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CHAMPIONING HEALTH EQUITY WITHIN YOUR ORGANIZATION

WEBINAR TRANSCRIPT

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CHAMPIONING HEALTH EQUITY WITHIN YOUR ORGANIZATION

In collaboration with Nonstop Administration & Insurance Services, Inc., Nonprofit HR hosted a special conversation about how employee health benefits, when viewed through a lens of equity, can positively impact employee recruitment and retention, and also employee productivity and engagement.

Over half (63%) of 675 respondents in Nonprofit HR's 2021 Nonprofit Diversity Practices Survey indicated that their organizations have made adjustments to prioritize/reprioritize diversity objectives, programs and/or initiatives. While compensation equity remains a focal point for employers, turning to employee health benefits as a tool to tackle health equity also came to the forefront.

Join this conversation and hear:

- Why leadership should care and champion health equity internally and among peers;
- How health equity impacts nonprofit organizations and why the social sector employers should attempt to exceed the health benefits status quos;
- Why quality affordable healthcare is critical to recruiting and retaining staff; and
- How an organization's approach to their employer-sponsored health insurance plan design can reflect and also impact its values and mission performance

Lisa Brown Alexander
President & CEO
Nonprofit HR

David Sloves
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Insurance Services, Inc.

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Alicia Schoshinski: Hello, everyone and welcome. Thank you for joining us this afternoon for Nonprofit HR's virtual learning educational event. Today's session is entitled Championed Health Equity Within Your Organization.

My name is Alicia Schoshinski, I'm the Managing Director of Talent and Development at Nonprofit HR and I'm going to be your moderator for today. We have a lot of great content to cover, so let's get started. But before we do, I would like to go over a few items so that you know how to best participate in today's event.

You've joined the presentation listening using your computer's speaker system by default. If you prefer to join over the telephone, just select telephone in the audio pane, and the dial-in information will be displayed. You'll have the opportunity to submit text questions to today's presenters by typing your questions into the questions pane of the control panel. You may send in your questions at any time during the presentation, and we will collect the questions and answer them in the Q&A session at the end. Today's event is being recorded, so you will receive a follow-up email within the next few days to view the recording.

Today's session is hosted by Atokatha Ashmond Brew, Managing Director of Marketing and Strategic Communication for Nonprofit HR. She will be interviewing CEOs David Slope of Nonstop Administration and Insurance Services and Lisa Brown Alexander of Nonprofit HR.

Here's a little bit about our interviewees: In 2000, Lisa Brown Alexander founded Nonprofit HR, the leading talent management firm in the country that works exclusively with the nonprofit sector. Since then, Lisa has inspired her firm to become a force that thousands of nonprofit and talent management leaders look to for their strategy and advisory; HR outsourcing; total rewards; diversity, equity and inclusion; as well as search needs.

David Sloves route to health insurance innovation was not a straight line. He's always had a passion for mathematics and economics, and has used his aptitude for numbers to lead a variety of different ventures through his career. As the CEO of Nonstop, he is a dogged advocate for breaking down barriers that inhibit equitable, affordable and high-quality healthcare and access.

You'll get to know more about David and Lisa during the event, and you will learn more about their organizations as well. So, without further ado, I'll turn it over to Atokatha.

Atokatha Ashmond Brew: Thank you, Alicia, and hello, Lisa and David. We have a lot to explore today. At the root of this conversation is a recently published Health Equity Guide, co-presented by your two companies. The guide is meant to help executives of nonprofits begin removing barriers to healthy living for their workforce. The opening of the guide is especially insightful and it reads, "It has

taken centuries to create the societal structures that exist in America that enable healthy lives for some and unhealthy lives for others. It will take decades to unravel and rebuild, but as leaders of mission driven organizations, you are uniquely poised to drive social movement broadly, and within your organizations, removing barriers to healthy living for your staff. It is a daunting task, but the time to start is now."

What an opening, and it sets us up nicely for our first set of questions. But before we jump in, Lisa, I wanted to ask you to take a few moments to share with our audience about Nonprofit HR.

Lisa Brown Alexander: Certainly, thanks Atokatha. As many of you know, Nonprofit HR is the nation's leading talent management consulting firm dedicated solely and exclusively to the social impact space.

We've been in place for 21 years, and really have committed all of our resources to advancing talent management practices within nonprofits, associations, foundations and more recently, social enterprises. Our services really cover the whole lifecycle of talent management, so today's topic is particularly germane. It falls into a number of our areas of expertise and I'm looking forward to today's conversation.

Atokatha Ashmond Brew: Thank you so much, Lisa. David, can you spend a few moments sharing with our audience about Nonstop?

David Sloves: Sure, I'd be delighted. Nonstop is a mission-based for-profit business that has historically served the nonprofit, mission-based community. And we have a particularly strong affinity in partnership with the Community Health Center movement.

Our basic notion is that providing a more just access to healthcare can be done, both at a lower cost and with better outcomes in the existing system, and we've spent the last six plus years building our program, Nonstop Wellness, and delivering just that.

As the issues of social justice have risen to a greater level of visibility, we have been able to use our bully pulpit in serving this community in support of those voices.

Atokatha Ashmond Brew: Alright, thank you so much, David. We would be remiss if we did not highlight the efforts of Nonprofit HR's Total Rewards team and our DEI team for pulling together this piece, this Health Equity Executive Guide, in collaboration with Nonstop Wellness. You may access this guide if you're interested in seeing it during this conversation at nonprofithr.com/healthequity.

Before we jump into some of our questions, Lisa and David, Lisa, will you please spend a few moments talking about what exactly health equity is, and how it relates to the global workforce, especially the nonprofit workforce?

Lisa Brown Alexander: Yeah, so the nonprofit workforce is a microcosm of the world; within it exists a really high level of diversity and difference, but also common traits.

But in terms of health equity, when we talk about health equity, what we're really talking about is the ability for every person to have equal access and to be able to equally live a healthy lifestyle. And so, what does that mean? That means regardless of difference regardless of geography, race, gender or orientation, that you have equal access and equitable access to healthy living—and that's really critical. So, without that, we don't have health equity. That's how we look at health equity.

Atokatha Ashmond Brew: Thank you, Lisa. David, would you spend a few moments talking about your understanding of health equity?

David Sloves: Absolutely. Well, I appreciate the Johnson Foundation's definition, but I disagree with that one of their basic words, which is the word "fair." I always find "fair" to be a word that's loaded because, what I think is fair and what you think is fair or not necessarily the same. I strongly prefer the word "equitable" and really view that as a fundamental consequence of moving forward to make the system more equitable.

And I really believe that these issues are now clearly understood. And so, now, it's about forging both the political will and the economic might to actually make good on that. We're at a point where many of the problems that we assume were beyond our capacity to address. We have the abundance societally to do so, but whether or not we have the will and the desire to focus on that equitable, just world is really the fundamental question, I think, for the generation in front of us.

Atokatha Ashmond Brew: All right, thank you so much, David.

Why has diversity, equity and inclusion made it onto the radar of forward-thinking CEOs? Meaning, why is it imperative that CEOs are at the table problem-solving health equity and elevating DEI as a workforce priority? Can you take that question first, Lisa?

Lisa Brown Alexander: Sure, I can take it first.

Every organization is only as effective as the people in it. So, despite our tendency to elevate programs, and fundraising, and donors, and funders, what really drives the economic engine behind organizations are the people. And so, if we want to be impactful in the communities where we're

serving, we need to make sure we make an appropriate investment in the talent that are responsible for driving the mission forward. And so, talent is what drives mission and results, but if the talent is not healthy, either emotionally, physically or otherwise, the organization is going to be directly impacted.

