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How COVID-19 is

Reshaping Primary Care

SHARP DEMAND FOR VIRTUAL CARE EXPECTED TO SAVE PCPS, IMPROVE OPERATIONAL EFFICIENCIES, CUT COSTS AND ELEVATE OUTCOMES

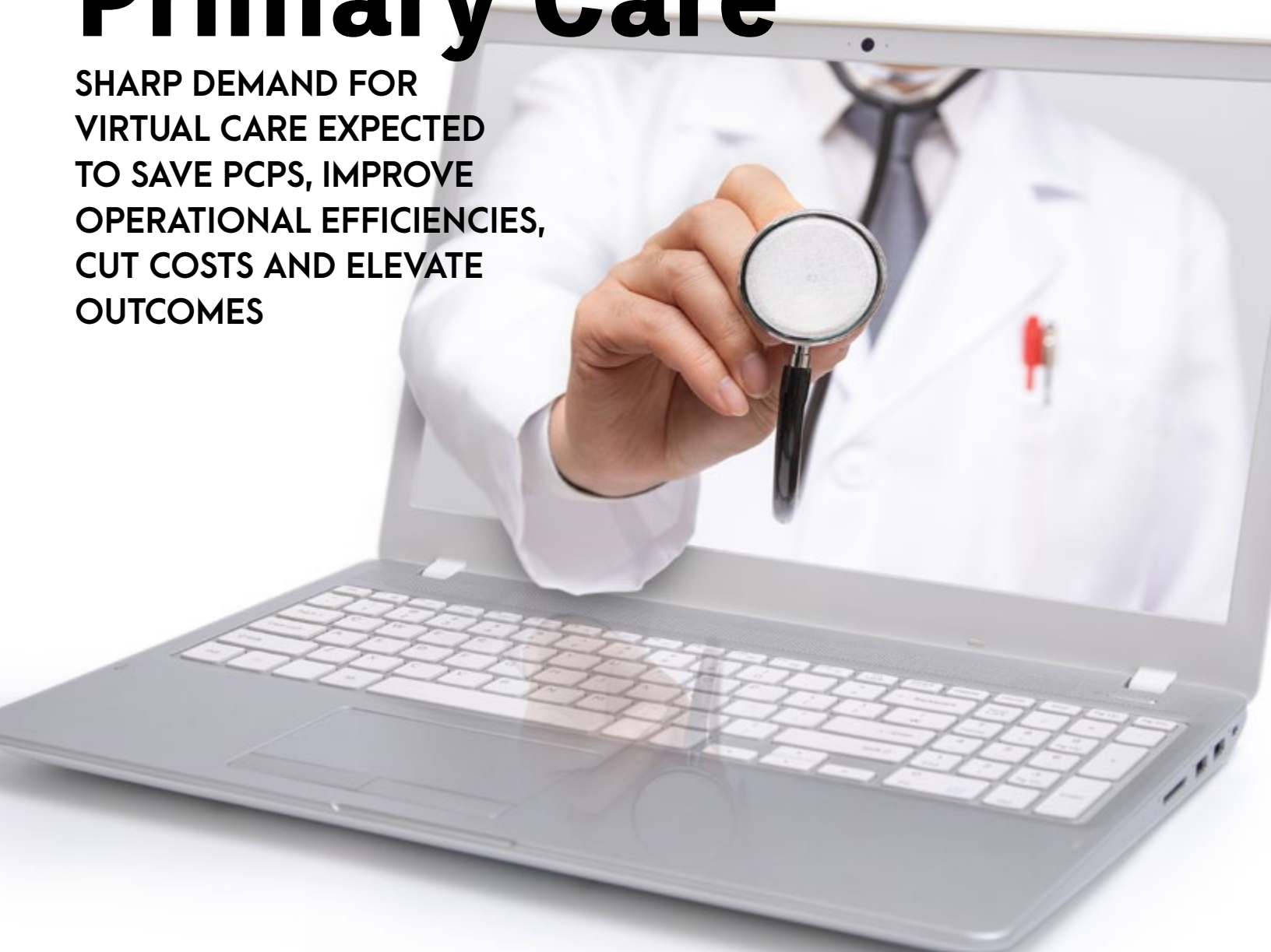

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TABLE OF CONTENTS

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AUGUST 2020
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FEATURES

ARTICLES

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How COVID-19 is Reshaping Primary Care

SHARP DEMAND FOR VIRTUAL CARE EXPECTED TO SAVE PCPS, IMPROVE OPERATIONAL EFFICIENCIES, CUT COSTS AND ELEVATE OUTCOMES

Written By Bruce Shutan

COVID-19 cracked the foundation of U.S. healthcare several months ago, threatening the livelihood of primary care physicians. To make matters even worse, as many as half of the nation's PCPs could disappear because of ineffective compensation and an over-reliance on specialty care, Elizabeth Mitchell, president and CEO of the Pacific Business Group on Health, recently warned.

There has been a historic decline in the number of PCPs, the result of fewer medical school graduates pursuing primary care, whose physicians are the lowest paid in their profession. PCPs must contend with a host of rising expenses involving office rent, malpractice insurance and employee payrolls, as well as the absorption of unpaid patient bills.

