LIVE VIRTUAL BOARD MEETING

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Attention: Public comment requests must be submitted via email to PublicComment@lacera.com.

LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION
300 N. LAKE AVENUE, SUITE 650, PASADENA, CA

LACERA 2021 BOR

BOARD OF RETIREMENT
OFFSITE

LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION

A REGULAR MEETING OF THE BOARD OF RETIREMENT LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION 9:00 A.M., WEDNESDAY, OCTOBER 27, 2021

This meeting will be conducted by the Board of Retirement by teleconference under California Government Code Section 54953(e).

Any person may view the meeting online at https://LACERA.com/leadership/board-meetings

The Board may take action on any item on the agenda, and agenda items may be taken out of order.

9:00 a.m. **Call to Order**

Public Comment

(Written Public Comment - You may submit written public comments by email to PublicComment@lacera.com. Correspondence will be made part of the official record of the meeting. Please submit your written public comments or documentation as soon as possible and up to the close of the meeting.

Verbal Public Comment - You may also request to address the Board at PublicComment@lacera.com before and during the meeting at any time up to the end of the Public Comment item. We will contact you with information and instructions as to how to access the meeting as a speaker. If you would like to remain anonymous at the meeting without stating your name, please let us know.)

9:05 a.m. **Welcome & Opening Remarks**
Speakers: Santos H. Kreimann, Chief Executive Officer

9:10 a.m. **Long Term Consequences of Covid-19 Infection**
Speaker: Dr. Glen Ehresmann, LACERA's Medical Advisor

Long Term Consequences of Covid-19 Infection (Continued)
Speaker: Dr. Glen Ehresmann, LACERA's Medical Advisor

While the acute consequences, morbidity, and mortality of Covid 19 infection are generally well know, there is emerging information about long term effects of Covid infection, which include severe consequences for some people. This presentation will update information available about post Covid complications present in "Long Haulers", that group of patients who have serious post Covid impairments.

10:15 a.m. Break

10:30 a.m. Medicare Basics
Speakers: Stephen M. Murphy, Segal and Cassandra Smith, Retiree Healthcare Division Manager

An overview of Medicare's history, its multiple components, and insights into how it coordinates with LACERA's Retiree Healthcare program.

11:30 a.m. Break

11:40 a.m. Healthcare Legislation: Legal and Regulatory Update
Speakers: Kathy Bakich, Sr. Vice President and Amy Dunn, Vice President, Segal's National Healthcare Compliance Practice

The Legislative and Regulatory Update will address potential policy changes, proposed legislation, and updates impacting benefit programs, including COBRA and other American Rescue Plan Act changes, the status of the ACA, the No Surprises Act and Transparency.

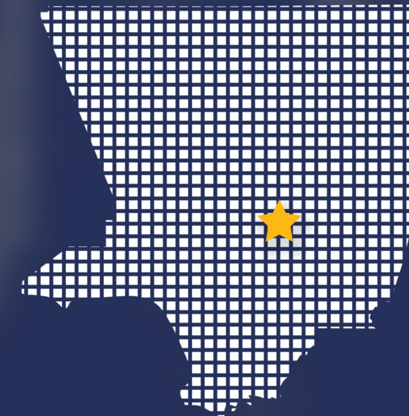
12:30 p.m. Closing

Documents subject to public disclosure that relate to an agenda item for an open session of the Board of Retirement that are distributed to members of the Board of Retirement less than 72 hours prior to the meeting will be available for public inspection at the time they are distributed to a majority of the Board of Retirement Trustees at LACERA's offices at 300 N. Lake Avenue, Suite 820, Pasadena, CA 91101, during normal business hours of 9:00 a.m. to 5:00 p.m. Monday through Friday.

Requests for reasonable modification or accommodation of the telephone public access and Public Comments procedures stated in this agenda from individuals with disabilities, consistent with the Americans with Disabilities Act of 1990, may call the Board Offices at (626) 564-6000, Ext. 4401/4402 from 8:30 a.m. to 5:00 p.m. Monday through Friday or email PublicComment@lacera.com, but no later than 48 hours prior to the time the meeting is to commence.

LACERA 2021 **BOR**

BOARD OF RETIREMENT OFFSITE



WELCOME & OPENING REMARKS

Long Term Consequences of Covid-19 Infection

Glenn Ehresmann MD

LONG TERM CONSEQUENCES OF COVID-19 INFECTION

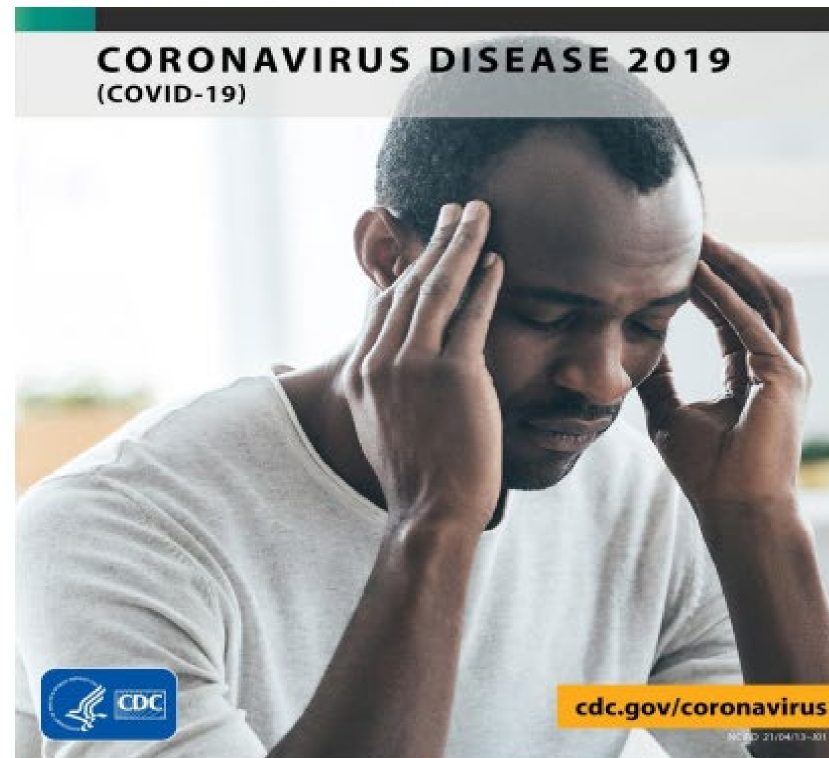
Speaker: Dr. Glen Ehresmann

While the acute consequences, morbidity, and mortality of Covid 19 infection are generally well known, there is emerging information about long term effects of Covid infection, which include severe consequences for some people. This presentation will update information available about post Covid complications present in "Long Haulers", that group of patients who have serious post Covid impairments.

Covid Long Haulers

Post-COVID Conditions is an umbrella term

- "**Post-COVID conditions**" is an umbrella term for the wide range of physical and mental health consequences experienced by some patients that are present four or more weeks after SARS-CoV-2 infection, including by patients who had initial mild or asymptomatic acute infection.



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Symptoms of Post Covid Long Haulers

- Shortness of breath
- Cognitive Dysfunction
- Fatigue
- Also, 200 other symptoms have been reported
  - Chest pain
  - Trouble speaking
  - Anxiety
  - Depression
  - Myalgias
  - Loss of smell and taste

Covid Long Haulers: Associated Conditions

For clinical features warranting further evaluation, consider broad range of possible post-COVID conditions

Body System	Conditions (subject to change and not mutually exclusive)
Cardiovascular	Myocarditis, heart failure, pericarditis, orthostatic intolerance (e.g., postural orthostatic tachycardia syndrome [POTS])
Pulmonary	Interstitial lung disease, reactive airway disease
Renal	Chronic kidney disease
Dermatologic	Alopecia
Rheumatologic	Reactive arthritis, fibromyalgia, connective tissue disease
Endocrine	Diabetes mellitus, hypothyroidism
Neurologic	Transient ischemic attack/stroke, olfactory and gustatory dysfunction, sleep dysregulation, altered cognition, memory impairment, headache, weakness, neuropathy
Psychiatric	Depression, anxiety, post-traumatic stress disorder (PTSD), psychosis
Hematologic	Pulmonary embolism, arterial thrombosis, venous thromboembolism, other hypercoagulability
Urologic	Incontinence, sexual dysfunction
Other	Weight loss, dysautonomia, allergies and mast cell activation syndrome, reactivation of other viruses, pain syndromes, hearing loss, vertigo, and progression of comorbid conditions

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Duration of Post Covid Syndrome Variable

- Has been documented for 3-6 months and up to 9 months
- We are still over 18 months into the pandemic so we will continue to see how long these will continue

Post Covid Laboratory Testing

At this time, no laboratory test can definitively distinguish post-COVID conditions from other etiologies

- A positive viral test is not required to establish a diagnosis of post-COVID conditions
- Lab testing should be guided by clinical findings
- A basic panel of lab tests might be considered between 4 and 12 weeks
- Consider additional testing if symptoms persist for 12 weeks or longer