Why does diversity equity inclusion matter now? Because we know, and the research tells us, that the more diverse, the more equitable and inclusive an organization is, the better results it achieves. And who needs to be more concerned about results than those of us who are in the social impact space? We're trying to make changes in the way people live and how they're able to experience life.

We're not talking about widgets and screws and envelopes and products. We're talking about people and the quality of the lives that they're able to live. If we're trying to drive impact with the quality of life that people experience, we can only do that if we have the richest, most diverse, most inclusive people and practices within our organizations.

Atokatha Ashmond Brew: Yeah, right. David, I am going to toss that same question to you. Why is it imperative that CEOs are at the table problem-solving health equity and elevating DEI as a workforce priority?

David Sloves: Well, first, I think Lisa has already hit the fundamental issue, but I'm going to perhaps take a slightly different spin on it.

I think, as CEOs, we have a tendency to assume that if our business has a mission and a focus, that the organization then walks that walk and talks that talk consistently. I think what we've discovered over the last 10 years, and particularly since COVID and the inherent introspection of all this time that we have talking to one another in this format, that we've really recognized that the misalignment of our current healthcare system is just destructive. And that it's a pattern of destructiveness that we see in every aspect of the DEI conversations we have. Whether it's jobs or housing or food, all of these things, we've allowed this situation to roll on its own without any particular control and a sense of hopelessness. Until all of a sudden in this generation that is taking charge of our businesses, the millennials, and who comes after them, have already established that they're the primary population in our companies and are now establishing leadership roles, and they don't view the “not walking the walk” as OK.

As a CEO, I think most of us, particularly if we’re older, are hearing from our own people, who we've brought on because of our business's mission, that, “Hey, you gotta walk that walk more consistently.” And I think that health equity has been one of these areas that's been allowed to slide under the economic heaviness that it's brought for us as employers, to the point where it's become truly not a benefit but a destructive characteristic of most organizations in this country.

Atokatha Ashmond Brew: Yeah, I echo a lot of what you said, and we're going to really get into, in this conversation, that intersection for equity and healthcare benefits by employers. Before we move in that direction though, I really like what you were talking about regarding talent management and some of those higher-level objectives. And Lisa, from what you've seen in our Nonprofit Diversity Practices Survey, 33% almost of respondents said that they changed their compensation and benefits practices in response to better support DEI while compensation and equity remains a focal point for employers as they're turning their health benefits into an opportunity to truly maximize that effect. This has become something that they are tackling, but there's still a lot of work to do in this area. What is your response to those statistics?

Lisa Brown Alexander: Well, I applaud those organizations that are in that 33%, who recognized that the opportunity for them to realize equity within their organizations is multifaceted. It's not just having people of color around your staff; it goes far beyond that, which is often where we start with recruitment. But for the organizations that have stepped into changing systems and practices and policies within their organization to be more equitable, more inclusive and more diverse, I applaud them. For the 67% of those that have not moved in this direction, I'd say it's never too late to get started on your journey. And so use this conversation, perhaps, as a catalyst to stimulate dialogue within your organization about why your nonprofit needs to pay attention to equity, not just in terms of race and gender, but also in terms of health.

Atokatha Ashmond Brew: Right. And David, I wanted to shift gears a little bit to talk about Nonstop's inspiration for, first of all, creating this as a priority initiative internally within your organization, and then partnering with Nonprofit HR to actually create this equity guide. What is the message you're hoping to share with leaders on today's webinar?

David Sloves: Well, I think it really starts with the whole notion that we're fighting the same good fight, that the issues of mission-based businesses and impact is fundamental across the spectrum. And I think that if nothing else, the last year has really integrated people's thinking on that, so the notion that walking the walk and aligning is critical.

The second thing is the whole notion that it's not just human capital. They're human beings. And I think when we abstract things into terms like human capital, we fall prey to the same kind of emotionless construct that gets used to justify really bad behaviors as if the invisible hand of the market was all knowing and perfect in all situations. I think that we've learned the hard way that's not true.

I think the last thing, and really, the fundamental one, is this isn't just theory. It's about bringing solutions forward. I was super turned on looking at the DEI practice that Nonprofit HR has put

together and that there were people really, seriously committed to delivering not just talking points, but how you actually do it. And we spent six years building out this program, so it truly could work and be scalable because it's damned hard. Healthcare is a morass and I think the issue of racial justice and the history of racial injustice in this country is a morass of such epic scale that we need to really be focused on, what can we do today? What are the steps? That's really the excitement for me is finding people who are saying, "Yeah, let's take the steps. Let's lean into our imperfections and move forward and get better."

Lisa Brown Alexander: Yeah, I'd love to just weigh in there.

Last year, when we did our Diversity Practices survey, the reality of what's happening in the sector came to the forefront. While we would like to believe that many nonprofit organizations are leading the way with diversity practices and strategy and policies, we learned that that was in fact not the case. There are many organizations that operate without a statement, without a strategy and without budget. And so, I think it's really important for us to acknowledge that a lot of organizations are at the beginning of their journey, just like for-profit corporations are. A lot folks kind of woke up to the realities of racism, in particular, last summer. But for many other people, they've been living with it for centuries and decades, and so I applaud the awakening that's happening in society and has happened. But we're at the beginning of the journey, and I think it's really important for us to acknowledge that, and that many organizations have not even gotten their arms around their own positions related to equity, let alone figured out how to implement equitable health strategy and equitable policies and practices within your organization.

So, if you're that organization that doesn't have a statement or a strategy or budget or dedicated resource to advance this work, please know that you're not alone. But what we're hoping that today's conversation will kind of stimulate you to think about equity more broadly and not just focused on the traditional dimensions of diversity, of race, gender and age maybe.

Atokatha Ashmond Brew: Yeah. Thank you, Lisa, for bringing that up because that sets us up very nicely for your next question. It's really around things that you have said in the past which is what the DEI discussion tends to focus on, which is race and gender and ethnicity, and certainly not health, especially in the way we've been talking about it in the equity guide. How can leaders, especially those that are in organizations where they actually do have a strategy for DEI, how can they emphasize this discussion without deprioritizing their current DEI practices and programs?

Lisa Brown Alexander: Yeah. I think the way to look at DEI is to look at it through a holistic lens; to recognize that it's not just compensation, but it's also benefits, culture, the sense of belonging that people have and purpose to work. All of those things contribute to DEI and they're all "Yes, and…" It's not an either/or, it's not that if I'm doing something around recruitment, I can't do anything

around health. Or if I'm doing something around health, I can't address issues of age. It is it taking a holistic approach and recognizing that people bring their whole selves to work, including their health status. And so, if we are truly wanting to advance DEI fully, we want to look at the collective person, the whole person, that person has a physical being, a social being, a financial being; we all have those multiple elements. And so, I would say that there's absolutely no need to deprioritize whatever you may be doing, it's simply recognizing that someone's health status is a contributing factor to the extent to which they can engage in the work that they're doing for your organization and help you realize impact.

Atokatha Ashmond Brew: Right. Did you want to weigh in on that, David?

David Sloves: There's not much more to add. That's beautifully phrased.

I really think this whole notion of walking and continuing to move is so much the fundamental of this and that they're not "ors," they're "ands." Many of us are small businesses and we can't solve all these problems at once because we don't have the skills, the money or the time. That's not a hopeless response, that's realistic in saying, "Okay, what are you going to do then?" And I think that's what Lisa has really spoken to. And, for me, that's what triggered this emotional reaction to your mission; more than just the alignment of business, it really struck me that you hit that chord.