But virtual care presents PCPs an opportunity to operate far more efficiently and produce better results from both a cost and quality standpoint. "It's going to give them a larger pool of patients to have access to their services," explains Augusteen Cowan, VP of group sales for CareClix, a leading virtual telehealth platform.

Augusteen Cowan

A year-over-year increase of 64.3% is expected in the telemedicine or telehealth market this year, laying the groundwork for seven-fold growth by 2025, according to a recent Frost & Sullivan analysis. In addition, a Forrester Research report noted that virtual health care interactions are on pace to top one billion by year's end. It's also worth noting that the U.S. Department of Health and Human Services has earmarked $15 million to 159 organizations across five health workforce programs to increase telehealth capabilities in response to Covid-19.

Explosive growth in telemedicine isn't just happening with the diagnosis and treatment of physical ailments and injuries for both group health and workers' compensation; it's spreading like wildfire across the behavioral health area – and for good reason. There's mounting concern over the impact of sheltering in place and economic devastation on mental health and substance abuse during the pandemic.

"Unfortunately, it took a pandemic to really gain momentum," says Rey Colon, founder and CEO of MyTelemedicine, Inc. who has been in the space for 12 years. His company has developed a proprietary, HIPAA- and HITECH-compliant virtual care platform that allows health care providers to consult with patients remotely.

A shift in mindset is necessary considering that PCP practices lose up to 20% of their annual revenue in unpaid reimbursements, according to Colon, "because they're not in the business of having to chase money."

As much as telemedicine helps PCPs, it can do the same for specialists and, in turn, help reduce traditionally high-cost services. "We bring specialty physician service into rural and critical-access locations, so patients anywhere in the world can be seen by a specialist," explains Jonathan Wiesen, chief medical officer of MediOrbis, a multi-specialty telemedicine company with a first-of-its-kind integrated specialty and chronic disease management program.

Virtual care can be a key component of how primary care not only survives but thrives, says Dan Trencher, SVP of product and corporate strategy for Teladoc, billed as the nation's first and largest telemedicine provider.

Dan Trencher

SOARING DEMAND

He noticed "a real acceleration, and almost sea change, in how providers and provider groups were adopting telehealth" dating back to late February. Those who already had Teladoc's platform suddenly needed to use it exponentially more and were quickly able to embed virtual care as the principle way to interact with patients for both primary and specialty care.

In early March, business volume essentially doubled over the course of several weeks with greater adoption on the behavioral health side. "We worked with 30-plus hospitals to set up virtual COVID clinics," Trencher reports, also noting the acquisition of a leader in telehealth services that are delivered into hospital facilities.

There also was a rapid adoption of virtual care platforms across the provider community, and as the dust settled a bit with COVID-19 protocols, he says there was a continuation of this approach, which is expected well into the future. On a macro level, his understanding is that the number of doctors using telemedicine as the primary means of supporting patients mushroomed to more than half from roughly 20%.

Noting the dramatic embrace of telemedicine since COVID-19, Cowan reports that "it's definitely put a bandwidth strain on our staff. Everybody in our company is working 18-hour days, seven days a week, just trying to meet client demands and specifications on the telemedicine platform."

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Some MediOrbis clients have experienced a 100% increase month-over-month compared to last year. "Almost every single telemedicine company has seen increased volume, but the key is not just that the volume has gone up, but that the acceptance has gone up," Wiesen observes. "It's gone from just the fringe as very convenient medicine to an absolute necessity and a crucial need for health care in the United States and worldwide."

Even President Trump has declared that telemedicine is life-saving, which Wiesen says has pushed the Centers for Medicare & Medicaid Services (CMS) "to deregulate what was otherwise an extremely tightly regulated environment, and allow patients the freedom and flexibility to use telemedicine." He describes the documentation requirements from CMS as so burdensome and overwhelming that they impede a physician's ability to provide crucial services to patients.

One promising sign that telemedicine services are here to stay is that Medicare is becoming "very aggressive and proactive in reimbursing primary care physicians for telemedicine consults," Cowan observes, noting the windfall for PCPs struggling through the pandemic. Payment parity means a WhatsApp video call is now on par with a face-to-face visit.

FUTURE OF CARE DELIVERY

In the near future PCPs will leverage virtual care as part of their daily routine as efforts continue to reduce exposure to patients with COVID-19, Colon believes. Patients can expect a hybrid of telemedicine and in-person visits, which he says could "boost productivity, which means boosting revenue, and not having to hire as much, because it's done in a virtual setting. I think doctors are going to realize that no longer is my practice subject to maybe a 20-mile radius."

There also will be an embrace of bold new business practices such as the cash-pay model with no copays or other out-of-pocket costs, as well as direct primary care's monthly membership fee, Colon forecasts. Beyond that, he expects PCPs will become savvier marketing their practices, touting a new mix of virtual delivery of services alongside chronic care management.

Given how U.S. consumers have become better educated and increasingly reluctant to pay full price on a host of good and services, there's no reason to think this trend won't trickle into health care. For example, Colon says the rhythm of using Uber or Lyft instead of a taxicab means more patients will prudently select telemedicine over any knee-jerk reaction to visit the ER.

Long after COVID-19 is in everyone's rearview mirror, Cowan says there will be germophobes who insist on still donning masks and gloves. But even prior to the pandemic, he notes that telemedicine was growing astronomically and could turn into a $130 billion industry by 2025.