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Basic Laboratory Evaluation of Post Covid Patient

Basic diagnostic tests to consider ≥4 weeks after SARS-CoV-2 infection (or sooner if clinically indicated)	
Category	Laboratory tests
Blood count, electrolytes, and renal function	Complete blood count with possible iron studies to follow, basic metabolic panel, urinalysis
Liver function	Liver function tests or complete metabolic panel
Inflammatory markers	C-reactive protein, erythrocyte sedimentation rate, ferritin
Thyroid function	TSH and free T4
Vitamin deficiencies	Vitamin D, vitamin B12
Specialized diagnostic tests* to consider ≥12 weeks after SARS-CoV-2 infection (or sooner if clinically indicated)	
Category	Laboratory tests
Rheumatological conditions	Antinuclear antibody, rheumatoid factor, anti-cyclic citrullinated peptide, anti-cardiolipin, and creatine phosphokinase
Coagulation disorders	D-dimer, fibrinogen
Myocardial injury	Troponin
Differentiate symptoms of cardiac versus pulmonary origin	B-type natriuretic peptide

* The specialized diagnostic tests should be ordered in the context of suggestive findings on history and physical examination

Covid Long Haulers: Medical Management

For most patients, the goal of medical management is to optimize function and quality of life

- Creating a comprehensive rehabilitation plan may be helpful for some patients
- Many post-COVID conditions can be improved through already established symptom management approaches
- Evidence indicates that holistic support for the patient throughout their illness course can be beneficial

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Treatment of Covid Long Haulers

- No specific treatments as we don't understand fully the mechanism of post-COVID-19 condition
- Unclear interaction of COVID-19 vaccine and post COVID-19 condition
- Compassionate supportive Care
- Rehabilitation: PT, OT, Speech Therapy
- Recognize comorbidities will affect outcomes; patients with pre-existing conditions will have a more challenging recovery

Break

Stephen E. Murphy, CEBS

Vice President and Benefits Consultant, Glendale, CA

Expertise

Mr. Murphy is a Vice President and Benefits Consultant in Segal's Glendale office with over 35 years of health benefits experience. He works with state, city and county governments as well as other public sector clients to develop and maintain their employee benefit plans. Mr. Murphy has specialized expertise in health strategy development and implementation, claim reporting and data analysis, and vendor evaluation, selection and management.

Professional background

Prior to Segal, Mr. Murphy worked at other national consulting firms where he developed and maintained total rewards programs that were tax-efficient, cost-effective and valued by participants.

Education/professional designations

Mr. Murphy holds a BS in Business Administration from the University of Southern California and a MS in Human Resource Management from Boston University. He is a Certified Employee Benefits Specialist and holds a certificate in Global Business Management from the International Foundation of Employee Benefit Plans.

Stephen E. Murphy, CEBS
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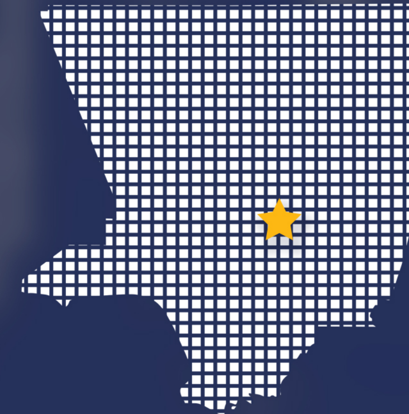
Medicare Basics

Stephen Murphy, Vice President, Segal
Cassandra Smith, Retiree Healthcare Division Manager, LACERA



MEDICARE BASICS

Speakers: Stephen M. Murphy, Segal Consulting and Cassandra Smith, Retiree Healthcare Division Manager

An overview of Medicare's history, its multiple components, and insights into how it coordinates with LACERA's Retiree Healthcare program.

What We'll Cover

Introduction and History of Medicare

Medicare Parts A, B and C

Medicare Part D

Medicare Enrollment

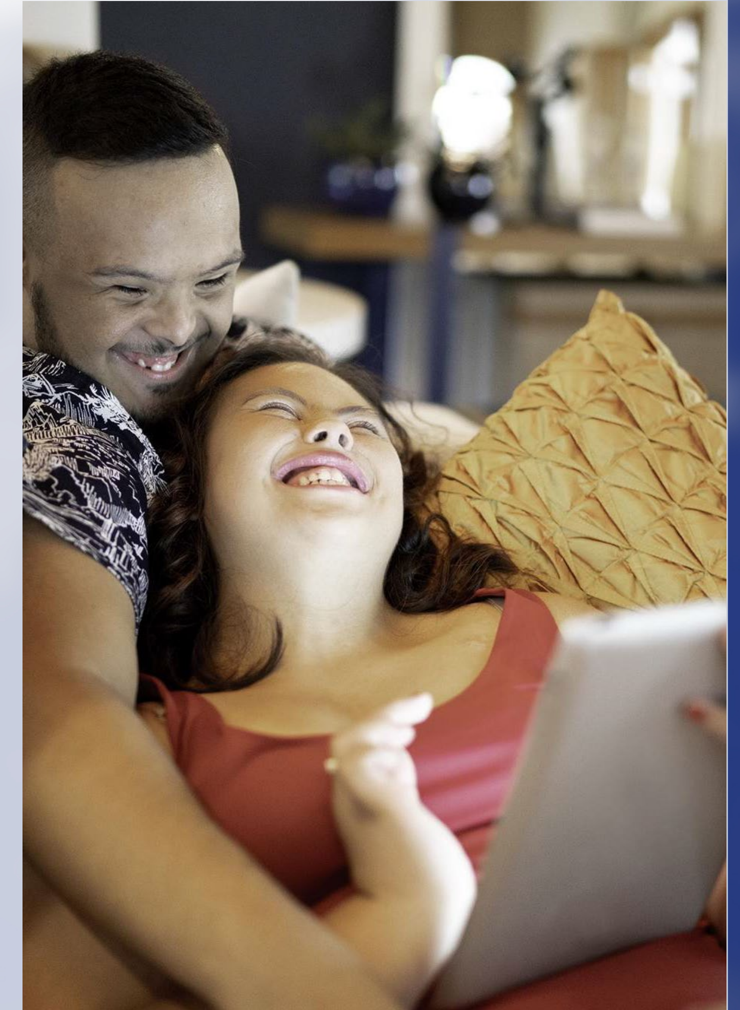
Medicare Secondary Payer (MSP)

1 Introduction and History of Medicare

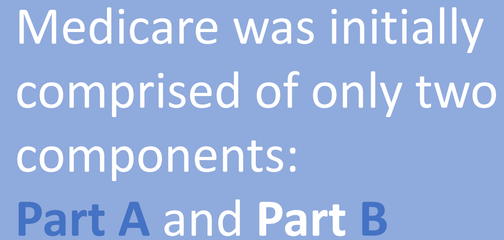
Introduction to Medicare

Medicare a federal health insurance program that provides health coverage for U.S. citizens who are:

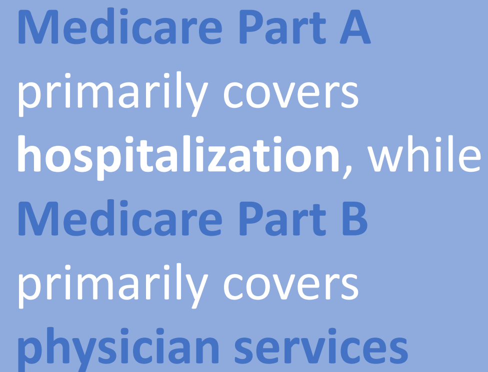
- Aged 65 or older;
- Disabled; and
- Diagnosed with End Stage Renal Disease (ESRD)
- Today, more than 60 million Americans receive some form of coverage through Medicare



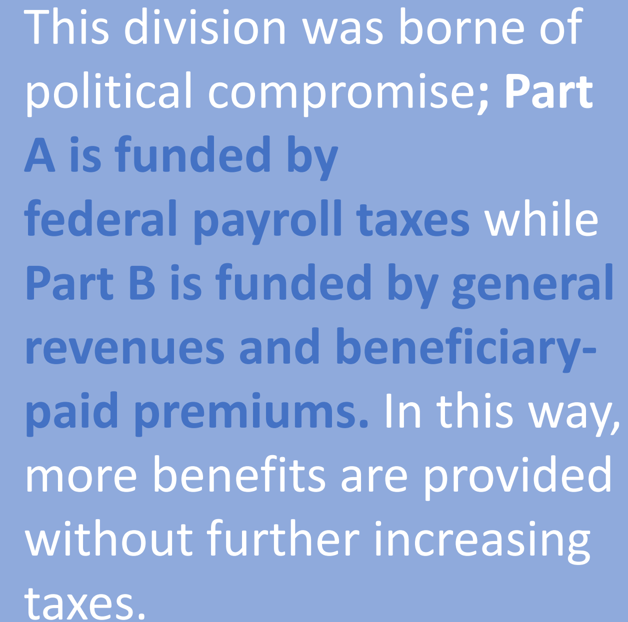
History of Medicare



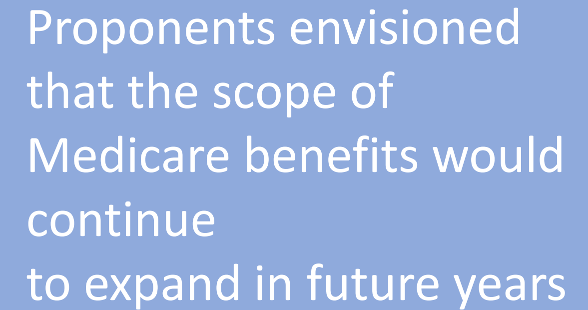
Medicare was initially comprised of only two components:
Part A and **Part B**



Medicare Part A primarily covers **hospitalization**, while **Medicare Part B** primarily covers **physician services**

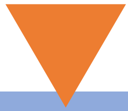


This division was borne of political compromise; **Part A is funded by federal payroll taxes** while **Part B is funded by general revenues and beneficiary-paid premiums.** In this way, more benefits are provided without further increasing taxes.