Atokatha Ashmond Brew: Yeah. One thing, David, that I've read that you speak about and you mentioned in a little bit earlier today regarding the healthcare crisis is that the insurance and medical community would agree that our healthcare system remains in a vulnerable position. You've shared thoughts on how a toxic approach to health insurance sets the stage for a healthcare system collapse as a result of COVID-19 and the pandemic. Can you share more about that point?

David Sloves: Sure. I mean, unfortunately, all too much. A lot of this really started as the healthcare system realized it had thinned the herd and become a very small community of very large businesses, and the natural tendency then to act in a fashion that in economics we call an oligopoly. So, we would start to bend the supply and demand to take advantage of our known ability to control supply. And we started to see inflation and most of the healthcare that we work with at Nonstop is employer sponsored. And so, employers started feeling the pain of that, increased premiums for insurance and increased exposure to big changes in their budgets, and that got passed down to the employees both in the way cost sharing was done then and how the actual plans themselves were designed.

Little by little, we accepted this notion that things like co-payments and deductibles and higher out of pocket exposure were all a requirement to make healthcare affordable as a benefit. At some point, somebody lost fact that if you couldn't access it, it wasn't a benefit, it was a cost. And a huge portion

of the consumers who are in employer-sponsored healthcare, who have high deductible health plans without any kind of support for that, or even some of the traditional plans with high co-payments, are getting taken out of access to primary care and basic day-to-day medical healthcare. As a result, we've created this situation in which these big entities are winning, but the two primary elements of the system, the doctors and the patients, are losing.

And people forget, the doctors have been losing for a couple of generations. Their real incomes look like American workers in the middle class. They've held constant, and then went on decline as inflation gutted them and insurance companies gutted their reimbursements. And so, the hospitals, the drug companies, the insurance companies—all good there—but the consumers and the people delivering these services were left to kind of fend for themselves as it got worse and worse.

When you throw in a pandemic, both from the actual health consequences, but also just from the fear it brings to bear. The whole notion that we learn as children of the bubonic plague and rats in the street color our perspective of what this would be. And so, it just became a really horrifying cycle and the mental health derivatives of this, probably are going to outlast the medical side by far.

As part of the healthcare system, we were right at the gut of the offensive on how this came to be and what made it worse, not better. And that's one of the sad realities of the American healthcare system right now.

Lisa Brown Alexander: I think it's really important to highlight the fact that the vast majority of Americans get their health insurance through their employers. And nonprofits are no different. There are 12 million plus people working in the nonprofit sector, and I would venture to say, at least 75% of those individuals are relying on their employer. Those of you who are on the phone today, they rely on you for their health insurance.

And so, if you're not employed or you're underemployed, likely you're also underinsured. That creates another equity concern for many, and we're seeing that now that countless people have lost their employment and therefore lost their health insurance.

Now, of course, we have the Affordable Care Act that allows people to purchase coverage through exchanges and thank goodness for that. But that's relatively new in the history of the country. And not everyone has taken advantage of that because they afford to. So, it's a real challenge, and the social determinants that come from not having health insurers are, there are more of them than we have time to talk about.

Atokatha Ashmond Brew: Yeah. Were you going to say something, David?

David Sloves: Yeah, I think it's important to understand that even in the exchange model with subsidies, the plans that are subsidized are what are called silver plans. Silver plans are the third tier down, and so inherent in there is a lot of co-payments, co-insurances, deductibles and high out-of-pocket expenses. So even if you make it affordable from the premium perspective, again, you're delivering this perceived benefit of catastrophic loss when most people can't handle $400. And people are getting subsidized care, it's a terrible loop that you're creating.

Atokatha Ashmond Brew: Yeah, David, and you've said yourself that deductibles discriminate and that, in fact, health insurance philosophy about deductibles and co-pays can actually work against health equity. Can you share what Nonstop's philosophy is about this notion of skin in the game rhetoric?

David Sloves: Yeah. First of all, that expression now makes the hair on the back of my neck up every time I hear it, because it's this load that, "Well, we're putting all this money for you, and you should be appreciative." "Yes, sir." But no. What we're doing is we're giving people an illusion, and then telling them, "Don't look over here."

Many people may be aware that Forbes just had an article in which they referred to the American Health Insurance System as a three-card Monte game. And for those of you not familiar with it, it's a street hustle that gets done. And it wasn't a complimentary article.

The real reason is because if you don't give people real access to care, then it's not a benefit, it's a cost. And the problem is that if you are talking about even a $25 co-payment to go to the doctor for somebody who has to choose that $25 or getting their bus pass for the month, that's not going to work out well. If you look at that, it's right at the point of about $60,000 a year of household income, where even the small deductible and co-pay plans don't work—don't work means people don't get healthy, they get unwell.

That's fundamentally discriminatory in its design because there's zero reason for it. If we were talking about something that actually were improved efficiency of delivering health care, dandy. But when you spend $25 on a transaction that six or seven transactions actually spin out from, each of which costs $4 or $5 to actually make real, not only does it not reduce the cost of delivering healthcare, it increases it and it taxes you for using the system. It's kind of sad parody, but the notion that the insurance system is meant to keep you out of the health care system is way more true than not.

I can tell you, in our business, this notion of first-dollar coverage, period, end stop. We won't do anything with our program in which there's not first-dollar coverage, we will walk away from opportunities if the HR department says, "Well no, we want skin in the game." We will go, "No, then you don't want us. That's not what we do." It's driven by that observation and we know it works.

And the one thing that we really know now, analytically, without question, is that when people use our program, the organization's costs for inpatient services, like hospitalization, the most expensive part of the healthcare system, goes down steeply year after year, and that is 100% consistent across our client base. And if you want to understand how that discrimination really works, look at the decaying health of people with things like diabetes and congestive heart failure who don't get access to primary care and their meds versus people who do. Not only is it bad health policy for the individual, but it's terrible fiscal policy for you as an employer. You're going to pay for those hospital days instead at many, many times more money.

Atokatha Ashmond Brew: Right, thank you so much for that, David. And Lisa, I just wanted to ask you, for the person who's listening right now, and we have a really relevant question that just came into the box as well, and I want to get to that in just a second. But for the person who's listening right now and they're saying, "This is so great and I really relate to it," but they may be feeling powerless or don't know their role in actually creating that bridge. What would you say to them?

Lisa Brown Alexander: Well, if you're the CEO or the executive director of your organization, you have a lot of power.

You have the power to establish priority and to convey those priorities to your board and compel them to sign on. If you're the HR leader, you have the opportunity and the power to improve leadership, and hopefully, you're part of leadership. Influence leadership to understand the importance of creating an equitable organization.

If you're a staff member, you have the power of your voice which allows you to raise the concerns related to not only health equity, but equity in general within your organization.

That covered the key stakeholders within an organization: leadership, the HR and talent management folks and the voice of the people. The staff who are doing the work every day. I think it's critically important when we talk specifically about health equity to also recognize that while you may have equal access to a health insurance plan with your colleagues, your zip code could completely alter what you have access to. And so, as organizations, it's important for us when we're thinking about our health insurance to be sure that it's not just, "Well, everybody pays and there's a 70/30 split, or 25/75 split between employer and employee when it comes to premiums," but also asking the questions, looking at your employee census, figuring out where they live and making sure that the health plans that you put in place have resources for the communities where your employees reside. So they're not having to spend $25 to go across town, to the good side of town, to get health insurance that they're paying the same amount of as their colleagues who happens to live in that zip code.

I know that was a very long-winded answer, but in practical terms because I'm an HR person by profession; that to me brings it real, makes it kind of tangible. What kinds of things can we do as organizations, whether we're the CEO, the HR person or the employee to say, "It's great that you gave me this employer-sponsored healthcare and health plan, but can we make sure that they actually have resources where I live?"