Jonathan Wiesen

As a pulmonary and critical care specialist who has lauded the merits of telemedicine for nearly a decade, Wiesen never thought that infection control would one day drive his endorsement of this model. "Telemedicine is a great way of being able to bring care to patients without putting the patients or physician at increased risk," he says.

Apart from cost savings and return on investment, Wiesen notes that "satisfaction numbers are through the roof with telemedicine because you have a physician available and accessible 24/7 at your fingertips."

VIRTUAL TEAMWORK

While a huge proponent of telemedicine, Wiesen cautions proponents overstating their case and ignoring built-in limitations. It can save money and lives, in many

instances, he says, but shouldn't replace face-to-face encounters that build trust and strengthen doctor-patient relations.

What has happened in medicine during the past two decades, however, is that it has been nearly impossible for PCPs to focus on patient relationships and decision making because they're so bogged down in the protocols, paperwork, procedures and regulatory minutiae, he adds.

The future of primary care through a virtual lens will continue to evolve. Prior to the pandemic, Teladoc began developing virtual care teams with PCPs, medical assistants, nurse practitioners and allied professionals such as nutritionists, therapists and dermatologists for case review. This comprehensive approach, featuring more value-based components and the need to address more mind-body connections, resembles the medical home model. Trencher says it has piqued the interest of employers, health plans and providers, and believes it will help drive how primary care is delivered not only in the U.S. but worldwide.

"We see chronic condition management, along with screening and prevention, as key areas of fulsome primary care that can be very effectively delivered through a virtual primary care model," he says.

Telemedicine is expected to provide PCPs more tools and resources to help combat chronic conditions that represent 80% of the health care spend, Cowan notes. "If you're self-insured, you don't want to have a patient on dialysis," he cautions. "You don't want to have an employee that has a stroke or heart attack."

Bruce Shutan is a Portland, Oregon-based freelance writer who has closely covered the employee benefits industry for more than 30 years.

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Smarter Rehab

QUICK AND CAREFUL INJURY EVALUATION SEEN AS CRITICAL TO IMPROVING WORKERS' COMP OUTCOMES

Written By Bruce Shutan

The knock on U.S. health care is that reactive medicine is practiced as part of a perverse system that's too busy treating symptoms to catch root causes, or even prevent illness and injury in the first place. It's an increasingly loud argument that applies not only to self-insured group health plans but also workers' compensation. Longstanding frustration over these issues intensified during the early months of COVID-19's tightening grip on the nation's hospitals and other clinical facilities.

But the key to reversing a decades-long slide appears to be in a common-sense approach that embraces basic tenets and virtual care, according to industry observers. In the case of work comp, physical therapy may serve as ground zero in the battle against wasting resources.

The key to making a difference in worker's comp outcomes requires high quality evaluation and early intervention, suggests Scott Cherry, a doctor of osteopathic medicine and chief medical officer for Axiom Medical Consulting, LLC. These two fundamental concepts have helped his


Scott Cherry

firm effectively manage more than 77% of cases with first-aid measures that avoid both days lost and excessive prescriptive therapeutics.

"If there's not a culture of health or early reporting, a minor injury may be nagging, and then it slowly gets worse," he cautions. "But by that time, it's gotten so bad that the injured employee feels like they need to now over-emphasize their symptoms to hit that threshold by which the company has set – and it's probably an invisible bar."

Given the human anatomy's interconnectedness, a holistic approach to physical therapy will expediate recovery and rein in workers' comp claims. Addressing any shoulder pain, for example, requires careful examination of mechanical issues involving everything that's connected to the injured limb.

Michelle Despres, VP of business development and national clinical leader for One Call Physical Therapy, makes the following analogy: "If your wheels are out of alignment and now your tires have worn bald on the edges, you go buy new tires, but if you don't fix the alignment, you haven't solved your problem."

BOLSTERING PATIENT EVALUATIONS

The quality of a clinician's evaluation skills and patient-centered focus are making a tremendous difference in musculoskeletal care, particularly workers' comp outcomes, says Aideen Turner, CEO of Virtual Physical Therapists (VPT). Her firm, which requires the providers it works with to earn a mechanical-diagnosis certification that usually takes two years to complete, reports clinical savings of $1,908 and total savings of $4,800 per case.

"VPT's requirement of a mechanical assessment enables the clinician to uncover and address the root cause of problems rather than treating symptoms," she explains. "For example, shoulder pain can be associated with neck dysfunction, as research has shown this to be the case in over 43% of isolated extremity symptoms." Once the true cause of symptoms is identified, patients are able to quickly regain full function, as well as avoid unnecessary and costly treatment.


Aideen Turner

Intermittent pain, such as knees that only hurt when someone squats or climbs stairs and shoulders that only hurt when they're lifted, involve mechanical pain, which is found in 90% of musculoskeletal cases. This is not a chemical issue that requires drug treatment for chemical pain is constant and lasts only a few days, she explains. Confusing mechanical versus chemical pain is why musculoskeletal costs $213 billion a year and is getting worse, according to Turner, who cites a 60% increase in disability in the past 30 years. The result is increased surgeries and a growing population of chronic pain sufferers.