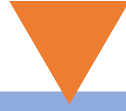


Proponents envisioned that the scope of Medicare benefits would continue
to expand in future years

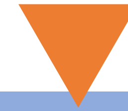
History of Medicare



Medicare **Part C**, which enables beneficiaries receive Medicare benefits through private **health plans** who contract with the federal government,
was formally established in 1997



Medicare **Part D**, which provides outpatient **prescription drug benefits**,
was established through the Medicare Modernization Act of 2003



Some hoped that it would continue to evolve further than this to provide federal health insurance to all Americans. We continue to see this today through recent "Medicare for All" proposals by various members of Congress

Medicare ABCs (and D)

Medicare has four parts:

Part A

Hospital Services

Part B

Physician Services

Part C

Medicare Advantage

Part D

Outpatient Prescription Drugs

- Each has different rules regarding enrollment, benefits and payment
- Most beneficiaries receive their Part A and Part B benefits through "**Original Medicare**", the traditional fee-for-service program offered **directly through the federal government**

Medicare ABCs (and D)

Original Medicare (Parts A and B) does not cover:

- While these items/services are not covered by Original Medicare, private Medicare Advantage plans (Part C) may cover these gaps in coverage
- Medicare outpatient prescription drug coverage (Part D) is available to cover the costs of drugs for Medicare beneficiaries who are enrolled in Original Medicare or a Medicare Part C plan

Section 1 Quiz

Choose all that apply.

1. What does Medicare Part B cover:

a. __ Outpatient prescription drugs

b. __ Long term care

c. __ Hospital services

d. __ Outpatient services

2. How is Medicare Part B funded?

a. __ Federal employment taxes

b. __ General federal revenues

c. __ Employer contributions

d. __ Beneficiary premiums

3. When was Medicare Part D enacted?

a. __ 2015

b. __ 1932

c. __ 2003

d. __ 1997

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Medicare Parts A, B and C

Medicare Part A Coverage

Part A Hospital Insurance

- Inpatient hospital stays, including stays at critical access hospitals (CAHs) and inpatient rehabilitation facilities
- Skilled nursing facility stays (but not for long-term care)
- Hospice care
- Home health care services

Medicare Part A Eligibility

In general, those eligible for "premium free" Part A coverage include:

U.S. citizens or permanent legal residents age 65 and older	Individuals under age 65 who have a disability	Individuals diagnosed with ESRD
• Who have worked at least 10 years (40 quarters) and paid Medicare taxes during that time • Who have **not** worked at least 10 years (40 quarters), but are married to a spouse who is at least 62 years and **has** paid at least 10 years of Medicare taxes	• Who have been receiving disability benefits from the Social Security Administration for 24 months	• Who have worked at least 10 years (or are married to a spouse who has worked 10 years) and paid Medicare taxes during that time • Have waited the applicable waiting period

Medicare Part A Premiums

Most people qualify for "premium-free" Part A coverage due to their (or their spouse's) work history

However, those age 65 and older who do not meet the criteria for receiving premium-free Part A coverage may buy-in to Part A by paying a monthly premium:

If you are age 65 and older and you or your spouse **worked between 7.5 and 10 years** (between 30 and 39 quarters), the Part A monthly premium is **$259** in 2021

If you are age 65 and older and you or your spouse **worked fewer than 7.5 years** (fewer than 30 quarters), the Part A monthly premium is **$471** in 2021

Medicare Part A Cost Sharing

Deductible: $1,484 for each benefit period

Coinsurance:

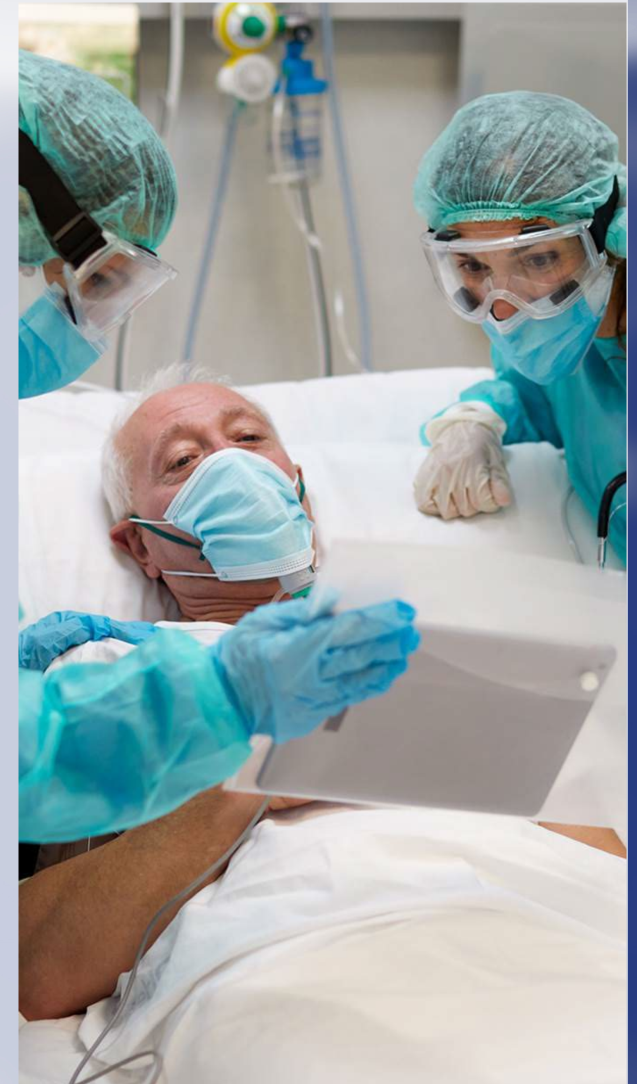
Days 1-60: $0 coinsurance for each benefit period*

Days 61-90: $371 coinsurance per day of each benefit period*

Days 91 and beyond: $742 coinsurance per each "lifetime reserve day"** after day 90

Beyond lifetime reserve days = Beneficiary responsible for all costs

* A benefit period is begins the day one is admitted and ends after the beneficiary does not receive any further inpatient care for 60 days in a row
**Each beneficiary has an additional 60 days of coverage, called "lifetime reserve days", which can only be used one per lifetime



Medicare Part B Coverage

Part B Physician's Services

- Physician services
- Preventive Services
- Services and supplies incident to physician professional services, including drugs that cannot be self-administered
- Outpatient hospital services
- Outpatient PT, OT, and ST service
- X-ray, laboratory, and diagnostic testing
- Durable Medical Equipment (DME)
- Prosthetics, orthotics, and supplies
- Ambulance services
- Mental health services
- Etc.