That's a voice that the employee can have, but that the HR folks can have as well and go from there.

David Sloves: Yeah, I'd add one thing to that, which is the actual contributory plans that employers use. Very often, there is a uniform plan for all employees rather than the compensation-based tiering system. And the problem with that is, very often, just as Lisa is indicating, the by-ups to the better-quality plans that have a broader network or better coverage are inaccessible to those workers because you're using this uniform pricing model that doesn't reflect the facts of their incomes. And so, we really advocate for tiered-based contribution models and doing away as much as possible with the notion of by-ups to get better access to care. Part of our success with the Community Health Center Movement is the very notion behind which they were formed by the Black Panthers and various activists coming out of the sixties, this notion of making care available to everybody, regardless of income.

And so, bringing a health program forward that matches to your values really starts with recognizing those values have implications that you can influence in how you purchase your healthcare for your employees.

Lisa Brown Alexander: I would go further, actually. If your values say, and your mission says, that you are advocating for social justice and healthcare, if that's the type of nonprofit you are, but you don't look inward to your own internal practices, then there is a disconnect between the values you spouse to the public and those which you practice internally. And I think that's something I've been talking about for a long time. We know, organizations sometimes don't align what they do internally to what they speak about externally. Particularly those of you on the call today who are healthcare organizations and social justice organizations, the kind of model that that David was talking about in terms of healthcare premiums is a really simple, or not so much simple, but an important place to start.

Are there disparities in what people are getting based on their income? Or are you changing the premium cost-sharing model by income?

If you're a human service organization and have a large percentage of frontline staff earning minimum wage, if they have equal access to health insurance, that's great. But if the premium is set

more to be suitable for those who are inside and not frontline staff, but in the administrative and senior-level positions, then in fact, there is inequity right there. That's a good example.

I know we're talking so much, my goodness, take it away Atokatha.

Atokatha Ashmond Brew: That's alright, this is good stuff. As I mentioned, there is this relevant question that I wanted to get in from one of our viewers here in the Washington, DC region. This person shares, how can organizations cause the current commitments to DEI to live beyond the current agency? I'm concerned that the level of present circumstances may cool off at some point, and people may dampen the commitment to following through on this important work.

Would you like to take that one first, Lisa?

Lisa Brown Alexander: It's a great question, and we have feared that ourselves. We've seen a lot of demand from the nonprofit organizations that we work with for this work. We haven't seen a cooling off, so I'm glad about that, but eventually it may cool off.

How do we prevent it from doing that? By continually measuring the impact of a more diverse, more equitable, more inclusive workforce.

How have your retention levels gone up? How have your results gone up? How have your program outcomes been improved as a result of making meaningful investments in diversity, equity and inclusion? Continue to measure that, continue to celebrate, so that people associate your organization's success with the extent to which you've created an equitable environment. And then, it becomes much more difficult to associate and see DEI as a program as opposed to an imperative. That would be my suggestion.

David Sloves: I would add only one thing, which is recognize the passion of your people for this topic and literally create an environment in which it's not just encouraged but institutionalized. I love the notion of creating permanency to the function of DEI, whether it's in a direct staff person or a process that you put into place, and back it up with money. Because otherwise, you're kidding yourself. If you don't budget for this, if you treat it as a one-time expense, I assure you it's going to disappear quickly.

It's very hard for all of us dealing with difficult fiscal circumstances in the world to make these choices. But if this is something that you believe is fundamental to who you are as a community, then the institutionalization of the process and the money needs to be part and parcel of it.

Lisa Brown Alexander: And strategy, tie it to strategy.

David Sloves: Aboslutely.

Lisa Brown Alexander: Tie it to results, tie to impact, then it becomes less program oriented and *flavour du jour* and more so, essential to who you are.

Atokatha Ashmond Brew: David, you started talking earlier about first-dollar coverage and I'm wondering if you can go a little deeper on that especially for people that are on the call who may not be familiar with it.

David Sloves: Sure, the whole notion of first-dollar coverage is something that we used to take for granted. If you were in a health plan that was a traditional HMO or PPO, you went to your doctor and you saw your doctor. And if you had to pay for something, which was typically if you didn't get the drug they prescribed but you wanted a different one, or if you didn't want the shared room, you had to pay for the upgrade. And so, we kind of got the notion of cost sharing by exception into the mainstream a generation or two ago.

And then, we just kept ratcheting it up, and not paying attention to the outcomes. It wasn't just the health outcomes, and those were bad, undeniably bad, but the economic outcomes were worse.

What you're seeing now is this kind of incredible denial that we, the healthcare system, are responsible for. It's just the nature of how complicated the world is. Well, this isn't complicated. If people can't access a doctor visit and they don't go when they need one, they get worse. Eventually, they show up either in urgent care or in the ER and it costs 10 times as much. And if it decays their health and they end up being an inpatient person, it becomes 100 times or 1,000 times, and if it becomes chronic, 10,000 times, more expensive. You multiply this by a percentage here and a percentage there and, as Warren Buffett says, it adds up to real money.

That's really what has happened, and now you're seeing this rise of self-insurance, so that employers can take back control. And what we hit early on was the notion that we could take this self-insurance and use it in the insurance system and not make people give up their networks or their HMO doctors. I'm in California and a Kaiser person. I don't want to give up Kaiser necessarily, but I don't want to feel like I have to pay them an obscene amount of money so they can make more money than any other company in their field, which they kind of do in California, which, as mission-based organization, is not really their mantra, but it's the facts.

And so, we've given people the ability to take control of the plan design. You can give people first-dollar coverage. Maybe you can't afford to cover every expense, but cover up to a certain amount so

that 80% or 90% of the people are 100% covered and shrink exposure to something that they can afford. It's not that complicated.

Atokatha Ashmond Brew: Right. And Lisa, you mentioned something earlier regarding values and the values that you espouse and communication and how those things align. When I think of talent acquisition and talent retention and even engaging employees, I wonder if you can speak to how this concept could make its way, health equity and especially regarding benefits, into either helping to accentuate and enhance a talent acquisition strategy, or vice versa.

Lisa Brown Alexander: Well, we know that the decision to give your time and talent to an organization is a multifaceted one.

So, you're oftentimes first attracted to the mission, then you might be attracted to the leadership if there's a particularly dynamic leader or the work of the organization in the community. But you also want to know that you're going to be paid appropriately and that will be able to have benefits. If you're working full-time, you're going to have the expectation, more likely than not, even if you have a spouse who has covered elsewhere, you're going to expect access to healthcare. You're going to expect that, with my full-time time and talent, you're giving me decent benefits.

And so, to the extent that organizations are practicing the first-dollar model or have a particularly equitable approach to healthcare, sing it from the rooftops; let it be part of your employer brand, let it be a part of the story that you tell about why somebody might choose to work with you because, increasingly, organizations are making different decisions about health insurance. And to the extent that you can not only be equitable in your practices, but equitable in your policy and your benefits, you're going to stand head and shoulders above the rest. Now, I say that with a caveat.

If you have really rich benefits and a charismatic leader and an amazing mission, but your culture is toxic, you have not won. We have to take a holistic approach to attracting talent and retaining talent. It can't just be, we've got really great health insurance, but if you're a woman, not so much. Or we've got a really charismatic leader, but if you're under 30, your voice will never be heard. Or we've got this great mission, but if you're a person of color, you will not have a seat at the table. And that goes back to that holistic look of equity. We have to look at it all the way around, including what type of health insurance we offer our employees, the cost-sharing model that we extend, the extent to which people can access benefits where they live without having to go across town. And if they have to go across town, how do we make it so that it doesn't cost them, as David said, rather than benefit them?

