M&G|exposure

INSIDE THIS ISSUE

MESSAGE FROM THE CEO: M&G|EXPOSURE TURNS 1 YEAR OLD!

It was our vision, one year ago, to start a monthly communication to you, our valued clients, which would provide you with education on various topics, address potential questions and concerns on key issues, share our experience and knowledge, and welcome you into the Morris & Garritano family. We are very proud of the product we have delivered over the last twelve months and hope that you have found it to be beneficial, educational, and enjoyable to read.

Perhaps one of my favorite features of our newsletter is the collaborative nature behind it. Each month, we have employees and subject-matter experts eager to contribute their voice and their expertise. It is truly a team effort to ensure we are providing you with helpful information that adds value to the services you regularly receive from Morris & Garritano.

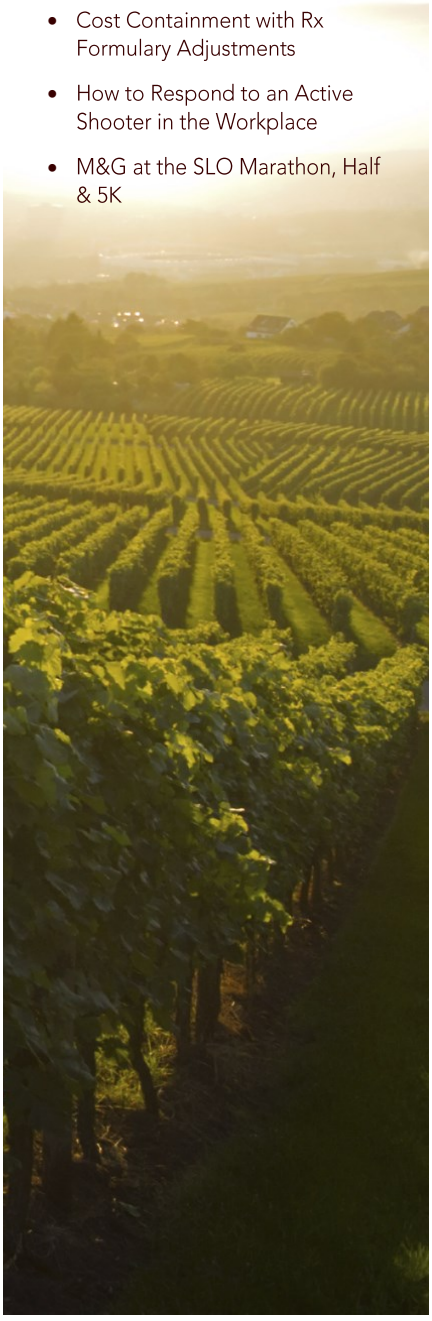
Over the last year we've covered topics that include California's minimum wage increase, proper workplace safety, the inner workings of our health care system, and the nuances of commercial insurance. We have also enjoyed being able to show you some of the behind-the-scenes events at M&G including our Annual Employee Appreciation Party and our participation in the SLO Marathon, Half & 5K.