Medicare Part B Cost Sharing

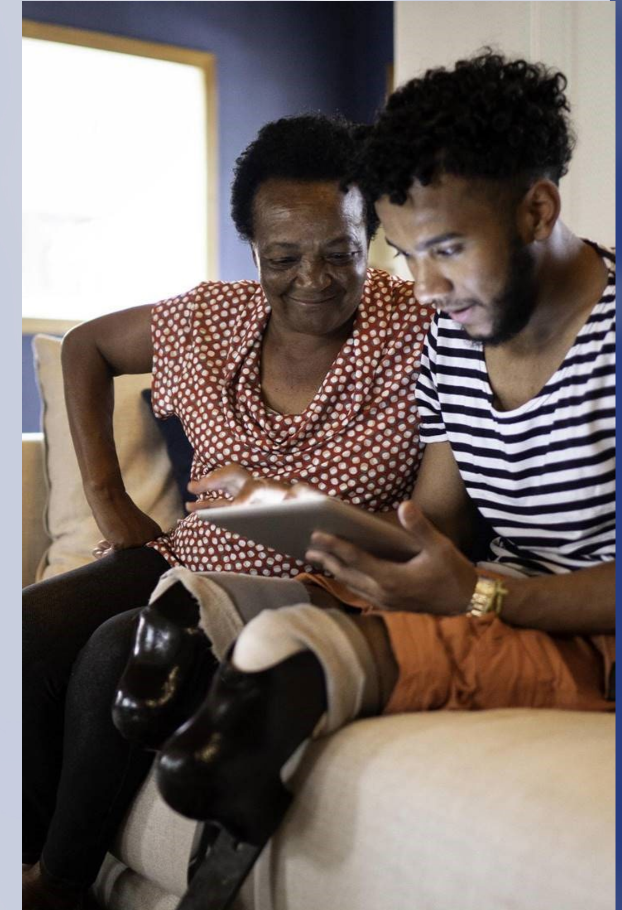
Those eligible for Medicare Part A benefits are also eligible for Medicare Part B

Premium: Based on annual adjusted gross income

- Standard is $148.50 per month for those with lowest incomes
- Up to $504.90 per month for those with highest incomes
- Unless the individual qualifies for a Special Enrollment period, failure to enroll in Part B at the time of initial eligibility results in a **late penalty on premiums of 10%** for each 12-month period the individual did not enroll

Deductible: $203.00 per year

Coinsurance: 20% of the Medicare-approved amount after deductible is met for most services



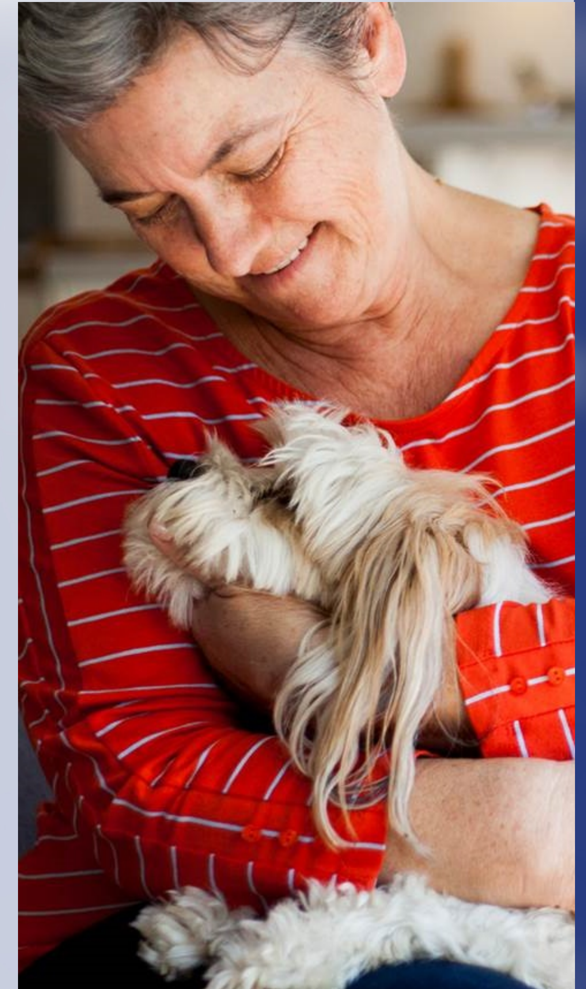
Medicare Part C Coverage

Part C Medicare Advantage

- Medicare Part C plans, referred to as Medicare Advantage (MA) plans, is **alternative coverage** to Original fee-for-service Medicare (Part A and Part B)
- Part C plans are offered by **private insurance companies** contracted with Medicare.
- The plans are **required to provide all the benefits offered by Part A and Part B**, and many also provide Part D prescription drug coverage
- **Part C plans may also cover many benefits not covered by Medicare**, such as dental, eye care, hearing care, and wellness services

Medicare Part C Costs

- Most Part C plans are traditional HMOs that require the patient to have a primary care physician, but there are also PPO and hybrid HMO-POS plans
- Part C plan beneficiaries typically must pay a monthly premium **in addition to also paying the Medicare Part B premium** (and Part A premium, if applicable) to cover costs of those items/services not covered by Original Medicare
  - **Thus, beneficiaries must be enrolled in both Medicare Part A and Part B in order to sign up for a Part C plan**
- Each Part C plan sets its own specific premiums and beneficiary cost sharing (deductibles, copayments, coinsurance)
  - Some Part C plans have $0 premiums and some even pay the cost of the beneficiary's Part B premium



Section 2 Quiz

Choose all that apply.

1. **What benefits are covered under Part A?:**

   a. __ Hospital Services
   b. __ Custodial Services
   c. __ Durable Medical Equipment
   d. __ Skilled Nursing Facility Services

2. **Medicare Part C is provided:**

   a. __ On a fee for service basis
   b. __ Through an HMO
   c. __ Through a PPO
   d. __ None of the above

3. **Medicare Part A covers expenses on the basis of:**

   a. __ A calendar year
   b. __ A plan year
   c. __ A benefit period
   d. __ A six-month period

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Medicare Part D

Medicare Part D Coverage

Part D Prescription Drugs

- Part D is Medicare's **outpatient prescription drug benefit**
- Can be obtained through two types of plans administered **by private insurance companies:**
  - Those with **Original Medicare** (Part A **or** Part B) coverage may join a stand-alone **Prescription Drug Plan (PDP)**
  - Beneficiaries may also an enroll in a **Medicare Advantage** (Part C) plan that also covers outpatient prescriptions drugs **(MA-PD plan)**

Medicare Part D Costs

- Medicare PDPs must offer at least the **“Standard Benefit”** in order to be qualified as a Medicare Part D plan
  - The standard benefit is defined in terms of **benefit structure** (i.e. min/max deductibles, coinsurance, and out-of-pocket limits), but **does not mandate** what specific drugs must be covered in the formulary
- Most plans do not offer the Standard Benefit and instead offer actuarially equivalent or more generous plans
  - While structured differently with copays/coinsurance, the plans still cannot impose a higher deductible or out-of-pocket thresholds
- Each Part D plan sets its own monthly premiums, however those with higher incomes must pay an additional amount to the Social Security Administration in addition to the Part D plan premium amount

Medicare Part D Costs

Standard Benefit Design Parameters

Coverage Period	Total Drugs Costs	Cost Sharing
Annual Maximum Deductible	$445	**Beneficiary** pays 100%
Initial Benefit Period Maximum	$4,130	**Beneficiary** pays 25% **Plan** pays 75%
Secondary Coverage (aka the "Donut Hole")	$6,550	**Brand Name Medications** (70% manufacturer discount) • **Beneficiary** pays 25% • **Plan** pays 5% **Generic Medications** • **Beneficiary pays 25%** • **Plan pays 75%**
Catastrophic coverage	$6,550+	**Beneficiary** pays 5% (or a small copayment, whichever is less) **Plan** pays 15% **Medicare** pays 80%

Effective as of 2020, Affordable Care Act provisions "closed" the Part D "donut hole" by imposing less cost sharing for brand name and generic drugs during the coverage gap. Both brand and generic drugs now impose 25% cost sharing to beneficiaries, with almost the entire cost of brand drugs counting towards the beneficiary's total out-of-pocket drugs costs.

Part D and Group Health Plans

The federal government also offers programs to incentivize group health plan sponsors (municipalities, unions, employers) to offer prescription drug benefits to retirees and take cost burdens off of the Medicare program

The Retiree Drug Subside Program (RDS)	The Employer Group Waiver Plan (EGWP)
The Retiree Drug Subside Program (RDS) gives plan sponsors a federal subsidy equal to 28% of the retiree's costs for prescription drugs that would otherwise be covered by Medicare Part D	The Employer Group Waiver Plan (EGWP) is an official Medicare Part D program that ensures retirees will receive benefits at least equal to those of the active plan the employer currently offers; wraps around other post-employment benefits (the medical plan) • Is similar to the RDS, but may provide greater cost savings given some recent changes to taxation of benefits under the RDS program • Gives additional subsidy dollars unavailable under the RDS