Atokatha Ashmond Brew: Yeah, and a follow up question to that for you, Lisa, has to do with a point that the guide was making regarding engaging stakeholder groups, both internally and

externally. One point of emphasis was to create or invest in a DEI council or committee within your organization. Should organizations that are venturing into this element, into this space, decide that we really want to start at that place, what impacts might employers experience from this type of decision?

Lisa Brown Alexander: Well, first, I would say yes. Engage a DEI council if you can.

We've done it at Nonprofit HR. We created that council last year shortly after the murder of George Floyd and I have absolutely no regrets having done it. We were very intentional about making sure that the council was a representative body of all of the dimensions of diversity that we knew about at Nonprofit HR: age, race, gender, ethnicity, religion, area of work. Because we all know about program staff versus non-program staff, that's the thing in nonprofits. And so, making sure that your council is representative of your organization and that all of the dimensions of diversity within your organization have voice. So that's the first thing, yes on the council concept.

Two, making sure that the council has direct access to leadership. Either assigning someone from your leadership team to be a sponsor of the council to advocate on behalf of the council, to carry the water for the council or in partnership with the council, is important. But I would also say that it's important for leaders to integrate the work of the council in your organization's strategy.

It's sounds like a lot of work. It does, but if you want to make this real and tangible and elevate your DEI practices, those would be the things that I would suggest. Starting with the council is a great thing. That council can also help you craft your statement, help you think through your strategy, be a voice, be a representative body when it comes to recruitment and retention, and help you think through the elements of your culture that serve as a barrier to having an equitable culture. So, there are so many benefits to having a council. And for those organizations that already have one, I definitely applaud them.

David Sloves: Lisa, do you provide people with either a sample how-to guide, or is that a consulting service that you guys deliver for organizations? I'm a little curious as to how you've brought that in a product sense to market.

Lisa Brown Alexander: Yeah. Well, we've not commoditized that, but we do have a very robust DEI practiced at Nonprofit HR.

Through our DEI practice, we help organizations first understand the landscape of what is and help them get to what they want to acquire and attain in terms of policy, practice and systems. And so, the recommendation to create a council would perhaps be an outgrowth of an assessment and an audit of equitable practices.

Atokatha Ashmond Brew: Thanks. Speaking of external stakeholders, David, you've spoken about benefits brokers and the role that they have to play. I know you mentioned this in a recent blog that you authored as well. What action items would you say they have immediately to begin advancing change or to at least buck at the status quo?

David Sloves: Well, in our case, we started as a broker, and we're selling direct to the nonprofit community. As a product evolved, we came to that moment of decision. What are we as a business? We realized that our mission of serving the nonprofit community was being consumed by this larger mission of health equity and real justice to the workforce.

And we made the decision. The product had reached a point of maturity that we could work with other distribution channels to get it to a broader market, even in the nonprofit world through associations who had partnerships and otherwise. And so, we went out looking to do so a couple of years ago, and we looked for out-of-the-box thinkers. We wanted people who weren't part of the problem, which is those who say, "We're just going to all get rich on this, and we're going to grow the share of the American economy that we own more and more of, and that's our deal."

We wanted people who called that BS. And there's a whole bunch of out-of-the-box thinkers in this community, happily. One of the like-minded people that we ran into quite a number of years ago is a fellow by the name of Dave Chase, who really phrased it beautifully, that healthcare has killed the American Dream.

He has created a cohort of consultants and brokers who all share some of those values, and so we've been working with a lot of those folks and through our association in the nonprofit community, we've met more. And these are brokers who share these values. We've been fortunate in getting a fairly good-sized cohort together, despite the difficulties of COVID and not being able to meet face-to-face, because of these common values. And so, I think one of the things that has been very positive over the tragedy of 2020, which is so broad and deep that trying to find the silver lining feels a bit like a fool's errand sometimes, but I think there have been certain things that really are leaving a mark in the most positive ways. Communities literally say, "We identify with one another, we should be partners in this process." Then, co-opting the narrative has been something that the broker community has been exceptionally motivated to do at that powerful 5-10% of community, which is a very big community.

I am a long-tale history kind of guy. I look at things not necessarily in the moment, but over the longer experience that is real. I tell the tale of Mao and his retreat through a year in the snow and mountains to survive and then, coming back 15 years later. Racism in this country has got a long history and the destruction of the Indigenous people, even longer history. And so, these things aren't

going to happen on my nickel, and on my watch, this is going to take my kids and my grandkids and their kids to all be part of something. I think engaging this community is where it starts. And for us, that's been brokers who are like minded.

Atokatha Ashmond Brew: Yeah, I like what you're sharing. I think Lisa is going to come back with us in a moment. I wanted to follow up with your question with a statement that you mentioned earlier, and it really has to do with healthcare and literacy and for employees actually understanding what's being made available to them; actually being able to break apart their benefits in the first place before they can even utilize them, of course. Can you speak to that and what your passion is around that?

David Sloves: You've hit it right on the head, it's that people don't understand what's being done to them. Math is hard. It's not something we focus on in this country historically, certainly not over the last few decades, we're far more interested in media literacy. Not that those are bad things, but the fundamentals of personal mathematics have really crippled people. "Killing the American Dream" is a phrase that as distasteful as it sounds, is for real. Real wages have not increased for the vast bulk of people in this country. Healthcare has become a crisis. Education has become a crisis, particularly for college education and the debt loads. These things are not coincidence. And for me, at least, educating people as to what the real value of benefits is means telling them not with the insurance plan costs, but what the total exposure is. And it is unconscionable to me that, after all the years of PPACA and all its middle tiers, it's still not required for any health plan to say, "The average person is going to spend this much on premium and this much on out of pocket."

It's left to somebody to translate it to them and people are not transparent in this industry about that. They don't want to do the math, but the math isn't complicated. We algorithmically figured out how to do it six years ago. We know what out of pocket spending is going to be for a group and how it's going to be aggregated across the mass. How many people are going to get hurt, how much?

And the truth is, it bankrupts people, whether they know it or not, and it's even worse when they don't know it.

Atokatha Ashmond Brew: What do you mean by that, it bankrupts people?

David Sloves: I run into people at open enrollment meetings, when I'm involved with them, who will quietly say to me, "Hey, I've got three credit cards maxed out for my daughter's medicine that I have to buy her every year, what do you think I should do?"

And I say, "Well, let's take a step back. What?"

And I'll find out that this worker who's maybe working in a non-union manufacturing job at $16 an hour, above the proposed $15 minimum wage, but is making 30 some odd thousand dollars a year. She is spending her share of the healthcare expend and the premium is several thousand dollars against that. But then, she's got this $6,000 or $7,000 little side habit. And the reality check is, they don't have the money and so they literally become the walking dead of economics. People who are bankrupt and don't know it, and can't understand why they're getting further and further behind. And healthcare is the number-one trigger of bankruptcy for personal reasons in this country. But it's worse because most people don't know they're bankrupt. They just know they're bust.

I mean, it's pretty simple. It's the difference between, I'm poor and I'm broke. Poor, it may be institutional and permanent broke is a current tense issue. People don't understand how those two came together to make something that felt like a short-term problem forever, sometimes, generationally.

And that's what healthcare education needs to actually get people's head around. How much we're really spending out of our paychecks to get access to care, and if we don't spend it, what happens when it gets worse to our paychecks?

Atokatha Ashmond Brew: Right, and then moving the needle forward, again, back to the concept of the CEO charging this discussion, leading this charge internally, advocating for the success of all of their employees to have access to health care in an affordable way. I'm sure our listeners are wondering if you could share a little bit about Nonstop's specific internal approach to DEI and belonging in your own talent management programs. How have you woven this concept through?