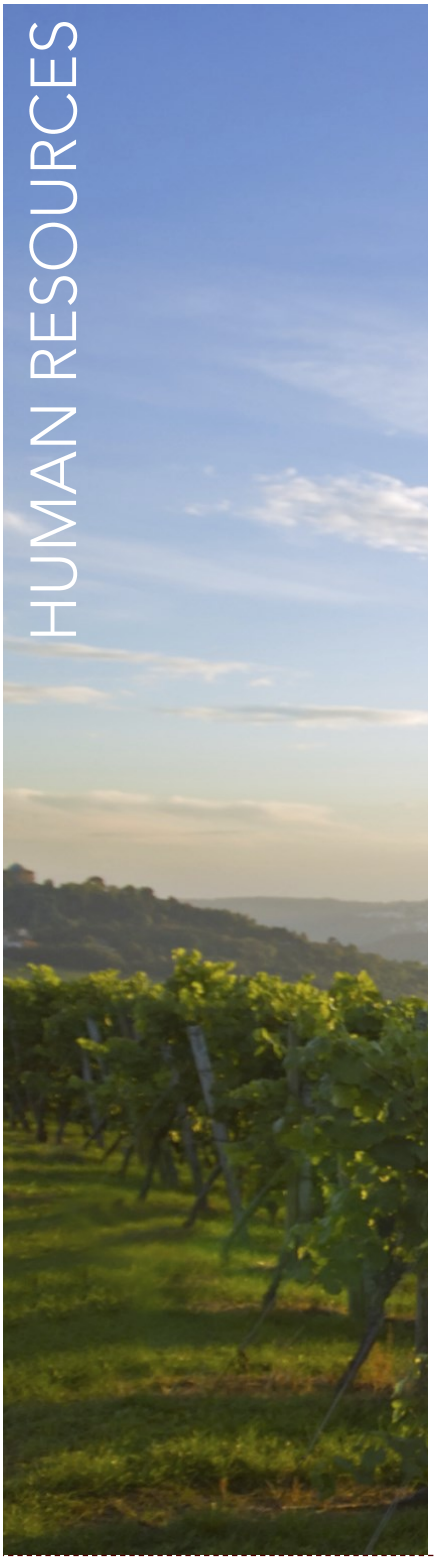
Thank you for taking a few moments out of your day to read M&G|exposure each month. In keeping with our core value to *Always Be Improving*, we look forward to continuing to provide you with updates, insights, and helpful information spanning the various landscapes of commercial, personal, and employee benefits insurance.

Brendan

SPECIAL POINTS OF INTEREST

- American Health Care Act of 2017 Passes on a vote of 217-213
- Cost Containment with Rx Formulary Adjustments
- How to Respond to an Active Shooter in the Workplace
- M&G at the SLO Marathon, Half & 5K





CASH IN LIEU OF BENEFITS

Contributed by: Louise Matheny, Human Resources Consultant

According to a Ninth Circuit court ruling, employers who provide compensation to employees who opt out of health insurance benefits, generally known as “cash in lieu,” must include those payments in an employee’s “regular rate of pay” for purposes of overtime calculations. The ruling came about during the case of *Flores v. City of San Gabriel*, in which the City of San Gabriel violated the Fair Labor Standards Act by excluding cash payments made to employees in lieu of benefits from their “regular rate of pay” used to calculate overtime compensation.

This case is significant because it addresses a common arrangement offered by both public and private sector employers. If employees do not use all or part of a benefits allowance, perhaps because they are covered under a spouse’s plan, some employers offer to pay cash in lieu of benefits to the employee. The legal issue in Flores was whether such payments must be included in the FLSA’s “regular rate of pay,” which is used in overtime pay calculations.

The Ninth Circuit’s decision that cash in lieu of benefits payments must be included in the “regular rate of pay” for overtime purposes may have a significant effect for employers. An increase of a few dollars an hour in an employee’s pay rate may increase overtime pay if the employee works extra hours.

However, there has been an update since the initial ruling. On April 25, 2017, the City of San Gabriel filed its reply brief in support of its petition for writ of certiorari to the U.S. Supreme Court, in the *Flores v. City of San Gabriel* case. Briefing on the petition is now complete. It is anticipated that the petition will be considered at the Court's May 2017 conference, with a ruling on the petition or call for the views of the Solicitor General to follow shortly thereafter.

The petition seeks to reverse the Ninth Circuit's ruling with respect to two issues. First, the City contends that cash paid to employees in lieu of health benefits contributions should be excluded from the regular rate for purposes of calculating overtime under the Fair Labor Standards Act (FLSA). Second, the City contends that the Ninth Circuit's standard for finding a "willful" violation of the FLSA, which increases the statute of limitations from two years to three years, fails to comply with Supreme Court precedent.

Morris & Garritano will be following this case. If you have any questions, please contact Louise Matheny.