The chief objective, of course, is to identify and eliminate the root cause of painful conditions vs. simply treat symptoms. Turner recalls a recent case involving a female secretary who worked at the same job for 40-some years. Diagnosed with bilateral carpal tunnel syndrome, she had surgery on her right wrist but developed keloid scarring so the left surgery was denied. "Bilateral symptoms generally indicate a spinal not local cause," she notes.

"It is critical that the clinician perform a thorough mechanical assessment to identify the causative factor and not simply address the symptoms."

After about five minutes of neck retraction, the patient's numbness in both her hands decreased significantly. But without determining the root cause, the danger is that she'd become a patient with chronic pain from carpal tunnel who won't improve. This expertise lends to excellent collaboration with the treating physicians to drive better results.

"The problem in health care across the board is we often turn early to diagnostic testing, such as MRI," Turner says. "We know that imaging often shows all anomalies in a joint, but do not necessarily tie to the functional deficits. When performed earlier than research suggests and the patient receives a label of a tear or joint dysfunction, there can be the introduction of psychosocial factors that may impact the recovery experience."

In another recent case, a patient whose MRI showed a tear experienced numbness and tingling down his arm. He also long complained of carpal tunnel symptoms. After therapists worked with him on some simple neck exercises, it eliminated all sources of pain, and he ended up cancelled his scheduled rotator cuff surgery.

"We need to flip the way we're treating musculoskeletal, especially with self-insured on the group health end," Turner suggests, which means seeing a specialist in musculoskeletal disorders first through direct access to physical therapists and then to be referred to a primary care physician if needed.

POWER OF EMPOWERMENT

Smarter assessments of workers' comp injuries and recommended treatment protocols not only save time and money, but also motivate claimants to improve their health outcomes. Despres recalls a crush injury case involving someone with complex regional pain syndrome for whom hands-on care in the rehab clinic was initially considered the most prudent course of treatment.

But after doing a series of de-sensitization exercises, he'd seen some measure of improvement the very next day and felt empowered to continue that regimen, which took just five or 10 minutes several times a day. After 18 visits, he was 90% better and ready for a return to work. This diagnosis was known to be very difficult to resolve and has a low success rate for injured workers. To achieve return-to-work readiness in 18 visits for complex regional pain syndrome is an incredible outcome, she adds.

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"If he'd gone into a clinic, then the PT would do that once a visit maybe for 10 or 15 minutes, three times a week," she explains. "The difference there is that instead of participating in passive treatments he was actually doing it himself. And because he saw some benefit, he was motivated to continue. And as he continued, he was in control. He achieved his goals through the guidance and oversight of his PT." Indeed, patient empowerment is a primary driver of tele-rehab.

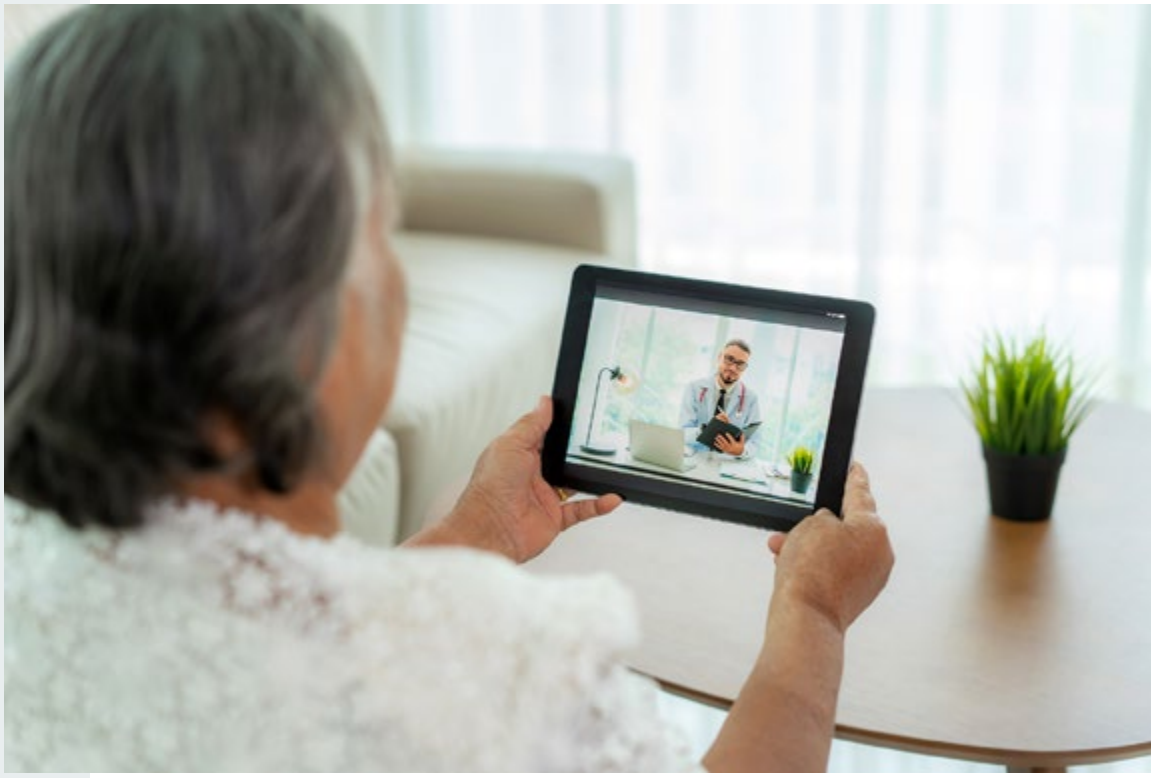
The importance of early engagement cannot be underestimated. Her company's data shows that workers who start physical therapy within three days of injury require 38% fewer PT visits to achieve successful outcomes. The result is in stark contrast to conservative care initiated more than 30 days post-injury, with the discharge time doubling to nearly six weeks from less than three weeks.