David Sloves: Sure, and we'll start with the obvious picture in the room, which is me. I am an older, entitled, well-educated White male who is the third generation of college attendants in my family since they were immigrants back in the early 1900s. And so, I represent both the historical tradition of immigration in this country and the entitlement that comes with being a White male and all of the above. And so, the natural tendency of organizations when they start is to look like you.

And what we've done and aggressively done is recognize that we need to get some of the old people out of the way, and let younger people drive not only the businesses creation, because that's the nature of any business, that as you get larger, you have more people drive it, but also the culture.

And so, we've created programs where we have cross-functional teams that address almost anything, including diversity. We've had people say, "Hey, we'd like to have a monthly program where each

month a year we recognize one or more groups in society and celebrate them." We'll do educational programs. We'll do celebrations. We'll have speakers.

What was great about that is they kind of quietly said, "By the way, it's going to cost some money," and I said, "Okay." They didn't tell me how much and I didn't actually even think to ask until literally months later when they said, "Well, it's about this much." I went, "Oh, okay." And then I thought about it, and went, okay, this is important. This is actually changing the dialogue.

Well, we were really fortunate, in some respects, in that some of the early key people in the organization were people from various backgrounds; people of color, many women, my businesses is almost two thirds female, so we're like many of you in the nonprofit world. We have a lot more women than men in our organization. And so, I think part of that culture of gender politics has served us well. Also, in terms of sexual identity, we're very diverse and we were based in the Bay Area, so it's not surprising. I am the odd guy in a conversation who was dealing with people who were transgender in the 1980s on a regular basis normally, because I dealt with the city and county of San Francisco as a business partner, and it was normal.

And so, I think part of this is just recognizing the humanity, and not the identifying characteristics, as what makes us the same. I think that's really the cultural inclusiveness, and it's hard.

Atokatha Ashmond Brew: Yeah, I'm glad you're saying this. Bringing you back up to speed, Lisa, with where we are and with where we were going, we were talking about the natural question that some of our viewers and listeners may have in that, what has Nonstop Wellness and what has Nonprofit HR done internally? And I know, you have talked already about our DEI council, our taskforce, but I wondered if you can shed some light on the other things that we have done as a firm in this very important space.

David Sloves: I only had one last thing to mention, and then I'll move off. One of the things that Lisa has said several times is the need to measure. Well, when we upgraded our HR system, one of the great aspects of it is it has a one-click diversity report. It was super gratifying for me to not be embarrassed when I clicked it the first time.

And I've been able to share it with my team and my board, which is not diversified at all, and say, "This is us as a company and this is us as a board. What's wrong with this picture?" And at least open the conversation up in a situation with closely held corporations with very few directors. But it's very hard.

Sorry, Lisa, I wanted to finish the thought before I get lost.

Lisa Brown Alexander: I think it is hard, David, whether you're a for-profit or nonprofit. You're talking about unpacking, unbundling, dismantling 400, almost 500, years of injustice and inequity, and so, we're impatient because it's right in front of us. But we have a lot of work to do. There are structural components all around us contributing to the kind of environment that we're all living in now.

So what Nonprofit HR has done, and as I mentioned, I'm very transparent about it, we are new to this journey. Some might assume that because I'm a Black woman and I'm the CEO, that Nonprofit HR would've been light-years ahead of the rest of the world when it came to DEI practices, we weren't.

And we weren't because we did not really focus on it. We focused on delivering services to nonprofit organizations and have not prioritized, have not made a strategic priority, diversity, equity or inclusion, quite frankly.

Now we've changed that and we got our wake-up moment like the rest of the world last summer. And in order for us to consult in this space, to me it was important that we model that which we espouse. And so, we went about the business of looking at our pay practices, looking at our benefit structure, looking at our workforce composition, taking a deeper dive in engagement and satisfaction, to be sure that we understood where we stood. We looked at the landscape, we did our own assessment and continued to assess our practices and our policies and our services to make sure that we are inclusive and as equitable as we possibly can be.

Our recognition of our inequity has a significant price tag to it, and we carved out money. We made a decision that it would be impossible for us to consult in this space if we did not address the "sweep around your front door," those of you who are from South, you've heard that phrase before. It's important for us to get our house in order. We've made internal compensation corrections and equity adjustments, largely based on race. We made adjustments regarding our practices from a benefits perspective. We created that the taskforce, we are implementing a strategy, and it's a journey. It's not a sprint. It's a journey and I am committed to doing this for the long haul. We are already seeing the benefits of being more intentional and we will continue to do so as long as we can.

Atokatha Ashmond Brew: Alright, and this next question sort of brings it back together in terms of creating programming and partnerships internally on the ground that make things easy for employees to understand and absorb. Speaking to what David was speaking about regarding healthcare literacy earlier today, how can CEOs work with their total rewards experts and partners to increase education for those out-of-pocket costs that influence overall wellness?

Lisa Brown Alexander: Yeah, I'm going make a statement at the risk of being controversial, which is healthcare literacy is kind of low across dimensions of diversity.

Whether you're rich or poor or Black or White or straight or gay, most of us are not health literate. We know limited amounts of information about our physical bodies, our minds. And so, in that regard, it's a level playing field, and to the extent that we can increase the health literacy of our employees by providing information, by partnering with our growth, by partnering with our service providers even. I remember the days when you would bring the carrier to your organization, so they could talk about what is available.

For example, many people are not aware of the Mental Health Parity Act, and the fact that healthcare organizations are required to provide mental health benefits. In these COVID streets that we find ourselves walking on, how can we elevate, remind and educate people on what's available to them through the health plan around mental health? And then, how can we create a culture that supports mental health?

Some is the responsibility of the carrier, the insurance company and the broker. Some of it is our responsibility of leaders in our organization. I can have a great health plan, but as I said before, if my culture is toxic, I'm undermining the health, the mental health, of my employees. And so, it is critically important for us to look at everything that we can do as employers to educate, inform and support our staff.

Atokatha Ashmond Brew: Did you want to weigh in on that, David, regarding total rewards?

David Sloves: I completely agree. I think there's a bit of a Pandora's box in the mental health area in that you mentioned having to take a bus across town to see a practitioner. Well, in the mental health networks that the carriers are required to have, there's no governance that I can see on how long you have to wait, or how many transactions it's reasonable for you to get access to in a given period of time.

We have a very large carrier in our market and the current waiting time to get through triage is six weeks—just through triage, not to see somebody.

Lisa Brown Alexander: That surpasses organizations; it was probably a bad example because mental health and the availability of mental health benefits in this country are abysmal regardless of your zip code. That was probably not the right example.

David Sloves: But it is because it's part of the whole issue of equitable.

If we agree that mental health is on parity with medical health, and we don't fight for that, then we're falling victim to the issue of, if we can't solve it, we should quit. And I think that's something that, as CEOs, we can take a more assertive approach on and recognize maybe you can't fix it all in the first place. But maybe where you start is you make your broker damn well go fight to get access to out of network mental health practitioners. Which, yes, you can do with every carrier because they're regulated by an insurance commissioner, Managed Care Commission, and you throw that complaint at them, so they will accommodate you.

Well, how many brokers actually even know that, or will help their clients do that? As a CEO, demand it. Demand your brokers taken more advocate-oriented role in that space. Some of this stuff we can do is CEOs, because dammit we can do it.

