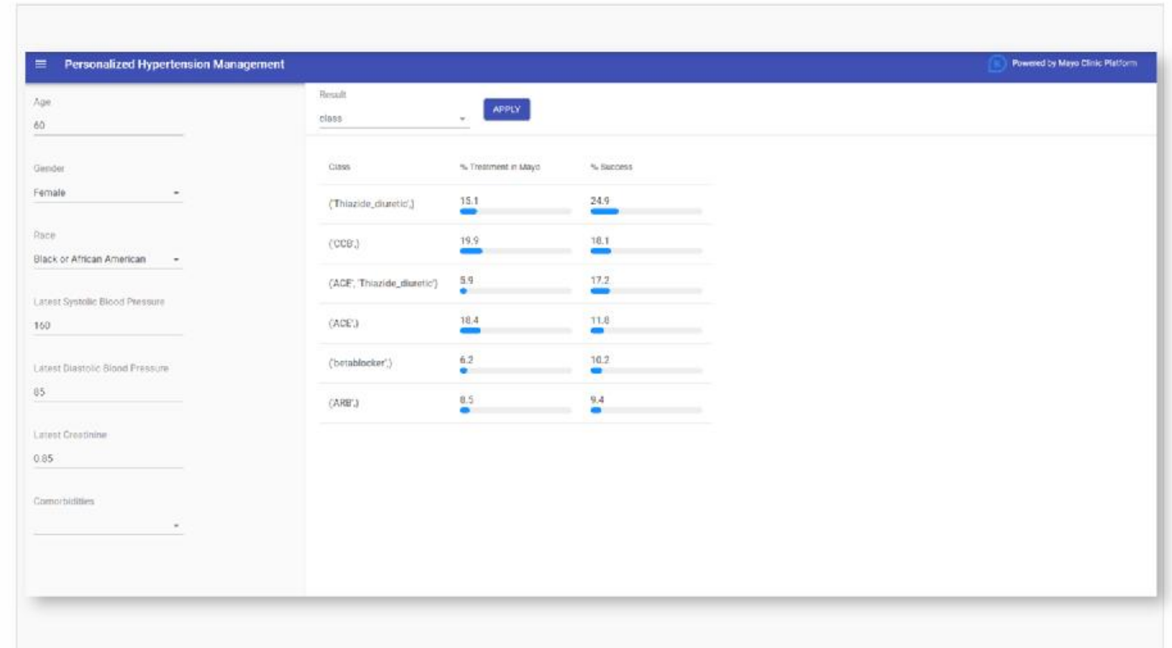
businesswire
A BERKSHIRE HATHAWAY COMPANY

HOME SERVICES NEWS EDUCATION ABOUT US

Search

K Health Launches Its Personalized Hypertension Treatment Algorithm Powered By Mayo Clinic Platform Insights

The clinical AI platform is using data insights from Mayo Clinic Platform_Discover to augment clinicians in real time with intelligent treatment planning for hypertension



(Graphic: Business Wire)

June 16, 2022 08:00 AM Eastern Daylight Time

NEW YORK--(BUSINESS WIRE)--Clinical AI-powered healthcare company K Health announced today a new collaboration with Mayo Clinic's digital healthcare initiative, Mayo Clinic Platform, which harnesses new knowledge, solutions and technologies to improve patients' lives. Primary Care clinicians practicing on K Health's virtual platform will be able to use a predictive model based on real-time insights from Mayo Clinic's de-identified medical data to treat hypertension more accurately and efficiently.

"Starting with hypertension, K Health's clinical and data science teams will unlock innovation using

Despite hypertension being one of the most common chronic conditions in the U.S. and globally, finding the optimal treatment can be complex and involve

Our solution has proven results.

Expected Engagement

3-4x engagement rate

56 days repeat usage

87% patient satisfaction rate

Savings Achieved

32% fewer ER visits

$200-$250 cost savings per clinical episode

54% fewer labs and radiology imaging

47% fewer inpatient admissions

It's clear, **we're different** and making an **impact.**

Thank you!

Networking Lunch

Please return at 1:00 PM

Employers:

Don't forget to have your door prize entry "validated" by at least 4 sponsors!

(Drawing for the Lenovo IdeaPad Flex 5i will be held at the 2 PM "wrap up". Winner must be present to win!)

Price Transparency at the Payor/Provider Level

What should we do with all that Machine Readable File data?