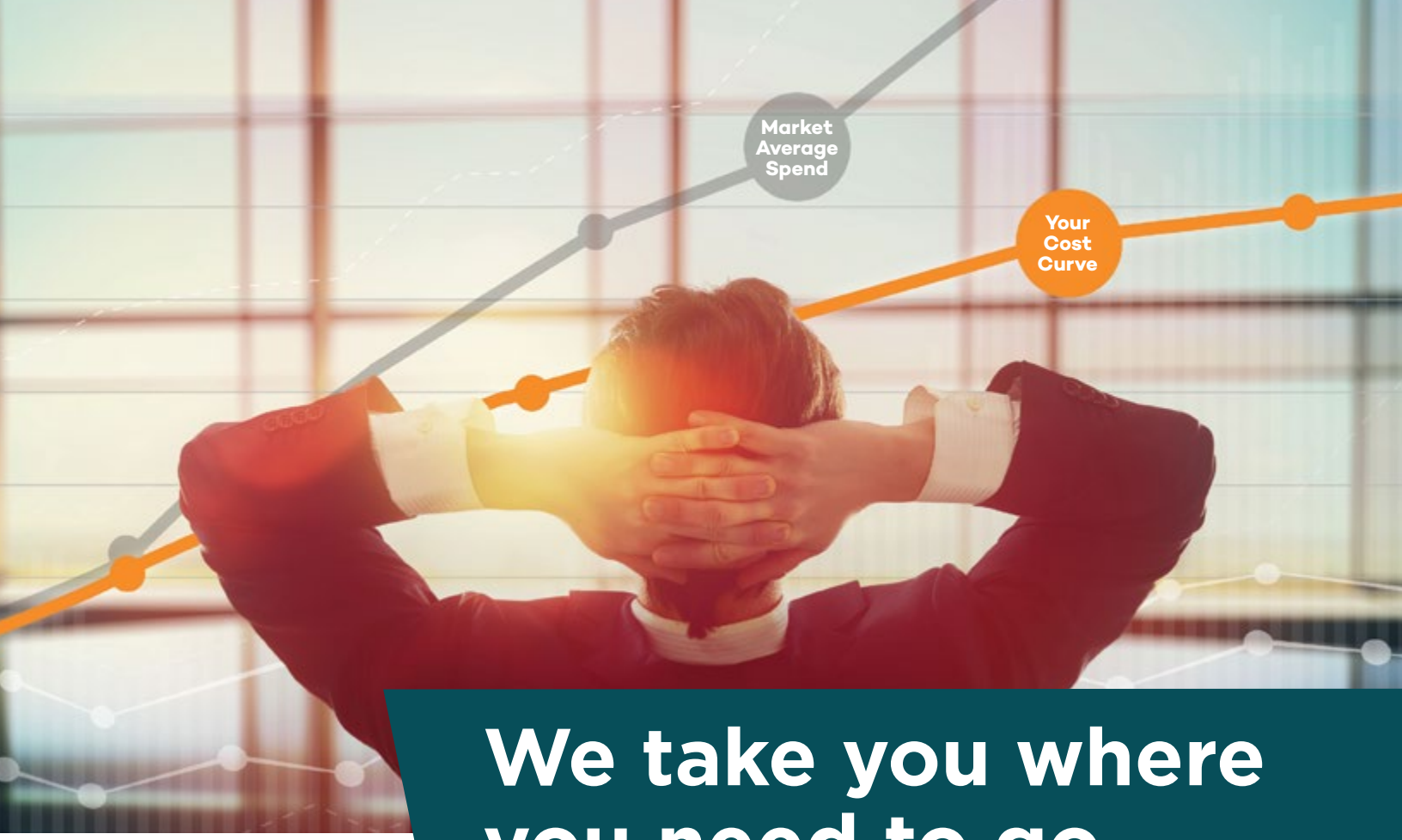
Shortening the return-to-work timeline can save self-insured employers indirect costs that include replacing absent workers, Despres adds. Ultimately, she says ensuring that injured workers receive prompt care involves a collaborative effort between employers and their work comp partners.

But results will vary. A statistical analysis of Axiom customers and prospective clients uncovered an interesting disparity in terms of how work comp injuries are managed from one company to the next. More than 75% of most injuries, for example, are going to be minor, but the largest proportion require more than first aid and enter the workers' comp system.

Sprains or strains account for roughly 40% of all lost-workday injuries, which swell, limit mobility and can cause significant pain if left untreated or care is delayed, according to Cherry. But the stakes are even higher for high-pressure injection injuries at work affecting hands and fingers that are frequently underestimated by clinicians. The danger is that failure to promptly recognize these injuries as a high risk for infection, swelling and underlying tissue damage can result in amputation.

Minor and even severe injuries are easy to assess, Cherry believes. What's tricky is the grey area where he says clinical decision making is needed to determine whether injured employees require hands-on evaluation in a clinic.