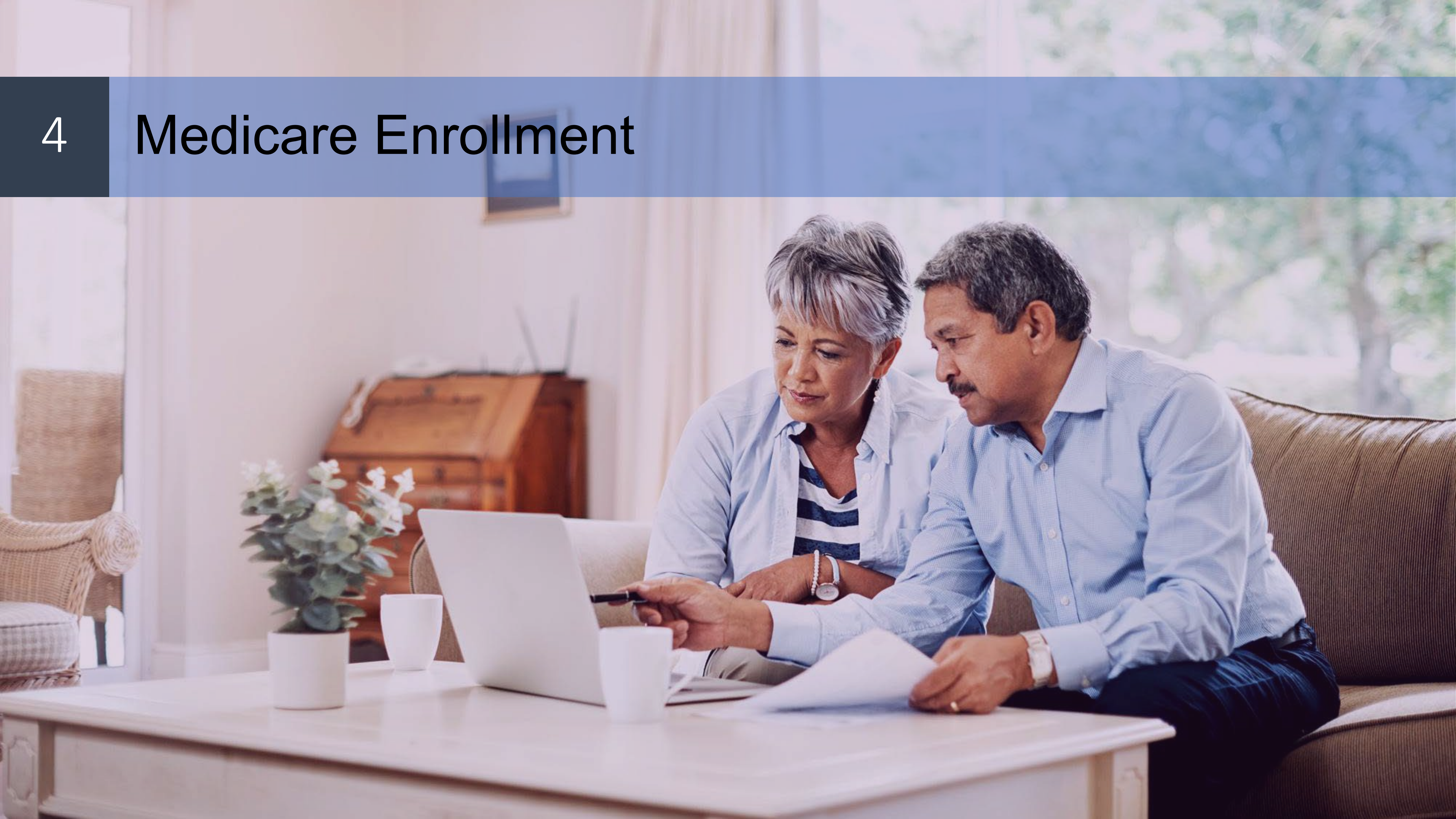
Section 3 Quiz

Choose all that apply.

1. **All Medicare Part D plans must cover the same prescription drugs?**
   a. __ True
   b. __ False

2. **The "donut hole" requires a Medicare beneficiary to pay:?**
   a. __ 100% of all incurred outpatient prescription drug expenses
   b. __ 5% of discounted prescription outpatient drug expenses
   c. __ 25% of incurred outpatient prescription drug expenses
   d. __ 25% of incurred inpatient and outpatient prescription drug expenses

3. **Each Medicare Part D prescription drug plan must use the same cost thresholds each year as prescribed by CMS' "standard benefit?"**
   a. __ True
   b. __ False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Medicare Enrollment

Medicare Automatic Enrollment

Enrollment in Original Medicare Part A and/or Part B can occur automatically for individuals

Automatic Enrollment for those eligible due to age	Automatic Enrollment for those eligible due to disability
• Those who worked for 10 years (40 quarters) and are receiving Social Security retirement benefits as a result of having paid into the system will be automatically enrolled in premium-free Part A and Part B, effective the month they turn 65 • Those who are not actively receiving Social Security retirement benefits will have to affirmatively enroll in Part A and/or Part B coverage during their Medicare initial enrollment period by applying through Social Security	• Those who become eligible for Medicare because of a disability and have been receiving Social Security Disability Insurance (SSDI) for 24 months will be automatically enrolled in Part A and Part B, effective the 25th month of their disability.

Medicare's Initial Enrollment Period

Those who are not receiving Social Security retirement benefits when turning 65 (and thus not automatically enrolled) will have to initially sign up for Medicare during the Initial Enrollment Period (IEP)

- May sign up for Part A, B, C, or D during the Initial Enrollment Period
- For Part A and Part B, the IEP is the 7-month period that begins three months prior to the month the individual attains age 65 and ends the third month after the month the individual attains age 65

If enrollment occurs:	Part B/Part A coverage begins:
3 months before age 65	At age 65
At age 65	1 month after age 65
1 month after age 65	3 months after age 65
2 months after age 65	5 months after age 65
3 months after age 65	6 months after age 65

Medicare's General/Annual/ Open Enrollment Periods

Individuals who did not enroll in Medicare during their Initial Enrollment Period may enroll during the General, Annual, or Open Enrollment Periods:

General Enrollment Period (GEP): Runs each year from January 1 through March 31. Coverage becomes effective on July 1st of the same year.	Annual Enrollment Period: Runs from October 15 through December
• During this time, individuals may enroll in coverage for Part A and Part B.	• During this time, individuals may sign up for a Part C plan, change Part C plans, or drop a Part C plan and return to Original Medicare • May enroll in a Part D plan, change Part D plans, enroll in a stand-alone PDP if dropping a Part C plan and returning to Original Medicare

Medicare's General/Annual/ Open Enrollment Periods

Individuals who did not enroll in Medicare during their Initial Enrollment Period may enroll during the General, Annual, or Open Enrollment Periods:

Medicare Advantage Open Enrollment Period:
Runs from January 1 through March 317

- Allows individuals to switch Part C plans, dis-enroll from a Part C plan and return to original Medicare, or switch Part C plans (subject to conditions)
- Individuals cannot switch from Original Medicare to a Part C plan or join a standalone Part D plan during this time

Medicare's Late Enrollment Penalties

Beneficiaries who delay enrolling in Part A, B, or D will face late enrollment penalties (premium surcharges) unless they otherwise qualify for a Special Enrollment Period

Part A premium 10% penalty	Part B premium 10% increase	Part D premium penalty
Part A premium penalty of 10% is payable for a period that is equal to twice the number of full 12-month periods during which the individual could have been enrolled in Premium Part A, but was not enrolled	Part B premium will be increased 10% for each full 12-month period during which the individual could have been enrolled in Part B, but was not enrolled. The surcharge is **payable for life**	Part D premium penalty is imposed if a beneficiary goes without "creditable" prescription drug coverage for a period of more than 63 continuous days. The amount of the penalty varies depending on how long the individual went without creditable coverage.

Medicare's Special Enrollment Period

Individuals who are covered under a group health plan based on current employment may have a Special Enrollment Period (SEP) to sign up for Part A and/or Part B as long as:

- The individual or their spouse is working
- The individual is covered by a group health plan through the employer

The SEP lasts for 8 months, beginning on:

- The month after the individual's employment ends
- The month after group health plan insurance based on current employment ends

The result is that individuals will not pay late enrollment penalties (premium surcharges) when signing up for Medicare during a SEP

Medicare’s Special Enrollment Period

For Part C Medicare Advantage plans and Part D prescription drug plans:

Individuals will be afforded a Special Enrollment period to add, change, or drop coverage after experiencing certain events including:

- Losing current coverage or obtaining new coverage from an employer
- Moving out of the plan’s service area
- Becoming eligible for Medicaid or a Medicare Savings Program
- Being misinformed about the status of their creditable drug coverage

The length and conditions of the SEP, as well as effective date of coverage, vary depending on the event

Deferring Medicare Enrollment

Most people should enroll in Part A when they turn 65, even if they have health insurance through an employer plan

- Because most people receive premium-free Part A, they should enroll in Medicare when they turn age 65 — even if they have coverage through an employer's group health plan
- Those who have health insurance through an employer plan may delay enrollment in Part B since everyone must pay a monthly premium for Part B
- Individuals who are enrolled in a High Deductible Health Plan (HDHP) may wish to defer enrollment in both Part A and Part B when turning 65 so that they can continue contributing to their HSA on a pre-tax basis

Section 4 Quiz

Choose all that apply.