Lisa Brown Alexander: I think our responsibility as the CEO is to not look at other people to fix the problem. Sometimes, the problem sucks. Sometimes as CEOs, we have to create cultures where people feel that they belong, that they feel they have voice, where they feel that systems practices and policies are equitable. That is solely our responsibility, and we cannot allocate that responsibility to anybody else. That starts with us, and if we don't create equitable systems, we cannot expect a health plan or anything else to fix it. We are part of the equation, so we have that responsibility as leaders.

Atokatha Ashmond Brew: Yeah, and Lisa, something that both you and David spoke to earlier, and David, you mentioned Pandora's Box, a moment ago. These organizations get into these discussions, and they really realize at that time that this is deeper, this is much more systemic, even than our benefits, even than our total rewards and compensation. How do you suggest that they just step back then, at that point, and begin to look at this, even from a greater talent management lens?

Lisa Brown Alexander: I would go back to the notion of the whole self. Our work in organizations, and I've said it in the nonprofit world for many years before I started Nonprofit HR, when we sit in organizations to change the outcomes of the quality of people's lives, that's important work, that's ministry. Honestly, it's so important. How do we then disconnect ourselves from the people who actually do that work? And so, I would say, we do ourselves a disservice when we don't understand the power of a healthy, engaged, positive, inclusive, embracing workforce.

When you have an organization filled with people on fire for your work, who have access to health care, who are being treated equitably, there is nothing they can't do. But we look at people as an expense, and more often than not, we were focused on programs and fundraising and finance without recognizing that if we invest deeply in the people who have committed their time and talent for this work, the dividends will be paid tenfold, not only to the organization, but to the communities that we serve.

And so, I don't know how we disaggregate the two, but my personal experience has been that the investments that Nonprofit HR has made in its workforce have paid off tenfold and I have absolutely no regrets. I would do it again, if I were given the opportunity.

Atokatha Ashmond Brew: Did you want to weigh in on that, David?

David Sloves: Now, that's brilliant. Lisa's passion and her experience, it's compelling.

Atokatha Ashmond Brew: Yeah, there is one question here that has to do with federally-qualified community health centers. David, and for those of us who are unfamiliar with community health centers, will you share a little bit about what they are and how this particular community of nonprofits have become leaders in championing health equity, not only within their communities, but within their workforce as well?

David Sloves: Sure, so the very notion of the federally-qualified health centers, and what are called look-alikes, is that these are medical facilities that are staffed with medical professionals, sometimes dental professionals, all care professionals, et cetera. They are paid for delivering services to people in their community locally, typically, low-income, Medicaid or non-Medicaid, legal or illegal, members of our community. They are the systems front-end for this local community that does not have access to other care. They can deliver service elsewhere, but their primary focus is on the working poor, the non-working poor, the elderly, et cetera.

They came out of the communities of color, out of the Black Panthers, in the '60s, who established some of the first health centers in the country. But they also came out of the anti-war activists who also established facilities, and young people who were helping the elderly. They started out very much as passion projects. Then, a funny thing happened as it worked. They turned out to be low cost and the healthcare system loves low cost. So, they started to get institutionalized and they became grownup businesses.

And then, under George W. Bush, they actually got a more permanent footing from the federal government, both for Medicare and Medicaid services and their funding model. They've become really substantial businesses and now there's about 1,800 organizations around the country that are part of this community, they have over a quarter million full-time employees and they serve as the primary healthcare system for over 30 million people. So it's a huge, huge service organization that's incredibly low cost and that works under very basic precepts: We will care for you, regardless of your economic or legal circumstances in our society, period, end stop.

And whether it's in the center of the larger urban centers or in the most rural areas of this country, you've got community health centers doing that work in a way that is powerfully effective both for the goodness of their community and the wellness of their community. They bring a real presence of caring and commitment to the healthcare system, that is almost entirely gotten disassociated from the more traditional care systems that we interact with.

When we connected with this community literally by accident in our earliest days, we were incredibly impressed. The leadership we met with were people who had taken these things from infancy to, in many cases, businesses with hundreds or even thousands of employees, and had become genuinely the hub for delivering not just basic health care services, but a whole host of community services. We were just awed by this. And so, we did whatever we could to make ourselves valuable to them, frankly, and become part of that community. They are literally the heroes of the healthcare system from where we sit. It's almost undeniable during COVID where they had been at the frontlines without PPE at the start and done it.

It's incredibly gratifying to see these nonprofit organizations, almost 100%, not only being able to compete in the marketplace and become successful businesses, but having a culture of support for their community, including their own employees. And so, we were embraced by them with our notions of health equity in a way that nobody else would at the outset because we were coming across his hair-on-fire revolutionaries. What do you mean, first-dollar coverage? We need skin in the game. And these folks were willing to give us a hearing because their executives went, "Huh, you kind of sound like us." And I went, "Oh, we do kind of sound like you!" And people in my organization who we're talking to them went, "These are the people we need to work with." So it became this kind of mutual lovefest.

And for us, it's enabled our culture, our commitment and our mission to really take shape and allowed us to go beyond that community. But we never forget our roots. They're our peeps and we view them as the heroes of the system in a system that's lacking heroes. That's for darn sure.

Atokatha Ashmond Brew: Wow, David and Lisa, this has been such an amazing conversation. I know that listeners and viewers are really excited about the information that you've had to share, and I want to make sure that we can get into more questions from our audience. And so, if you're listening, feel free to begin putting your questions into the questions pane, and we'll get to as many of them as we possibly can. And the first question that has come in is: If you're working with a broker, is the data that you were, and the things that you were, sharing earlier, David and Lisa, is this data that we can ask them to provide to us?

David Sloves: I'll take that one to start with. So, as far as the true cost of delivering healthcare, absolutely.

Even in the large group space, the brokers know what the deductibles and out of pockets are, and they know roughly how it gets distributed, the more sophisticated of them. Particularly in markets where the carriers aren't completely hiding their data. I unfortunately live in a state that likes to think of itself as pro-consumer, but is absolutely bought and sold by the healthcare system. That's California. We get nothing from carriers until we get to about 200 employees, and very little until we get to 500, or even 750, so you have to really pry it out of them. We built an analytic system, so that we didn't need their data, we could figure it out ourselves. I don't think that's necessarily something all brokers can or will do, but we have.

I know that brokers who work in the self-insured space are very expert on this. And generally speaking, you can find people in any good brokerage who can walk you through at least the basics of the equity of different health plans, the cost value equation. Even more importantly, all of them can do the network analysis that Lisa has been speaking to brilliantly. Where are the doctors? Where are my people? Almost any broker can do a basic geoanalysis for you. It's not hard anymore, and most of the carriers will do it for them.

Atokatha Ashmond Brew: Yeah. Did you want to weigh in on that, Lisa?

Lisa Brown Alexander: No, no. David's got it, this is his space.

Atokatha Ashmond Brew: Alright, here's the second question: How do you structure benefits that are based on pay range?

David Sloves: Okay, that's a simple one for most of my clients who do this.

They either take it based on annualized wages, using hourly rate times whatever their hourly model is—if it's 32 hours, 32 times 52—and they say up to this amount, your cost for this plan is X. If you're above that and if it's a three-tier plan, which is the most typical, it's going to be Y, and if you're at the high end of the comp, it's going to be Z. Depending on how family oriented they are, they'll do something similar across the full range of coverages. We tell employers, you want the kids in your plan. They bring your costs down, not up.

Lisa Brown Alexander: Not only that, but if you're want to be equitable for both those with families, and those without. Don't say, if you're single, you get a better deal than if you have kids, that kids kind of weigh you down. That's not the message you want to send.

Equity applies to family status as well, not just income. If you're giving 70%, or your covering 70% of the costs across the board, then don't do something less for the employees who have family coverage. What message is that sending to people about the value of family?