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COVID'S GROWING IMPACT

With traditional outpatient physical therapy, patients are scheduled every 15 to 20 minutes and, productivity for a physical therapist is usually an average of 12 to 16 patients in an 8 hour treatment day. Virtual visits are strictly one-on-one and provide additional opportunity for patients to share ongoing concerns about what's impeding their ability to work or return to their job, Despres notes. More active listening and motivational interviewing add a biopsychosocial layer to treatment that she believes amounts to a common-sense approach.

Prior to COVID-19, tele-rehab was offered as an option for any nonsurgical musculoskeletal disorder that was joint- or muscle-based, but she says there was very low adoption for multiple reasons, including concern about the technology.

"People questioned the quality," Despres reports, but now many of them are accustomed to this model. One Call saw a whopping 650% increase in adoption of tele-rehab compared to pre-Covid levels, while as many as 35% of injured workers using the service were 55 or older.

Telemedicine took root years prior to COVID-19 on the group health side and is only now gaining traction for work comp. Turner notes that the virtual care model she embraced three years ago is slicing in half the national average for workers' comp visits, which are 12 to 18 per case. "On the self-pay side, we average 2 to 2.5 visits," she reports, a number that includes herniated disks, ankle sprains and rotator cuff tears.

The public finally warmed up to virtual care, seeing value in one-on-one interaction vs. multiple people in a clinic where phones are constantly ringing and it's easy to be distracted. "They're in the comfort of their own environment, and we're teaching them how to lift properly where they live, not just in a sterile clinic environment," she says. "Empowerment and understanding the cause of their pain and how to self-treat which reduces pain and chronicity."

Patients and practitioners alike also escape any fear of being infected from in-person visits, and in some cases, avoid traveling long distances. What's more, expanded virtual hours during sheltering-in-place orders was a tremendous convenience, especially to patients who do shift work or need to work around their family.

The pandemic, no doubt, adds a layer of complexity to managing work comp. With COVID-19 forcing significant transformation across the U.S. health care landscape, Axiom developed an app for employers to quickly and easily pre-screen team members for infectious or contagious conditions before allowing access to work. Employee who are flagged for potential exposure or illness alert are referred to a clearance center for further assessment.

Self-insured employers now have a new reason to consider investing in total worker health, which is to direct resources to who suffer from chronic lung or heart problems, as well as diabetes and obesity.

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Cherry says all such groups have been identified by the Centers for Disease Control to be at high risk for severe disease from COVID-19.

"We really want to embrace a workplace culture of what I call zero tolerance of illness," Cherry says, "because whether it's the flu, COVID or strep, if you have a fever or you have some type of symptoms, coming into the workplace is really risky for the whole company."

He likens Axiom's contagious respiratory illness assessment program to syndromic surveillance at a time when COVID-19 testing protocols were still being developed. Given the pandemic's devastating economic impact, Cherry notes the emergence of proposed legislation that's "actually going to blur the line between personal medical and work-relatedness." ■

Bruce Shutan is a Portland, Oregon-based freelance writer who has closely covered the employee benefits industry for more than 30 years.


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HHS EXTENDS PUBLIC HEALTH EMERGENCY, PRICE TRANSPARENCY RULING, COVID GUIDANCE & CLARIFICATIONS, NEW VALUE-BASED DRUG PRICING PROPOSAL RELEASED

While the business climate remains unsettled, there continues to be important regulatory activities and court rulings affecting companies involved in the self-insurance marketplace plans, which SIIA's government relations team remains heavily involved in impacting and tracking. Watch for additional real time updates in the coming months as developments warrant. Should you have questions or would like to discuss these, or other policy or regulatory issues, please contact Ryan Work (rwork@siia.org) or Chris Condeluci (ccondeluci@siia.org).

HHS TO EXTEND PUBLIC HEALTH EMERGENCY

The U.S. Department of Health & Human Services (HHS) recently indicated that the agency intends to extend the current COVID-19 Public Health Emergency Declaration, currently set to expire on July 25th, for an additional 90 days.

A number of policy and regulatory mandates and guidelines are based on the public health emergency deadline, including COVID-19 testing cost-sharing requirements and the waivers surrounding telehealth. It is important to note that the Public Health Emergency Declaration is not the same as the National Emergency Declaration, which was implemented on March 13th by the President, and which other regulatory changes, such as the COBRA extension deadlines, are based upon.

HOSPITAL PRICE TRANSPARENCY COURT RULING

On June 23rd, a federal court ruled in favor of upholding the U.S. Department of Health and Human Services' (HHS's) final rule issued last November that would require hospitals to publicly disclose "standard charges" for items and services they provide, in addition to the negotiated prices of up to 300 "shoppable" medical services.

The final rule is set to take effect in 2021. This rule was challenged by the American Hospital Association (AHA), who has sought to rescind the rule before it took full effect. The judge disagreed with the AHA's argument of First Amendment protections for medical prices, as well as against the argument that revealing such prices would have a chilling effect on negotiations between payors and providers.

The judge stated that the final rule was reasonably related to the government's interest in lowering healthcare costs and giving consumers more pricing data to help them decide on medical treatments. The AHA is expected to file an appeal and ask for an expedited ruling.

The full ruling may be found here.