1. **When must a person age 65 without other health plan coverage first enroll for Medicare to avoid late premium penalties?**

   a. __ During his or her Initial Enrollment Period (IEP)

   b. __ During the Annual Enrollment Period

   c. __ During a Special Enrollment Period (SEP) following the loss of employment-based coverage

   d. __ During a Special Enrollment Period following the termination of COBRA Continuation Coverage

2. **The late penalty for premium Part A is for the life of the Medicare beneficiary.**

   a. __ True

   b. __ False

3. **A seven-month enrollment period is for the:**

   a. __ Special Enrollment Period (SEP)

   b. __ General Enrollment Period (GEP)

   c. __ Annual Enrollment Period

   d. __ Initial Enrollment Period (IEP)

5
Medicare Secondary Payer (MSP)

Medicare Secondary Payer (MSP) Law

The Medicare Secondary Payer (MSP) statute establishes the coordination of benefits (COB) when a Medicare beneficiary is covered under another group health plan or insurance policy

Circumstances	Additional Conditions	Primary Payer	Secondary Payer
Age-based Medicare entitlement + coverage due to current employment status	Employer has 20 or more employees	**Group health plan**	Medicare
Age-based Medicare entitlement + retiree health coverage or COBRA	N/A	**Medicare**	Group health plan
Disability-based Medicare entitlement + coverage due to current employment status	Employer has 100 or more employees	**Group health plan**	Medicare
Disability-based Medicare entitlement + retiree health coverage or COBRA	N/A	**Medicare**	Group health plan
ESRD-based Medicare eligibility or entitlement + group health coverage (including coverage due to current employment status, retiree health coverage, or COBRA)	First 30 months of Medicare eligibility or entitlement	**Group health plan**	Medicare
	After 30 months of Medicare eligibility or entitlement	**Medicare**	Group health plan

Medicare Secondary Payer (MSP) Law

The MSP law also imposes mandatory annual insurer reporting requirements for group health plans

- The purpose is to help CMS identify and recover mistaken Medicare primary payments and prevent Medicare from making mistakes in the future when it is the secondary payer to other insurance
- Enables CMS to correctly pay for health insurance benefits of Medicare beneficiaries by determining primary versus secondary payer responsibilities up front, instead of after claims are paid
- Insurers of group health plans and the plan administrators (or TPAs) of self-insured group health plans are required to report information on all active covered individuals who are (or may become) Medicare-eligible

Section 5 Quiz

Choose all that apply.

1. Medicare pays second when a beneficiary is covered under a:

a. __ Group health plan due to COBRA Continuation Coverage

b. __ Group health plan due to their current employment status

c. __ Retiree group health plan

d. __ Group health plan before receiving 30 months of Medicare coverage due to ESRD

2. Mandatory annual insurer reporting is required only for group health plans covering retirees.

a. __ True

b. __ False

3. A beneficiary under age 65 who has Medicare due to disability cannot have current employment status.

a. __ True

b. __ False

Questions

- Contact your local or national compliance consultant with any questions

Break

Kathryn Bakich, JD

Senior Vice President, National Health Compliance Practice Leader, Washington, DC

Expertise

Ms. Bakich is a Senior Vice President in Segal's Washington, DC office with over 20 years of experience in healthcare compliance. She is the firm's National Health Compliance Practice Leader.

Ms. Bakich is one of the country's leading experts on employer sponsored health coverage. She specializes in providing research and analysis on federal laws and regulations affecting health coverage, including ERISA, Medicare, HIPAA, COBRA, the Newborns' and Mothers' Health Protection Act, the Mental Health Parity Act and the Women's Health and Cancer Rights Act.

Ms. Bakich is a recognized expert on the Patient Protection and Affordable Care Act. She speaks regularly about the law, helps plan sponsors understand its short- and long-term effects on their plans and assists clients with preparing comments on the legislation for submission to regulatory Departments (Treasury, Labor and Health & Human Services).

Ms. Bakich leads the Segal team responsible for publishing information about new healthcare laws and regulations and trains internal staff on all legislation and related developments. She and her staff disseminate health compliance information, monitor federal and state laws and regulations, and prepare amendments for health plans and summary plan descriptions based on national models.

Professional background

Prior to joining Segal, Ms. Bakich was an attorney in private practice representing multiemployer health plans and an appellate administrative law judge.

Education/professional designations

Ms. Bakich graduated with a BA in Political Science, an MA in Public Policy and a JD from the University of Missouri. She has been admitted to the Bar in the District of Columbia, the United States Supreme Court and multiple federal district and appellate courts.

Ms. Bakich is a member of the Working Committee of the National Coordinating Committee for Multiemployer Plans (NCCMP), the Health Technical Issues Taskforce of the American Benefits Council (ABC) and the American Bar Association (ABA). Ms. Bakich is co-chair of the ABA Joint Committee on Employee Benefits Subcommittee on Welfare Plan Regulation. Ms. Bakich was named a Fellow of the American College of Employee Benefits Counsel in 2012. She has

served as a member of the Government Liaison Committee of the International Foundation of Employee Benefit Plans (IFEBP) since 2010.

Publication/speeches

Ms. Bakich has published multiple articles about employee health and welfare benefits, including a series of articles discussing HIPAA Administrative Simplification, EDI and Privacy in the *Benefits Law Journal*. She is a co-author of the *Employers' Guide to HIPAA Privacy Requirements,* published by Thompson Publishing Group, and a Senior Editor of *Employee Benefits Law*. Ms. Bakich speaks regularly on issues related to group health plans.

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Amy Dunn

Vice President, Senior Consultant, Health Compliance, Glendale, CA

Expertise

Ms. Dunn is a Vice President and Senior Consultant in the Health Compliance practice based in Segal's Glendale office. She has more than 20 years of compliance consulting experience, navigating federal, state and local health and welfare laws and regulations, including the Affordable Care Act, HIPAA, COBRA, USERRA, wellness plans and IRC section 125 plans.

Professional background

Prior to joining Segal, Ms. Dunn was Principal/Growth Leader in Buck's Compliance Consulting practice for more than eight years. She worked with public sector, corporate and multiemployer clients in a wide range of industries. She prepared plan documents, assisted with responses to the IRS and HHS, and designed and conducted employee training on compliance topics. Earlier in her career, Ms. Dunn was a compliance consultant at Mercer.

Education/professional designations

Ms. Dunn earned a JD from Whittier Law School (Costa Mesa, CA). She holds a Masters in Health Administration and a BA in Organizational Leadership from Chapman University (Orange, CA).

Ms. Dunn previously was on the faculty of the University of Phoenix's College of Health Professions, where she was named Faculty Member of the Year in 2019.

Publications/speeches

Ms. Dunn is a frequent speaker at seminars and conferences, including the National Business Group on Health, the Western Pension & Benefits Conference, the International Society of Certified Employee Benefit Specialists and the SouthWest Benefit Association.

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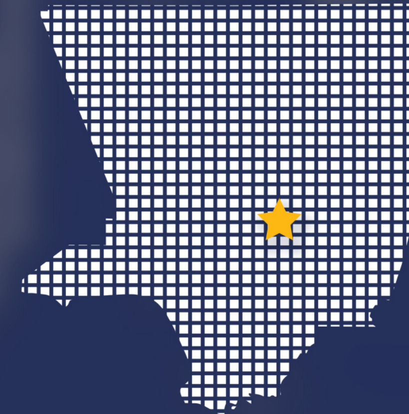
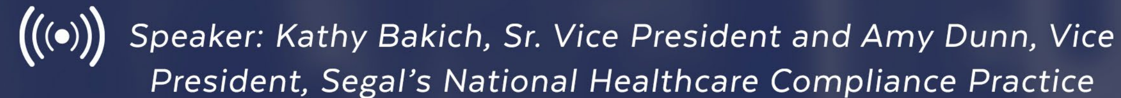
Healthcare Legislation: Legal and Regulatory Update

Kathy Bakich, Sr. Vice President, National Healthcare Compliance Practice, Segal
Amy Dunn, Vice President, National Healthcare Compliance Practice, Segal



HEALTHCARE LEGISLATION: LEGAL AND REGULATORY UPDATE



Speaker: Kathy Bakich, Sr. Vice President and Amy Dunn, Vice President, Segal's National Healthcare Compliance Practice

The Legislative and Regulatory Update will address potential policy changes, proposed legislation, and updates impacting benefit programs, including COBRA and other American Rescue Plan Act changes, the status of the ACA, the No Surprises Act and Transparency.