Please contact Louise Matheny, our Human Resources Consultant, with questions pertaining to these articles or any other HR inquiries.
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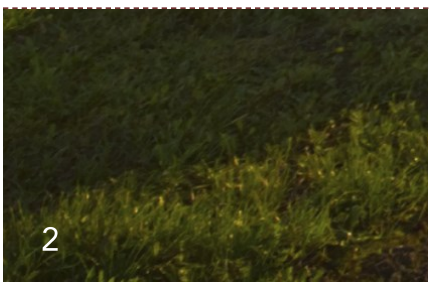


CA SUPREME COURT DECIDES IMPORTANT "ONE DAY'S REST IN SEVEN" QUESTION

Contributed by: Louise Matheny, Human Resources Consultant

On May 8, 2017 the California Supreme Court answered three questions related to seventh day of work rules (*Mendoza v. Nordstrom Inc.,* No. S224661 (May 8, 2017)). These questions are important for California employers and provide guidance for employers on how they can schedule employees.

The California Supreme Court has now provided the following answers, and the case will return to the Ninth Circuit for a decision on the underlying case. The three questions answered are:

Question 1: Is the required day of rest calculated by the workweek, or is it calculated on a rolling basis for any consecutive seven-day period? This question is important because it's likely most employers currently use the workweek approach.

Answer 1: A day of rest is guaranteed for **each workweek**. Periods of more than six consecutive days that stretch across more than one workweek are not *per se* prohibited.

Question 2: How does the exemption for part-time employees work? The Labor Code exempts employers from providing a day of rest "when the total hours of employment do not exceed 30 hours in any week or six hours in any one day thereof." Does this exemption apply so long as an employee works six hours or less on at least one day of the applicable week, or does it apply only when an employee works more than six hours on each and every day of the week?

Answer 2: The exemption for employees working shifts of six hours or less applies only to those who **never exceed six hours of work on any day of the workweek**. If on any one day an employee works more than six hours, a day of rest must be provided during that workweek, subject to whatever other exceptions might apply.

Question 3: The Labor Code states that no employer "shall cause his employees to work more than six days in seven." The question here relates to what the word "cause" means. What does it mean for an employer to "cause" an employee to go without a day of rest: force, coerce, pressure, schedule, encourage, reward, permit, or something else? What if the employee chooses to work an extra shift? Is that okay?

Answer 3: An employer causes its employee to go without a day of rest when it induces the employee to forgo rest to which he or she is entitled. An employer is not, however, forbidden from **permitting or allowing** an employee, fully apprised of the entitlement to rest, to independently choose not to take a day of rest. The employer can't conceal the right to rest and can't take any action to encourage employees to forego rest.

Overall, the Supreme Court's answers were helpful and the decision provided much-needed guidance to California employers.

An important note for employers – make sure you designate your **workweek**. If you do not set a designated workweek, the law presumes a workweek of 12:01 a.m. Sunday to midnight Saturday.

Keep in mind that there are also increased overtime pay requirements if an employee does choose to work seven consecutive days in a workweek. Time-and-one-half for the first eight hours worked on the seventh consecutive day of the workweek and double time for hours worked beyond eight.

Source: Gail Cecchettini Whaley, CalChamber Employment Law Counsel/Content

AMERICAN HEALTH CARE ACT OF 2017 PASSES ON A VOTE OF 217—213

Contributed by: Keith Dunlop, Director of Compliance

On Thursday, May 4, 2017, the US House of Representatives passed the American Health Care Act of 2017 on a largely party line vote of 217-213. The bill was previously pulled from consideration in March when it was clear that Republicans were not able to garner a sufficient number of votes among conservative and some moderate members in order to secure passage.