GROUP HEALTH PLAN TRANSPARENCY RULE EXPECTED THIS FALL

Earlier this year, HHS issued proposed regulations requiring both fully-insured and self-insured "group health plans" to publicly disclose the plan's negotiated in-network rates and out-of-network payments, along with a participant's cost-sharing liability for specific medical items and services.

While SIIA fully supports increasing the transparency we are also on record citing a number of concerns related to the difficulty that self-insured plans may have complying and accessing the various data and cost requests.

Most recently, SIIA members were able to speak directly with HHS officials explaining these difficulties and suggesting possible ways of resolving the issues of concern. We expect the proposed rules will be finalized sometime in the Fall.

CMS ISSUES COVID-RELATED FAQS & CLARIFICATIONS

On June 23rd, the Centers for Medicare & Medicaid Services (CMS) issued a Frequently Asked Questions (FAQs) document related to the implementation of the requirements set forth in the recently enacted Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). Among other things, the FAQs flesh out the types of FDA-approved and non-FDA-approved COVID tests that must be covered by an insurance carrier or self-insured plan sponsor with no cost-sharing.

The FAQs also clarify that at-home COVID tests must be paid for by the carrier or plan sponsor on a first-dollar basis if it is deemed medically appropriate by a licensed provider. Importantly, the FAQs explain that if an employer requires an employee to take a COVID test before returning to work, this test is not considered medically appropriate, and thus, the carrier or plan sponsor is not required to pay for the test on a first-dollar basis (i.e., cost-sharing can be applied).

CMS justified this conclusion by re-stating that COVID testing must be free if the test is recommended by a licensed medical provider as being medically appropriate, and CMS noted that a test required as part of a "return to work" program does not meet this standard.

One important clarification to note is that HHS underscores the daily monetary penalty for health care providers if they refuse to post publicly available cash prices for COVID testing under the CARES Act mandate.

Under this mandate, provider payments for COVID testing must be at an in-network or negotiated rates and, if none exist, similar to the cash price made available by the provider.

The FAQs also include a telehealth-related question, confirming that an employer can offer telehealth services to employees who are not other otherwise eligible to enroll in the employer's group health plan. Interestingly, this temporary rule is only available to large employers.

The full FAQ document can be found here.

CMS PROPOSED RULE ON VALUE-BASED DRUG PRICING

On June 17th, CMS issued a proposed rule governing value-based payment under Medicaid for high-costs prescription drugs, such as gene therapy, based on clinical outcome.

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According to CMS, this is the first update to the payment model in nearly 30 years and seeks to create more innovation in payment models and reduce health care spend. Although the proposed rule is limited to Medicaid programs, this will no doubt impact the private market and self-insured plans.

In short, CMS's proposed rule gives states more flexibility to enter into value-based purchasing agreements with drug-makers for new and high cost drugs and would make changes to the calculation of the average manufacturer price of a brand-name drug that has an authorized generic.

In order to encourage value-based purchasing arrangements, the rule would ease certain reporting requirements for drug manufacturers surrounding the average manufacturer price.

For example, a drug manufacturer could report multiple best prices for a therapy drug, but tie that to a value-based purchasing agreement. Other important provisions to note are a proposed change in the definition of performance requirements under bundled sales so value-based arrangements can be utilized, and changes to the calculation of the average manufacturer price for a brand-name product to exclude the sales of authorized generic drugs made by the original manufacturer.

CMS FACT SHEET

The full proposed rule can be found here

If you have questions or would like to discusses these or other issues in more detail, please contact Ryan Work (rwork@siia.org) or Chris Condeluci (ccondeluci@siia.org).

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OUTSIDE THE BELTWAY

This is an update of state legislative and regulatory developments affecting companies involved in the self-insurance/captive insurance marketplace. Should you have any questions regarding the information provided in these reports, or would like to alert SIIA of new state legislative and regulatory activity (health care, workers' compensation and/or captive insurance matters), please contact Adam Brackemyre, Vice President of State Government Relations directly at 202/595-0641, or via e-mail at abrackemyre@siia.org.

STOP LOSS:

Louisiana

In late May, the Louisiana Department of Insurance issued Rule 116, which creates new stop-loss regulations and requirements.

In general, the bulletin contains some minor form requirements and must be read carefully. For example, Section 16917 requires stop-loss insurance issued to a "self-insurance plan" to cover incurred claims if the health plan terminates. This plain language may be alarming.

However, in reviewing the definition of a "self-insurance plan: under Section 16905, it excludes "single employer plans." Therefore, SIIA believes the unpaid health plan liability provisions in 16917 appear to be limited to stop-loss issued to MEWAs.

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State Laws, Bulletins, Executive Orders and Guidance Relating to COVID Exposure and Workers Compensation

SIIA has compiled a chart for you to reference as many states have recently modified work comp eligibility for COVID-related treatment. The chart can be found here.

Michigan

On June 7th, Governor Gretchen Whitmer issued Executive Order 2020-125, establishing presumptive work comp eligibility for essential workers, defined as employees with specific job titles or working in specific locations.

Employees that have a work comp presumption should they contract COVID-19 include: law enforcement officers, fire fighters, volunteer civil defense workers and employees required to work in correctional facilities.

Employees also have a work comp presumption if they work in a hospital and other health care facilities, hospice, ambulances and nursing homes.