Mike Gaal
Principal & Consulting Actuary
Milliman

Brian Sweatman
Principal & Consulting Actuary
Milliman

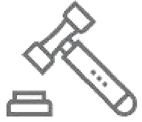
Price Transparency at the Payor/Provider Level:

What should we do with all that Machine Readable File data?

Mike Gaal, Principal, EMBA, FSA, MAAA

Brian Sweatman, Principal, EMBA, FSA, MAAA

OCTOBER 7, 2022

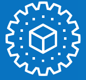


Caveats and limitations

- The views expressed in this presentation are personal to the presenters, and not the views of Milliman, Inc., or any of its global subsidiaries.
- This presentation is intended to provide an overview of hospital and payer price transparency data and other emerging information.
- We are not lawyers, and this presentation does not constitute legal advice. Please consult with counsel prior to taking any actions in response to this information.

Introductions

Background


Review of Posted Data

Data Challenges

Potential Use Cases: Overview

Stakeholder Impact

Direct Contracting Approaches

Questions

Introductions

Brian Sweatman

Principal
Atlanta
brian.sweatman@milliman.com

- 10+ years in healthcare, consulting to payors, providers, and other risk-bearing entities
- Deep experience with analytics, value-based contracting, and risk

Mike Gaal

Principal
Chicago
mike.gaal@milliman.com

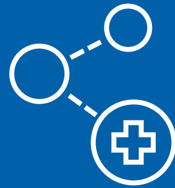
- 20+ years consulting to employers and other commercial payers with a focus on strategy, design, and risk management
- Co-leader of a Milliman team focused on transparency research

Background

- January 1, 2021 regulations introduced a new level of price transparency in the U.S. healthcare system
- For the first time, hospitals and health systems were required to publish price data annually
- Two types of data requirement:
  - A consumer-friendly website for “shoppable” services
  - A machine-readable file of payment rates
- On July 1, 2022 similar regulations went into effect for payers, but with a requirement to post on a monthly basis
- Pharmacy data forthcoming… maybe?

The walls are coming down

Health System A



Health System B

Health System C

What's in the posted data?

A machine-readable file of payment rates

Hospital Files

- Gross charges
- Discounted cash prices
- Payer-specific negotiated charges
- All contracted services
- Institutional (some professional)

Payer Files

- Allowed amounts
- Hospitals and Provider Groups
- All contracted services

The task at hand – Hospital data

MESSY PAYER/CONTRACT NAMES

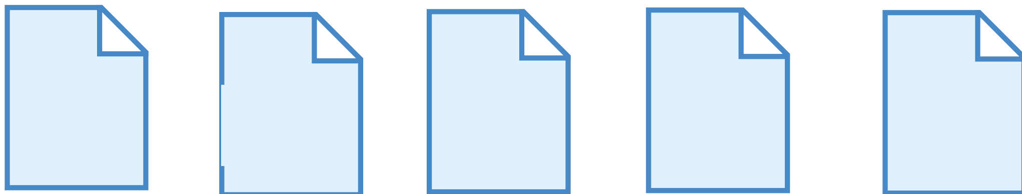
```
1  charge_description:  Egd perc plcmnt gast tube
2  cpt:  43246
3  rate:  1607.49
4  name:  University Of XXXXXX Hospital
5  npi:  1396946XXX
6  plan_name:  AETNA MCR PREMIER PPO C
```

CLEAN PAYER	LINE OF BUSINESS
Aetna	Medicare

VARIETY OF CODE TYPES

Service Code	Aurora	Ascension	UW Health	Children's
CPT/HCPCS	✓	✗	✓	✗
DRG	✓	✓	✓	✗
Revenue Code	✓	✓	✗	✗
Episode Grp	✗	✗	✗	✓

UNPREDICTABLE FILE TYPES



JSON XML TXT XLS CSV

LEVEL OF GRANULARITY

FACILITY	CHARGE CODE	TYPE	CC DESC	REV	CPT	1121 FEE	AETNA
BAY AREA	10002413	FS	XR HD 3 VIEW MINIMUM	320	73130	525	$477.75
BAY AREA	10002413	FS	XR HD 3 VIEW MINIMUM	320	73130	30	$27.3