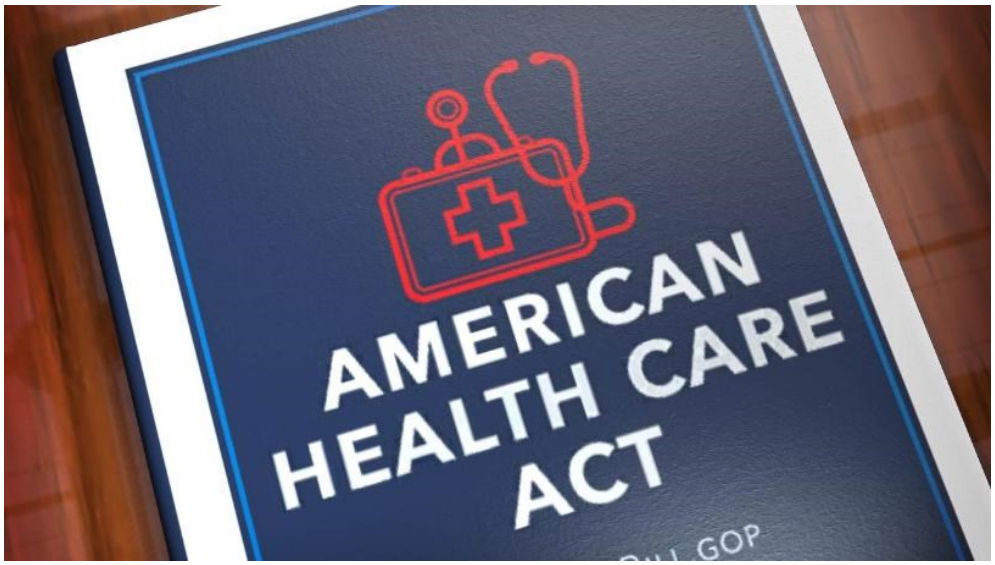
The primary components of the bill include:

- Repeal of the individual mandate;
- Repeal of the employer mandate;
- Repeal of premium tax credits (subsidies);
- Repeal of certain taxes on premiums, health plan benefits, over-the-counter medications, and medical devices;
- Modification of the Medicaid expansion program to a per capita block-grant system;
- Removal of abortion coverage from qualified health plans with the option to purchase separate coverage;
- The implementation of a new individual monthly tax credit program.

Two important amendments were then added to the bill. The first allows states to obtain a waiver from the key provisions of the Affordable Care Act (aka “Obamacare”) to provide essential health benefits. Those benefits as outlined by the ACA include: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health treatment, prescription drugs, rehab services, lab services, preventative medicine, and pediatric services. The waivers are automatically approved unless the Department of Health and Human Services objects within 60 days. The amendment also allows states to charge older enrollees more than younger ones at a ratio higher than the 5:1 level specified in the original bill. This would presumably be done through high-risk pools established by the states.

The second amendment, offered just hours before the House vote, provides $8 billion into the system to subsidize premiums for those with preexisting conditions.

The bill now heads to the Senate where it will certainly undergo substantial modification.



TREASURY INSPECTOR GENERAL REPORTS ON EMPLOYER MANDATE COMPLIANCE

Contributed by: Keith Dunlop, Director of Compliance

On April 7, 2017 the Treasury Inspector General for Tax Administration (TIGTA) released a detailed report on the IRS's implementation of a key provision of the Affordable Care Act – the Employer Shared Responsibility Provision (employer mandate) and the related information reporting requirements. Employers with 50 or more full-time and full-time equivalent employees are required to offer health care coverage to their employees and dependents. Employers who do not offer coverage—or offer coverage that does not meet minimum requirements or is not affordable—may be subject to significant penalties.

The ACA also imposes a reporting requirement for large employers related to the employer shared responsibility rules. Section 6056 requires ALEs to annually file information returns (Forms 1094-C and 1095-C) with the IRS and provide related statements to their full-time employees about the health coverage they offered (or did not offer). The information on Forms 1094-C and 1095-C is intended to help the IRS verify the accuracy of reported offers of coverage and calculate any applicable employer shared responsibility penalty.