What We'll Cover

- Legislative/regulatory actions and priorities
- COVID-related legislative action
- What to expect from the new Administration

New Administration

President Joe Biden

Vice President Kamala Harris

Biden Cabinet

Labor	Health and Human Services	Treasury	Justice
Mayor Marty Walsh (Boston)	**Xavier Becerra** (California Attorney General)	**Janet Yellen** (Chair of Federal Reserve from 2014-2018)	**Judge Merrick Garland** (Chief Judge of the United States Court of Appeals for the District of Columbia Circuit)

American Rescue Plan Act

Enacted March 11, 2021

- COBRA Subsidy
- Paid sick and family leave tax credit
- Expansion of ACA Exchange subsidies
- Expansion of tax credits and aid to governments

Paid Sick and Family Leave Tax Credit

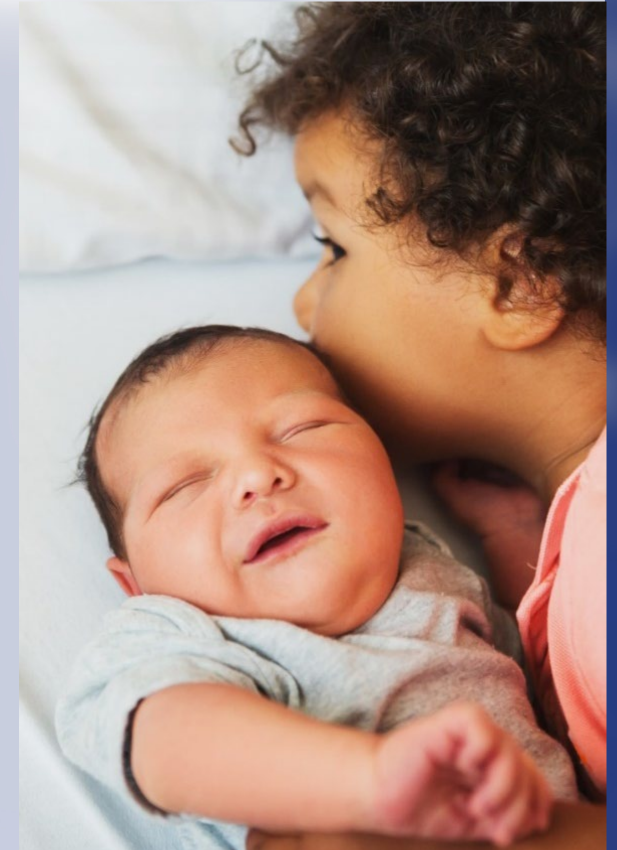
- Employers with under 500 employees and governmental employers may receive a tax credit for voluntarily providing COVID-19-related paid leave from April 1 through September 30, 2021
- Pay rates established and duration up to 14 weeks
- Advanceable and refundable—Use Form 7200 and Form 941

Families First and CARES Acts

COVID-19 Testing and Visits

Effective March 18, 2020 through the end of the Public Health Emergency (Currently October 18, 2021) group health plans must cover without cost sharing:

- COVID-19 diagnostic and serologic tests
- Test administration
- Visit (office, urgent, ER, telehealth) and items/services related to ordering of or administration of test



CARES Act

Interim Final Rule released 10/29/20

- Non-grandfathered group health plans must cover COVID-19 vaccine(s) without cost sharing within 15 business days of recommendation from ACIP/CDC
- Vaccines and other services must be covered in- and out-of-network during Public Health Emergency
- Plan must reimburse out-of-network providers a “reasonable amount” based on market rates
  - Medicare rate would be reasonable

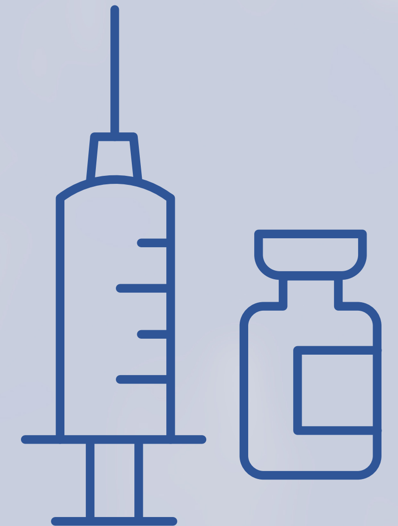
COVID-19 Vaccine and the EEOC

Existing guidance addresses obligation to provide accommodations to individuals with a medical or religious reason they cannot take the vaccine

- https://www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-rehabilitation-act-and-other-eeo-laws
- Guidance issued that HIPAA doesn't prevent asking about vaccine status

COVID-19 Vaccine Mandates and Incentives

- Mandatory vaccination requirement recently upheld with respect to a private employer and a public university
- Delta Airline announces $200 penalty through health plan wellness program
- Federal government announced health plans may provide incentives in guidance



Plan Coverage of PPE

- IRS Announcement 2021-7 clarifies that health plan sponsors can choose to cover COVID-19-related PPE such as masks, hand sanitizer and sanitizing wipes for the primary purpose of preventing the spread of COVID-19
- Plan sponsors can also permit reimbursement of expenses for such equipment from account-based plans such as Health FSAs and HRAs

Telemedicine

- Generally, there are two types of telemedicine benefits—those provided with a company that specializes in telemedicine, e.g., Teledoc, and those provided by an individual's treating physician through an electronic portal or app
- The federal government has waived certain security rules for health care providers to allow them to conduct visits using telemedicine more easily

Court Decides ACA Lawsuit

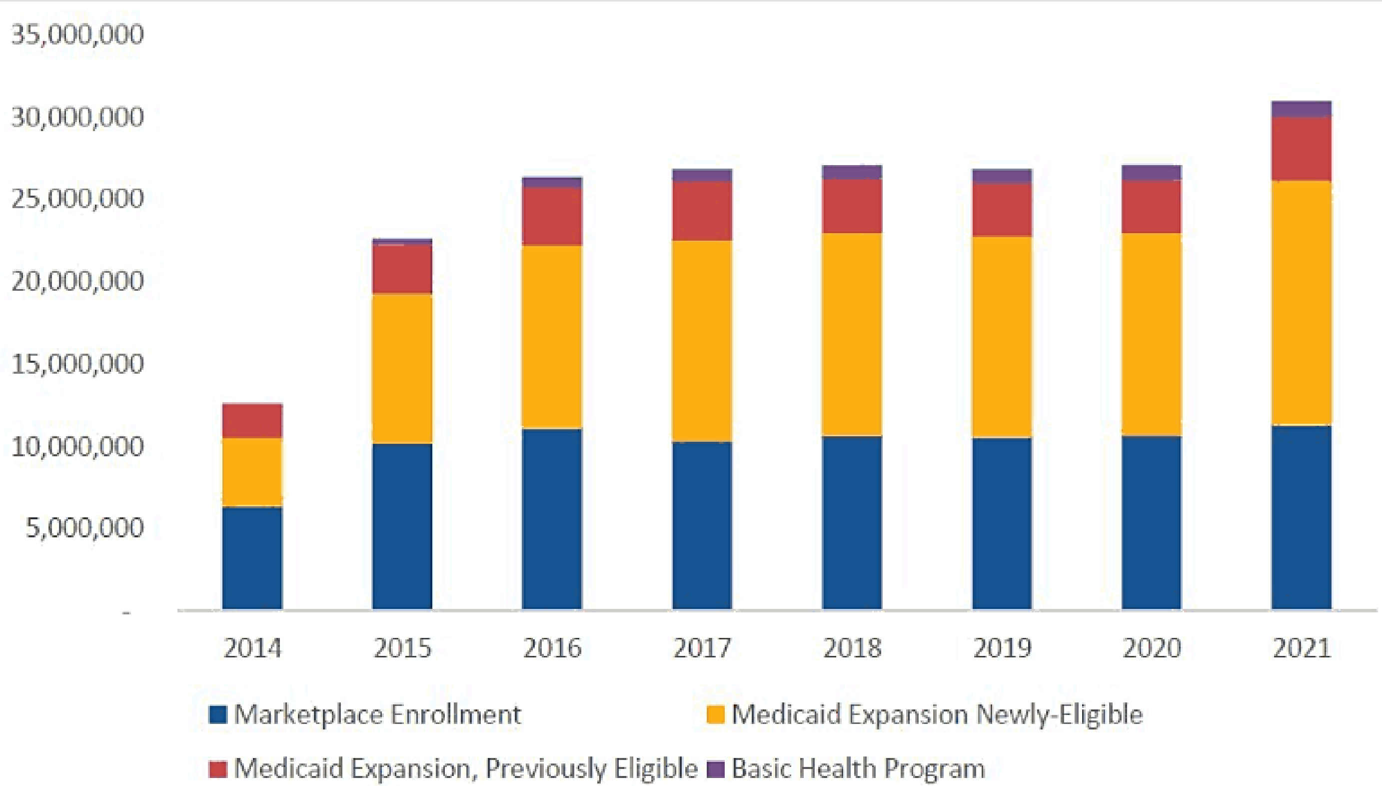
- In Texas v California the U.S. Supreme Court threw out the third challenge to the Affordable Care Act
- What's next?
  - Biden administration likely to seek to expand on ACA by making the ARP Act subsidy increases permanent, addressing Medicaid non-expansion states, and lowering Medicare age to 60
  - Executive Order 14009: Strengthening Medicaid and the Affordable Care Act

ARPA Expands ACA Exchange Subsidies

ARPA expanded financial assistance on a temporary basis to those eligible for coverage in the ACA Marketplace/Exchanges (two years)

- Individuals who do not have employer-sponsored coverage are eligible for subsidies on the exchange if income is between 100% and 400% of the FPL
- ARPA also expanded subsidies to people with income levels above 400% of the FPL, and people with incomes up to 150% of the FPL will qualify for zero-premium plans

ACA Exchange Enrollment Records



What's Happening on the Hill?