The task at hand – Payer data

Hierarchical Data

```
40  <description>Total Knee Replacement</description>
41  <name>Total Knee Replacement</name>
42  <negotiated_rates>
43    <item>
44      <negotiated_prices>
45        <item>
46          <expiration_date>2022-01-01</expiration_date>
47          <negotiated_rate>20000.0</negotiated_rate>
48          <negotiated_type>negotiated</negotiated_type>
49          <service_code>
50            <item>05</item>
51            <item>05</item>
52            <item>06</item>
53          </service_code>
54        </item>
55      </negotiated_prices>
56      <provider_groups>
57        <item>
58          <providers>
59            <item>1111111111</item>
60            <item>2222222222</item>
61            <item>3333333333</item>
62            <item>4444444444</item>
63            <item>5555555555</item>
64          </providers>
65          <tin>
66             <type>ein</type>
67             <value>11-1111111</value>
68           </tin>
69        </item>
70      </provider_groups>
71    </item>
72    <item>
73      <negotiated_prices>
74        <item>
75          <expiration_date>2022-01-01</expiration_date>
76          <negotiated_rate>25000.0</negotiated_rate>
```

Significant Data Volumes

700+ TB

Raw Data
Monthly Updates

Interpretation

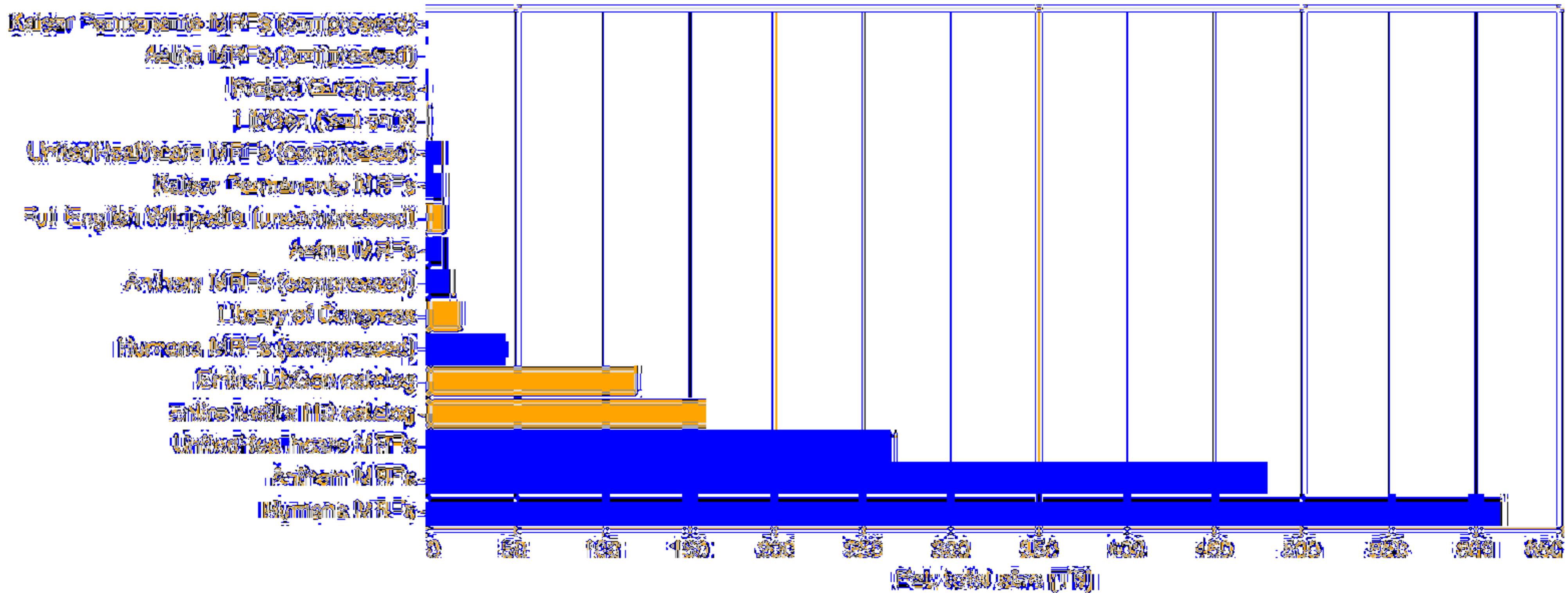
- Thousands of codes
- Service bundles
- Hospital mapping
- Provider groups
- Network identification
- Utilization weights
- Data quality

The task at hand – Payer data

How much data did insurance companies just publicly dump?