TIGTA Audit Report

The TIGTA audit was conducted to assess the status of the IRS' preparations for ensuring compliance with the employer shared responsibility rules and the related reporting requirements. The IRS implemented processes and procedures in an effort to ensure that ALEs could comply with the reporting requirements. However, through this audit, TIGTA found a number of major issues that hindered the enforcement of these provisions, including:

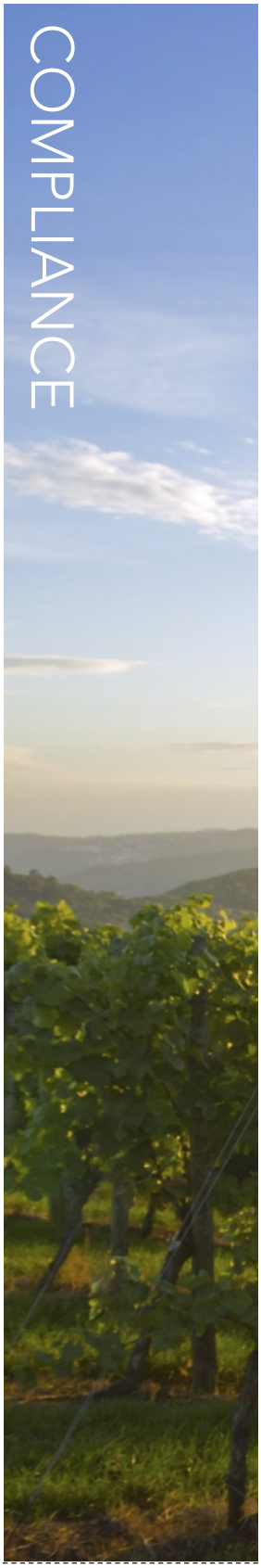
- System errors prevented the IRS from having necessary data to identify noncompliant employers potentially subject to the employer shared responsibility penalty;
- Slow processing of paper information returns;
- Problems identifying validation errors on information returns; and
- Delayed or canceled development and implementation of key systems needed to identify noncompliant employers subject to an employer shared responsibility penalty.

The IRS experienced significant delays in processing paper Forms 1094-C and 1095-C; basic processes were not functioning; form processing was halted on at least two occasions due to the regular tax filing season; and error identification systems did not function as designed, according to the TIGTA report.

The IRS has agreed to almost all of the TIGTA's recommendations for corrections, including the finalization of their new ACA Compliance Validation (ACV) system, slated to be complete in May 2017.

What Happens Next?

Notwithstanding the current debate in Congress over healthcare reform and the ACA "repeal-and-replace" efforts underway, this report appears to confirm that the IRS intends to enforce compliance with the current employer shared responsibility rules. With the correction of the system errors highlighted by the TIGTA report, and the completion of the IRS's new ACV system, we expect the IRS to begin issuing ACA assessment notices to employers any day.



Contact Morris & Garritano Director of Compliance, Keith Dunlop, for questions regarding these articles or any other ACA-related issue.
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COST CONTAINMENT WITH RX FORMULARY ADJUSTMENTS

Contributed by: Ben Hoover, Senior Employee Benefits Risk Advisor

While there are numerous opinions surrounding health care reform, one common theme that everyone can agree on is reducing costs. The insurance carriers are trying to use multiple tools to achieve lower premiums or reduced increases.