And I've seen those kind of plan designs in place, where if you have single coverage, they'll cover you 100%, but if you have a family, not so much. You're going to pay more. And while the premium certainly does cost more, the organization has the opportunity to be equitable in its approach to the cost sharing.

David Sloves: Part of this, simply, is economics. If your plan is already at the end of your budget, and you can't contribute more, you're going to have to make some hard choices about how to balance this. We had one really interesting organization that was almost entirely low-wage workers who moved concrete around a lot. And they have huge turnover and huge problems retaining staff, and it was causing them to not do well as a business. They put our program in place and moved from an expensive PPO to Kaiser, and the savings from that allowed them to offer full family coverage. What happened over the next year blew their minds. Their turnover dropped from over 100% a year, they were replacing 100% of their workforce every year, to under 10% in under a year. Their profits literally went up six times. I didn't have to make the case to that HR department because the CFO and the CEO said, "Yeah, why didn't we do this five years ago?"

So, this is for real, and I can tell you, as a CEO you want to keep your keep people happy, and you want your organization to feel good. And if people can't afford to cover their families and their families or under insured or relying on SHIP (State Health Insurance Assistance Program) or other programs, you can't really feel like that's going to have the same kind of partnership with your team that you want to have. And it is a tough investment.

Now, one huge advantage that nonprofits have, this is one of the few spaces where they can level the playing field or get ahead because the private sector doesn't buy this and the private sector is all about optimization on it. Maybe you can't compete with them on wages, but you can kick their butts on benefits. I can tell you in the healthcare sector that we work in, the doctors and the nurses and the dentists who are really hard to come by, this is a scarce resource, when they're getting crushingly good benefits, it's really tough for Kaiser to poach them. We can tell you that there is real competitive advantage in recruitment and retention with good benefits in the nonprofit sector. It's the only area I know of, beyond your mission itself, where you have a financial advantage in recruiting or retention, if you choose.

Atokatha Ashmond Brew: All right. Well, here's another question that has come in, and this one has somewhat of a legal spin to it.

Not essentially that organizations or employers can mandate, the vaccine is what we're talking about here, but essentially, you can't mandate it due to needing to grant accommodations. But it could be interesting to hear thoughts based on equity. There are some organizations that are planning to mandate COVID vaccinations for employees. From an equity lens, I think a policy that mandates the vaccine, regardless of accommodations provided, is highly problematic. She's asking for some insight.

Lisa Brown Alexander: To say that it is important because this is evolving practice to consult an attorney on this. You've got all kinds of interplay, ADA and all kinds of other things that play in. I would recommend that you seek an attorney guidance around what we can and can't mandate, and then think about practice. Why do you need everyone to be vaccinated? What's the business imperative? And then, how do you implement that from an operational standpoint, if you get counsel to tell you that that's the right way to go? I suspect that many employment attorneys are going to resist the urge to tell employers that they have to mandate vaccinations for a whole slew of reasons. Not the least of which is access to vaccinations, which we hope will be available to all, but is not yet the case. But also, for health reasons, there are some people who it is not in their best interest to get vaccinations because of other conditions. So, it's not black and white. It's complicated, it's messy, it's evolving. See an attorney, and that would be the best advice I could give.

David Sloves: This is a really tough one. On one hand, until the vaccines are actually certified as safe, and not just under emergency approvals, the legal issue is fairly serious and to be sure, not a minor point.

I'll answer the health equity question though. I think the health equity question is a much, much more difficult one because particularly the people of color in this country who've been jacked around by the healthcare system in so many ways, some of them really atrocious. The Tuskegee story isn't one we need to dive into, but there's nothing gentle about the history of the healthcare system's interaction with people of color in this country. So, with the distrust of that system and as a guy who's just said it's the most obtuse oligopolistic system I know of, it's not hard to understand why people wouldn't trust it.

As leaders, we have to kind of be able to separate the genuine human species survival issues that this pandemic brought to play with the systemic foul odor of the healthcare system. Get serious about that and educate our people that, "Look, you're not wrong, okay? The healthcare system has jacked with you forever, literally as long as we've had one in this country. And you're right, but let's get serious about what this is all about and your personal needs to be able to travel, to be able to meet with people, to protect your family, protect your elders in your family, to be part of the community."

We need to look to the leadership of those communities. If I'm trying to educate people, I'm going to go to where people trust and have the conversations with them, and not hard sell them. Let's just say, "Look, here's what we know and here's why we think it's important," to let them preach. And I didn't say preach by accident because I think the church and various other social communities that are important need to be on board with this. This isn't going to be employers dictating and everybody saying yes. That's just not where we are in this country right now.

And so, this needs to be something that is genuinely and honestly open. And if that sounds like the rest of the conversation about DEI, well, I think that's not coincidence. So, I love this question. I actually think we could do a whole session on this, and I'm going to ponder it further afterwards. I love whoever asked that. Brilliant. Well, well done.

Atokatha Ashmond Brew: Yeah. We're running out of time here. We have just about four minutes left and we need to turn this back over to Alicia so she can do any final remarks. As we do that, Lisa and David, do you have any final points that you would like to leave with CEOs as they're taking and processing all that you have share today?

Lisa Brown Alexander: Yeah, I would say, get on the journey. If you're not there yet, get onboard the DEI train and really, be honest about where you are, if you're at the beginning of the journey, then be transparent about that. Don't hashtag yourself to death, so let your hashtag be your truth, and Atokatha heard me say that before. Be explicit about what it is you are trying to do from an equity perspective. Measure it. Address those barriers to equity that exists within your organization, and be committed for the long haul. This is painful, difficult, but critically important work. And you've got the stuff that you need internally to make it happen. If you can survive and be a nonprofit leader, you can absolutely do this, you've got the chops. Commit yourself and your organization to advancing the nonprofit space to be a more equitable one.

Atokatha Ashmond Brew: Thanks, Lisa and you David, do you have any closing remarks for us?

David Sloves: I don't really want to steal the thunder of that. I'm just going to go back to basic thought that I try to remind myself of as a CEO which is, it's not human capital and human beings. Start from that place of your intentions and your mission, and you allow yourself the failings of the past. Now, I'm a tech guy by trade. We have the same basic *raison d'etre*: Fail fast. That's technologies whole mantra. Fail fast, find the right answer.

And that's what I'd say here, that whether it's about health equity, or about any of the broader range of issues with DEI. Do something, learn from it and keep moving forward, and keep moving forward is live to fight another day. It's the mantra of nonprofits and startups alike. It's probably why I

resonate with this community, live to fight another day is the only way to get through a lot of the hardships of dealing with a difficult world that doesn't always welcome you.

Atokatha Ashmond Brew: Thank you so much, David. I turn it back over to you now, Alicia.

Alicia Schoshinski: Great, thanks. Thank you so much, Lisa and David, as well, for all your contributions to today's conversation. I think it was very valuable for everyone, and certainly as evidenced by the Q&A and the chat. That is all the time we have for today, but we do have many, many more webinars coming your way in 2021. So be sure to check out events listed on our calendar at nonprofithr.com/events.

We also have a feedback survey that will be popping up on your screen once the webcast ends, so please give us your comments. It certainly helps us inform as we determine topics for future webinars. Then, if you'd like more information about available services and support for Nonprofit HR, you can email info@nonprofithr.com or visit us on the web at nonprofithr.com.

You can also learn more about Nonstop at nonstopwellness.com. If you want to explore how to get better benefits for less, you can schedule a brief conversation with them and you can see that address on the screen as well. So, we thank you so much for your participation today, and we hope you have a wonderful day.

Thank you to all the attendees.