- Bipartisan Infrastructure bill and Budget Reconciliation Legislation
- House was expected to vote on both by September 27, 2021
- New date for vote on both is October 31st

H.R. 3684: Infrastructure Investment and Jobs Act

- Includes support for roads, bridges and other forms of infrastructure around the country
- Original $1.8 trillion plan included “human infrastructure”
  - American Families Plan

H.R. 3684: Drug Manufacturer Refunds

- Will apply to drugs dispensed under Medicare Part B
- HHS Secretary will report amount of refundable single-dose containers to drug manufacturers
- Manufacturers will pay monthly refunds to Medicare for any discarded single-dose containers
- Payments will be enforced through audits and civil monetary penalties

Infrastructure Bill (H.R. 3684) – Medicare

- Trump Administration published regulation to eliminate the safe harbor for Medicare Part D drug rebates in favor of discounts
- Litigation resulted in regulation being put on hold by Biden Administration
- If passed, HHS Secretary would not be able to implement the Trump Administration regulation until 2026

Build Back Better Act -- Reconciliation

- This is the intended vehicle to pass health care legislation excluded from the infrastructure bill
  - Expand paid family and medical leave
  - Make childcare more accessible
  - Extend enhanced household tax credits passed during the COVID-19 pandemic
  - Lower the Medicare eligibility age
  - Expand benefits to include dental, vision and hearing
- Tax changes being carefully watched

Build Back Better Act

- Elijah E. Cummings Lower Drug Costs Now Act (H.R. 3)
  - HHS could negotiate certain drug prices, and those prices are available to private plans
    - Capped at 120% of international pricing index
  - Mandatory rebate by drug manufacturers for certain Medicare B or D drugs with prices increasing faster than inflation, beginning in 2023
    - Inclusion of commercial market in calculation of the rebate, but no mechanism to pass the rebate attributable to private plans back to plan sponsors
  - Medicare Part D benefit significantly modified to eliminate participant coinsurance during the catastrophic payment period, and change who pays during that period (30% manufacturer, 50% plan and 20% Medicare)

Build Back Better Act

- Changes employer-sponsored coverage affordability test to 8.5% of household income, no indexing; Begins in 2022
  - Applies for purposes of premium tax credit eligibility and employer mandate
- Makes permanent the expanded ACA premium tax credits in the American Rescue Plan Act to increase generosity for individuals eligible for assistance with household incomes below 400% of the federal poverty level (FPL); and provides credits for taxpayers with household incomes above 400% of the FPL
- “Firewall” removed for purposes of the premium tax credit for household income below 138% of FPL; but won’t give rise to employer mandate penalty

Build Back Better – Paid Leave

- Ways and Means Committee approved updated paid family and medical leave legislation in Build Back Better Act
- Based on earlier proposal from Chair Richard Neal (D-MA)
- Creates new federal family and medical leave benefits program
- 12 weeks of paid leave; approximately two-thirds wage replacement
- Broader eligibility than Family and Medical Leave Act

Build Back Better – Paid Leave

- New federal program created through Treasury or Social Security Administration
- Federal grants for "legacy" states with existing programs
- Federal grants for eligible employer programs in "non-legacy" states who choose to offer a plan at least as generous as federal program
  - Reimbursement for 90% of cost (grant from the federal government)
- Could be self-insured or through insurance contract; if self-insured – surety bond and separate account required
- Does not preempt laws in legacy states

What about the Public Option?

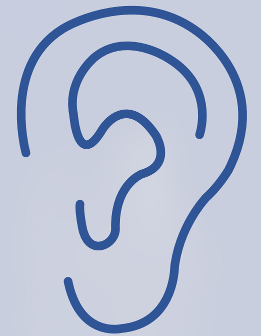
- Public Option: Administration's Actions
  - The administration's May 28, 2021 $6T budget proposal, which included President Biden's $2.3T infrastructure proposal, acknowledged support for the public option, but no funding for a public option was included in the broad budget proposal.
  - Currently there is lack of momentum among public option advocates and continued opposition from the health care industry.

Importation

- EO 14036 directed the Food and Drug Administration (FDA) to work with states to import drugs from Canada
- How will HHS implement the 2020 Regulation that permits States and other non-federal governmental entities to submit proposals to import drugs, including insulin and certain drugs from Canada?

Executive Order 14036: Hearing Aids

- Only about 14% of the 48 million Americans with hearing loss use hearing aids
- On average they cost more than $5,000 per pair
  - High prices are mainly driven by consumers requiring a medical evaluation
- Directs HHS to consider issuing proposed rules for allowing hearing aids to be sold over the counter



Transparency – It's not going away

- HHS required hospitals to make pricing information readily available to patients to compare costs and make more informed healthcare decisions as of January 1, 2021
- Hospitals must post both a machine-readable file with the negotiated rates for all items and services and display the prices of 300 shoppable services in a consumer-friendly format
- Congressional hearings found low compliance by hospitals
- Health plans must also post prices in 2022

Diversity, Equity and Inclusion in Health Policy

The Biden administration will put issues of diversity, equity and inclusion front and center in its health care policy

Biden Administration Diversity, Equity and Inclusion Initiatives: Executive Orders

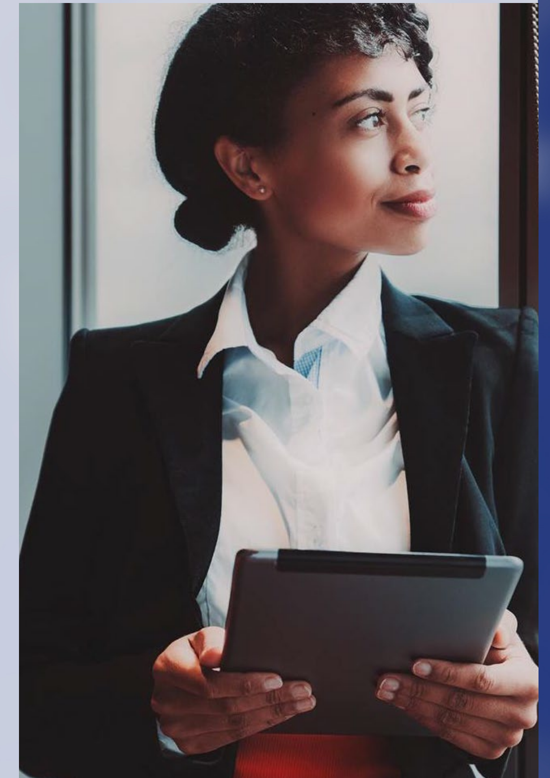
Executive Order 13895: Advancing Racial Equity and Support for Underserved Communities Through the Federal Government

- Explicitly defines equity to mean consistent, systemically fair and impartial treatment of all individuals
- Conducting equity assessments in federal agencies
- Allocating federal resources to fairness and opportunities

Biden Administration Diversity, Equity and Inclusion Initiatives: Executive Orders

Executive Order 14035: Equity, Inclusion and Accessibility in the Federal Workforce

- Intended to advance diversity, equity and inclusion within the Federal Government
- Ensures that LGBTQ+ employees have equitable health care and health insurance coverage
  - This includes coverage of comprehensive gender-affirming care



USSC Decision in *Bostock v. Clayton* County and Section 1557

Supreme Court ruled that federal protections against workplace sex discrimination under Title VII of the Civil Rights Act of 1964 extend to discrimination based on gender identity and sexual orientation

- The 6-3 decision in *Bostock v. Clayton County, GA* was handed down on June 15, 2020
- Plan sponsors should reexamine exclusions for gender dysphoria treatment and sex stereotyping

USSC Decision in *Bostock v. Clayton* County and Section 1557

- Section 1557 final regulation subject to several legal challenges
- Final rule eliminates notice and tagline requirements effective August 18, 2020
- Still requires language assistance programs, accommodations for those with a disability and website accessibility

New Guidance from HHS on 1557

- HHS Announced effective May 10, 2021, it will enforce federal prohibitions on sex discrimination in line *with Bostock v. Clayton*
- The Office for Civil Rights will interpret and enforce Section 1557 and Title IX's prohibitions on discrimination based on sex to include:
    1. Discrimination on the basis of sexual orientation; and
    2. Discrimination on the basis of gender identity

HIPAA Security Update: New Incentive to Adopt Recognized Security Practices

- New federal law enacted January 5, 2021 (Public Law 116-321)
- Applies to covered entities (e.g., health plans and health care providers) and business associates subject to HIPAA security rule
- HHS is now required to consider entity's adoption of "recognized security practices" in its enforcement activities under the HIPAA security rule
- Recognized security practices include standards, guidelines and best practices developed by the National Institute of Standards and Technology (NIST)
- Adoption of such standards can mitigate fines or result in early, favorable termination of HHS audit

Key Takeaways

- Agency enforcement of federal health laws continues regardless of Administration
- Headwinds of transparency, price regulation and federally subsidized benefits may inadvertently affect group health plan benefits and administration
- Privacy and security here to stay
- Diversity, equity and inclusion will become more important over time

Questions

- Contact your local or national compliance consultant with any questions

Closing Remarks