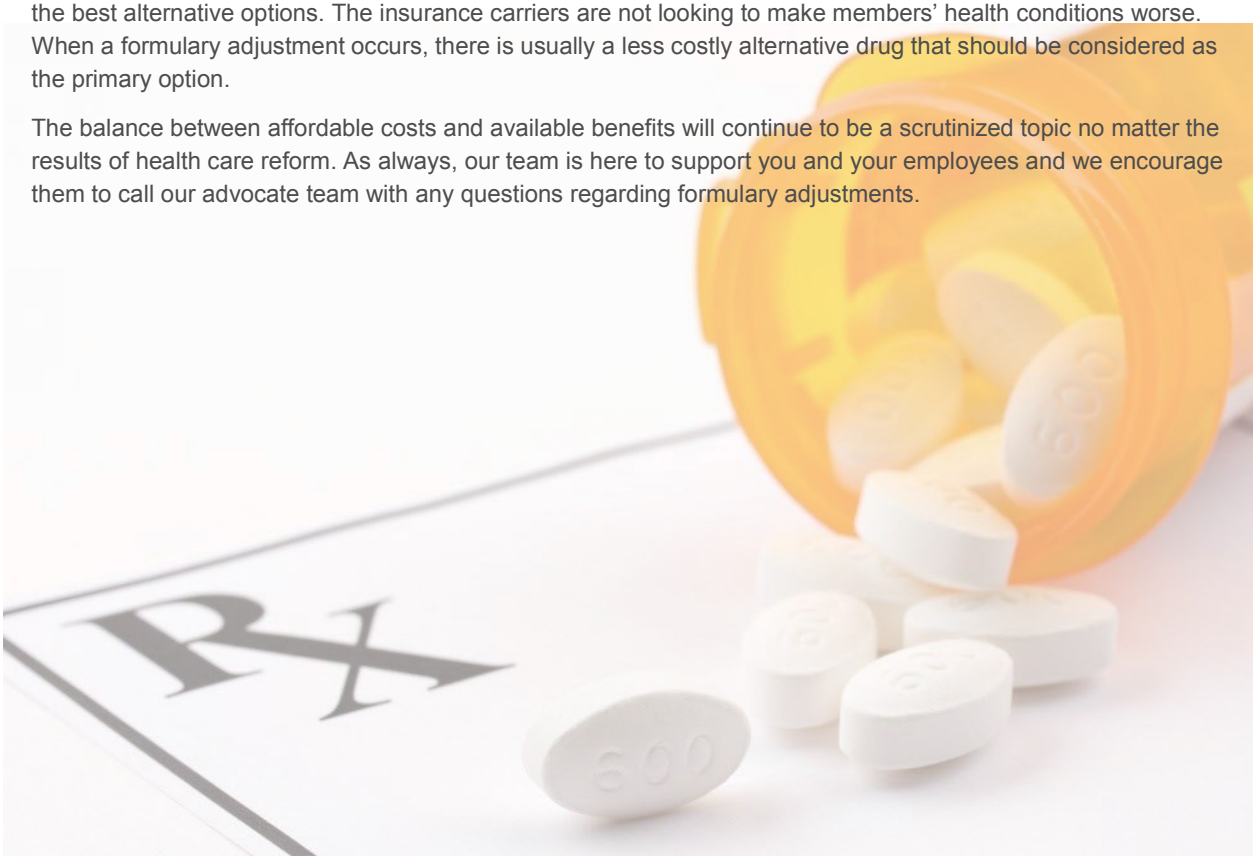
Pharmaceuticals are one of the main cost drivers today. One cannot watch the nightly news without seeing a barrage of advertisements for the latest and greatest pharmaceutical cure. And while many of these drugs achieve great things, it can come with a cost. Several of the common pharmaceuticals seen on regular advertisements exceed six figures for a round of therapy.

In an effort to contain costs, the carriers are continuing to adjust the “formulary” list. This list is basically a catalog of the preferred or approved pharmaceuticals. The carriers believe that these adjustments are necessary to stabilize the rates and avoid excessive increases.

In the vast majority of cases, groups are not able to avoid this formulary adjustment. The benefit modification is forced upon the group in a product change at renewal. And while only a small minority of the available pharmaceuticals are impacted with these changes, a mandatory modification can leave an employee and employer feeling very frustrated. Occasionally, due to a group’s size or product offering, the employer is allowed to evaluate the option of keeping the larger Rx formulary list of present, or considering the reduced formulary list being offered. In nearly every instance when a group has been presented with the option, they have elected for the reduced formulary listing as the savings can be in excess of five percent.

We will most likely continue to see formulary adjustments in the future as prescription costs continue to rise. If an employee is ever faced with their prescription falling off of the formulary list, they should talk to their doctor about the best alternative options. The insurance carriers are not looking to make members’ health conditions worse. When a formulary adjustment occurs, there is usually a less costly alternative drug that should be considered as the primary option.

The balance between affordable costs and available benefits will continue to be a scrutinized topic no matter the results of health care reform. As always, our team is here to support you and your employees and we encourage them to call our advocate team with any questions regarding formulary adjustments.



THE DOCTOR CAN SEE YOU….IN 3 MONTHS

Contributed by: Luzette Graves, Medical Case Manager

Why is it so hard to establish with a primary care physician? And why does it take so long to get an appointment with a specialist? And what's a patient supposed to do?