On July 1st, insurance companies were ordered to publish all of their negotiated rates. UnitedHealthcare, Aetna, Humana and others dumped dozens of TB of data onto their "transparency in coverage" pages, as required by law, in the form of "MRFs" or "Machine Readable Files". That's dozens of TB (compressed!) of prices they negotiated with hospitals and clinics.

I scraped the file headers for the major insurers to see how much data was available. Turns out that it would take months for an ordinary team to scrape and process this data. See how these MRFs (blue) compare with other databases (orange).



Source: https://www.dolthub.com/blog/2022-09-02-a-trillion-prices/

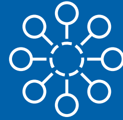
Milliman

Potential use cases: High-level overview

Negotiations

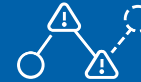
Empower payers and providers with insights on contracted rates, network status, and discounts

Contract Structures



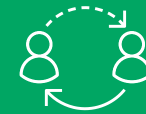
Understand competing insurers negotiated rates and contract structure

Track Rates



Maintain visibility into competitors rate changes based on regular data refreshes

Direct Contracting



Enable self insured employers to identify direct contracting opportunities

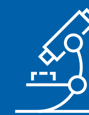
Care Navigation

Steer members towards high quality and low-cost providers and enable shopping behavior

Network Analysis

Understand where a network is less competitive than competitors

Weak Contracts



Proactively identify contracts that are over/underpriced to prioritize for re-negotiations

Assess Markets

Assess current and new markets by geography/region, product mix, and networks

Impact on various stakeholders

Payers

- Health Plans
- Employers

Providers

- Hospitals
- Physicians and specialists
- Surgery centers, labs, imaging, etc.

Others

- Consumers
- Technology vendors
- Researchers
- The media

Payers:

- Negotiate lower reimbursements
- Create efficient networks
- Develop plan design incentives
- Re-think contracting approaches

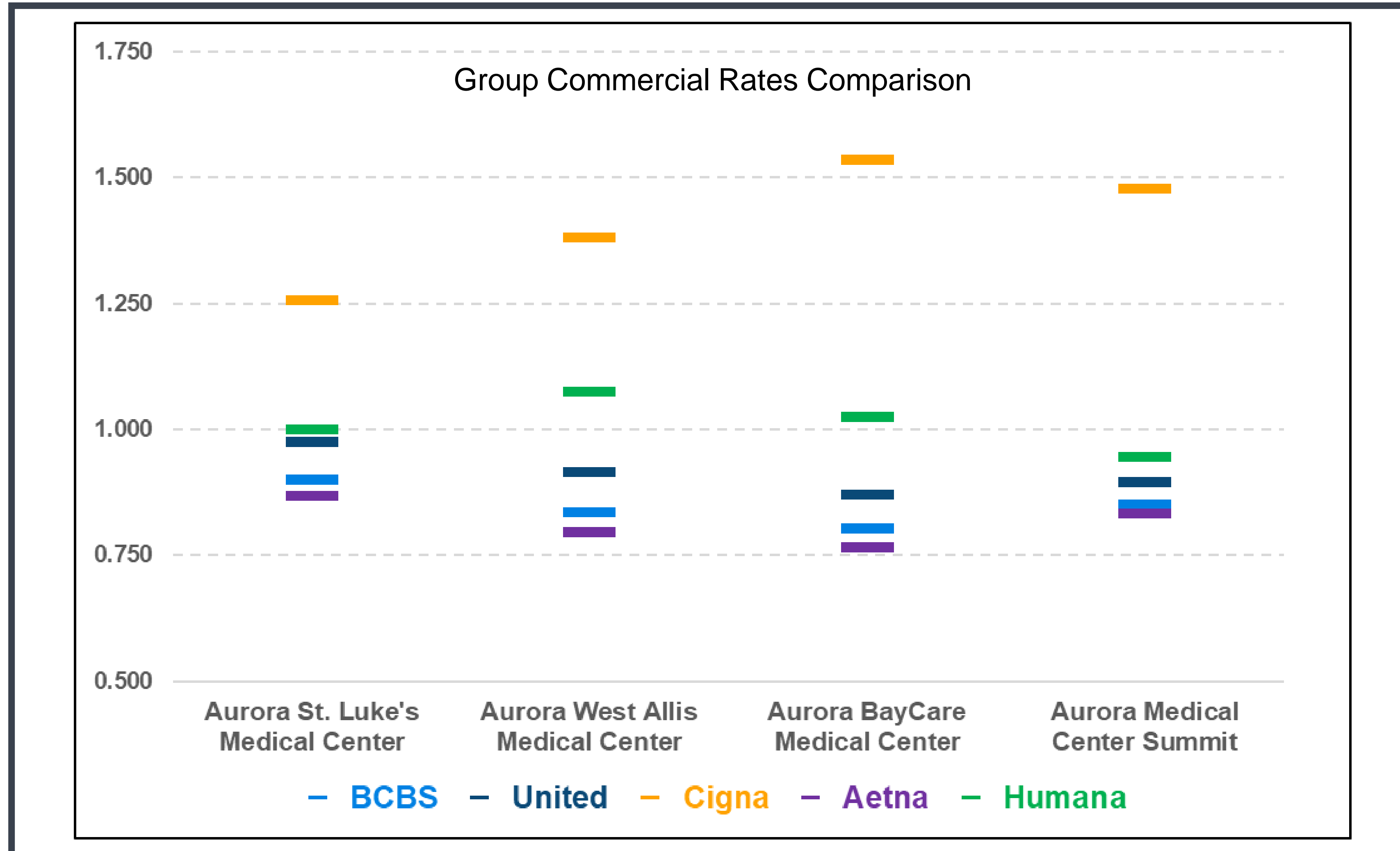
Providers:

- Negotiate to high end of market
- Subsidize “shoppable” services
- Increase bundling and value-based approach to mask costs

Others:

- Assess differences in costs to improve decision-making
- Create price transparency tools
- Highlight “bad actors” and push for better information

Case study: Payer relativity analysis



Understanding relative costs at any level requires utilization and standardized price values.

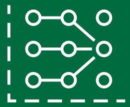
Direct Contracting

Approaches

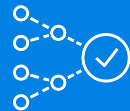
Strategic approach: Employer perspective

When developing a strategy, an employer needs to determine how wide to cast its net

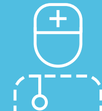
Dollars impacted by strategy



- **Specific conditions**



- **Specific services**



- **Primary care carve-out**

- **Total cost of care**

Strategic approach: Provider perspective

Provider should align their strategies with their current capabilities

Preparedness for advanced strategies

- Market differentiators
  - Transparent pricing
  - Best-in-class services
  - High quality

- ROI capabilities
  - Benchmarking
  - Cost accounting
  - Break-even analyses

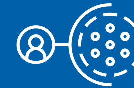
- Processes and procedures
  - UM / DM / CM
  - Advanced analytics

Ways to Pay

Payment Mechanisms

- Method of payment may vary according to chosen strategy
  - Fee-for-service
  - Fixed prospective payments
  - Bonus payments (or recoupment of losses)
- Considerations:
  - How will the approach integrate with the employer's existing TPA?
  - What is a reasonable payment rate?

Bundled Payments



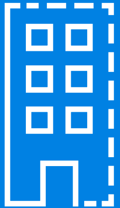
- Definition: a fixed-price agreement for a provider to perform a procedure or manage a condition and take responsibility for contractually defined related services for a specified period
  - Pre-operative and post-operative care may be included
  - Financial responsibility creates incentive to eliminate wasteful services
- Challenges
  - Administrative complexity
  - Understanding inclusions/exclusions
  - Prospective vs. retrospective methodologies
  - Data!
  - Scale

Shared Savings

- Definition: financial agreement whereby providers are rewarded (or penalized) for their performance against established targets for claims and quality outcomes
  - Common form of value-based contract
  - Usually covers total cost of care (sometimes including Rx)
  - Can be simple to execute agreement between employer and provider
  - Typically relies upon fee-for-service infrastructure
- Challenges
  - Prospective
  - Difficulty in understanding risk management provisions

Developing a new partnership

Assuming there is appetite on both sides to pursue a direct contracting relationship, how might each party conduct the appropriate due diligence to evaluate the opportunity?



Employers

- Analyze claims data to understand drivers of cost and opportunities
- Is there an opportunity to drive employees to higher-quality / lower cost providers
- Evaluate hospital price transparency information

- Providers
  - Understand the landscape of local employers, and who has a large concentration in service area
  - Assess utilization to find opportunities to increase market share
  - Determine how aggressive payment rates can be…

Possible Futures

Questions?

Milliman

“Final Items of the Day”

2nd Annual Culture of Wellness Award
Applications open January 2nd

Door Prize Drawing!

Join us earlier next Spring
April 20th – 21st
Focus: PDTs and Metabolic Disease

Thank you!