The California Academy of Family Physicians (CAFP) estimates that 23 of California's 58 counties don't have enough primary care physicians (PCPs) to meet the needs of their communities. San Luis Obispo and Santa Barbara are among the many counties struggling to meet their population's health care needs.

Historically, the ongoing shortage is due to California having the 3rd lowest physician reimbursement rate in the country. This makes it difficult for recently graduated physicians to pay off large college loans while establishing a home, a family, and a practice on the Central Coast. The situation is now compounded by the fact that 32% of California's physicians are of retirement age. Additionally, the Affordable Care Act has significantly increased the number of insured Californians (4.7 million) who are actively seeking specialty, as well as primary, care.

As a result, it sure is tough getting in to see any type of doctor these days and it's likely to get worse!

For these reasons, it is more important than ever to establish with a PCP so that he/she is available to you when you need more than a couple of stiches or relief from a nasty cold. PCPs are also your best advocate for accessing timely specialty care.

So, please don't wait! Regardless of the type of healthcare plan you have (PPO, HSA, HIA, HMO), get yourself on one of those long primary care waiting lists. In the interim, you can access care for minor issues through urgent care centers and, for true emergencies, through the hospitals.

You can visit www.familydocs.org/workforce/physician-shortage for more details.

HOW TO NAVIGATE THE WC MPN WEBSITE

Contributed by: Mary Jean Collins, Workers' Compensation Claims Analyst

Each insurance carrier has an established website to search for a local approved Medical Provider Network (MPN). However, no two websites are the same and it can be frustrating to navigate through all the information to find what you need.

Here are a few "tricks" to make the processes a little easier:

1. On your DWC-7 Workers' Compensation poster, find the listed MPN website and enter it into your browser.
2. Once on the MPN website, find the option to search by zip code or address and enter the corresponding information. Go to the website and put in your zip code and a 15 mile radius.
3. Use the Search Filter to select various provider types or specialties. Not all physicians will be registered under the same specialty, so we suggest selecting a wide assortment to give you the best options (ex: First Treatment Sites, Urgent Care, Emergency Medicine, Primary Care, Family Practice, and General Practice.)
4. The search should provide you with a list of MPN providers, phone numbers, and addresses.

Not all MPN websites provide the items above, so you may need to Google urgent care centers in your area and cross-reference the results to those listed on the MPN website in order to find the best fit for you and your needs.

As an added tip, if you know you will be out of town on a job, it is a good idea to research an MPN Urgent Care in the area you will be visiting prior to leaving and make note of it in your travel information.

If you have any issues regarding a Workers' Compensation MPN website, please do not hesitate to contact me and I will be happy to answer any of your questions or can run the search for you.

HOW TO RESPOND TO AN ACTIVE SHOOTER IN THE WORKPLACE

Contributed by: Michael Schedler, Loss Control Consultant

When thinking about safety in the workplace, our minds often go to everyday events like injury prevention or safe driving habits. We aren't likely to focus on worst-case-scenario situations, such as an active shooter. However, having an emergency action plan (EAP) in place that addresses such events is important and could even save lives.

Combining an EAP with training exercises will help prepare your staff to effectively respond to an active shooter situation and help minimize loss of life.

Creating an EAP

There should be several stakeholders involved in the creation of an EAP: your human resources department, facility owners/operators, property managers, your training department (if you have one), and local law enforcement and/or emergency responders. Your EAP should include:

- The proper method for reporting fires and other emergencies
- An evacuation plan and procedure
- Contact information and designated responsibilities for people to be contacted in the case of an emergency
- Information for local area hospitals

Training Your Staff for an Active Shooter Situation

Conducting a mock active shooter training exercise is the most effective way to train your staff. Local law enforcement can be an excellent resource in designing such exercises. The following elements should be addressed in your training:

- Recognizing the sound of gunshots
- Quickly determining the most reasonable way to protect your life

  Run: If you have an accessible escape path, attempt to evacuate the premises making sure to leave personal belongings behind, helping others escape if possible, and keeping your hands visible at all times.

  Hide: If you are unable to evacuate, find a place to hide where the shooter is less likely to find you and you are protected if shots are fired. Make sure you don't trap yourself or prevent your options for movement.

  Fight: As a last resort, and only if your life is in imminent danger, try to disrupt and/or incapacitate the active shooter by acting as aggressively as possible, throwing items or improvising weapons, yelling, and committing to your actions.

- Calling 911 when it is safe to do so and providing information about the shooter's location, physical description, possible weapons, and number of potential victims in the area.
- Once law enforcement arrives, it is important to remain calm and follow their instructions.
  - Put down any items in your hands (i.e. bags, jackets)
  - Immediately raise your hands and spread your fingers
  - Avoid making quick movements, pointing, screaming, and/or yelling

While it's easy to think that an active shooter may never enter your office, it is better to have a plan and not need it, then to need it and not have it. You can also work proactively to reduce your risk of an active shooter by fostering a respectful workplace, paying close attention to indications of workplace violence, and taking remedial actions when necessary.

THE IMPORTANCE OF INSURING TO VALUE AND BUILDING ORDINANCE OR LAW COVERAGES

Contributed by: Gary Dee, Commercial Lines Risk Advisor

Property losses, particularly fire, are less common than Auto, Workers' Compensation and General Liability claims. However, in many cases, they can be more problematic when it comes to a claims settlement. Two keys to ensure adequate property coverage are, Insurance to Value (ITV) and Building Ordinance or Law coverages.

Insurance to Value (ITV)

Since most building property losses are partial, in that they don't result in total destruction of the structure, the tendency of some insureds is to play the odds and limit the amount of insurance they purchase. Why pay the premium for full coverage when chances are the full amount may never be needed? The catch is that even partial losses are subject to the coinsurance clause, so by playing the odds you will suffer a penalty.

A coinsurance clause is a common part of your insurance contract which states that the insured must carry an insurance limit on its property in an amount greater than or equal to a certain percentage of its total value (commonly 80% or 90%).

For example, a $1,000,000 building with a 90% coinsurance should carry a minimum of $900,000 of coverage. Anything lower could result in a coinsurance penalty whereby the insured would be out-of-pocket for the underinsured portion of the building.

Building Ordinance or Law Coverages

Building Ordinance is commonly overlooked and may or may not be part of your policy. All insurance carriers are different in their approach to this coverage, but there are three components to look for:

Coverage A: Coverage for Loss to the Undamaged Portion of a Building

Coverage B: Coverage for the Cost of Demolition

Coverage C: Coverage for the Increased Costs of Construction

With aging and older buildings throughout San Luis Obispo and Santa Barbara counties, many of which don't meet current American with Disabilities Act (ADA) codes and other building codes (such as fire sprinklers), these coverages become very important. Just because the term "Building Ordinance" is included in your policy doesn't necessary mean that all three of these coverages are included.

We spend a lot of time talking about General Liability, Workers' Compensation and Business Auto, all of which are necessary. However, don't overlook the importance of having one of your most valuable assets – your property - Insured to Value or making sure that Building Ordinance or Law is part of your coverage.

M&G AT THE SLO MARATHON, HALF & 5K

Contributed by: Sara Holloway, Marketing Coordinator

Team M&G had such a great time at the SLO Marathon, Half & 5K this year! As sponsors of the Team Initiative, we always try to lead by example, and this year was no different. We had runners in all three races as well as a fully staffed water station to provide much needed fuel and motivation for all the runners.

MORRIS & GARRITANO INSURANCE

With a tradition of excellence in insurance services since 1885, we offer all lines of business and personal coverage with a staff of over 120 professionals.

Our monthly newsletter is where you can find informative articles relating to the Commercial Lines and Employee Benefits industries.

For day-to-day updates and more information about our community and our company, follow us on Facebook, Twitter or LinkedIn.

Visit our website, or check us out on Yelp!

Please contact us for more information or questions on anything mentioned in this newsletter.

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