This executive order replaces the temporary rule issued on March 30th.

State Department of Insurance COVID Bulletins (Accident/Health)

SIIA has compiled a chart of state insurance department bulletins that require or request carriers, generally accident and health carriers, to allow grace periods for premium payments. A link to each bulletin is provided so that you can review the language. The chart can be found here.

If you have any questions about either chart, see missing information or would like to obtain either in an XLS format, please contact Adam Brackemyre at abrackemyre@siia.org. ■

ACA, HIPAA AND FEDERAL HEALTH BENEFIT MANDATES: PRACTICAL Q&A

The Affordable Care Act (ACA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other federal health benefit mandates (e.g., the Mental Health Parity Act, the Newborns and Mothers Health Protection Act, and the Women's Health and Cancer Rights Act) dramatically impact the administration of self-insured health plans. This monthly column provides practical answers to administration questions and current guidance on ACA, HIPAA and other federal benefit mandates.

Attorneys John R. Hickman, Ashley Gillihan, and Carolyn Smith provide the answers in this column. Mr. Hickman is partner in charge of the Health Benefits Practice with Alston & Bird, LLP, an Atlanta, New York, Los Angeles, Charlotte, Dallas and Washington, D.C. law firm. Ashley Gillihan and Carolyn Smith are senior members of the Health Benefits Practice. Answers are provided as *general guidance* on the subjects covered in the question and are *not provided as legal advice* to the questioner's situation. Any legal issues should be reviewed by your legal counsel to apply the law to the particular facts of your situation. Readers are encouraged to send questions by E-MAIL to Mr. Hickman at john.hickman@alston.com.

GRACE PERIODS, CARRYOVERS, AND CAFETERIA PLAN HEALTH COVERAGE ELECTION CHANGES

On May 12, 2020 the United States Department of Treasury and the Internal Revenue Service ("IRS") issued Notices 2020-29 and 2020-33.

https://www.irs.gov/pub/irs-drop/n-20-29.pdf
https://www.irs.gov/pub/irs-drop/n-20-33.pdf

These Notices are in response to the ongoing COVID-19 pandemic and provide flexibility for cafeteria plan participants with respect to certain mid-year plan elections as well as increasing the carryover limit for health flexible spending accounts ("Health FSAs"). Also included in this guidance are some helpful clarifications concerning high deductible health plans (HDHPs) and coverage of both COVID-19 testing and telemedicine.

The permitted plan design/election changes contained in these Notices are all optional and employers may adopt none, some or all of these changes.

Notice 2020-29

Mid-Year Elections

Even before the IRS issued Notice 2020-29 a number of insurers were allowing a COVID-19 "special enrollment" and making that special enrollment available for the self-insured clients as well. COVID-19, of course, is not an enumerated event that would allow a mid-year change in elections for a cafeteria plan and there were questions raised about whether such a special open enrollment could be offered on a pre-tax basis. In Notice 2020-29 the IRS specifically permitted a special open enrollment only for 2020 and with certain conditions.

The first condition is that election changes were limited to "employer-sponsored heath coverage," Health FSAs, and depended care assistance programs/spending accounts (DCAPs). The IRS did not further define "employer-sponsored health coverage" and the aim was undoubtedly focused on group medical coverage but that reference likely includes other health coverage such as dental and vision coverage as well. With respect to employer-sponsored health coverage the following elections are permitted.

- Prospectively enroll employee or family member in employer sponsored health coverage;
- Prospectively change to another health plan option of the same employer;
- Prospectively revoke coverage but only if the employee provides an attestation that he/she is or will be enrolled in other comprehensive health coverage (e.g., individual health insurance coverage, Medicare, etc.) not sponsored by the employer.

With respect to revoking coverage, the IRS has provided sample attestation language. The IRS also stated that an employer may rely on the written attestation unless the employer has actual knowledge that the employee is not, or will not be, enrolled in other comprehensive health coverage.

Again, these changes are permissive, and consideration should be given to how various election options or combinations will affect claims. Indeed, the IRS specifically noted that an employer may want to limit elections to prohibit adverse selection and provided the examples of an employee switching from self-only coverage to family coverage, or from a low option plan covering in-network expenses only to a high option plan covering expenses in or out of network.

For Health FSAs and DCAPs an employer may permit employees to revoke an election, make a new election, or decrease or increase an existing

FSA election on a prospective basis. Employers will undoubtedly want to prohibit Health FSA election changes that would reduce an election below what has already been paid by the Health FSA, and appropriate limiting language may be required. Changes can only be prospective so an employee cannot retroactively reject coverage and request a refund.

The "consistency rules" that ordinarily apply to cafeteria plan mid-year elections do not apply here and changes to the coverages listed above can be made for any reason as long as permitted by the employer. The employee does not need to establish that he or she was in any manner adversely affected by COVID-19.

If an employer decides to permit any of these mid-year election changes a plan amendment must be adopted by December 31, 2021.

Extension of Grace Period/Plan Years Ending in 2020

Ordinarily cafeteria plans function under the "use it or lose it" forfeiture rules. Thus, as a general rule, amounts remaining in a Health FSA or a DCAP at the end of a plan year must be forfeited. There are two exceptions to this rule. The first is a grace period that may apply to Health FSAs and DCAPs and allows amounts from a prior year to be used for expenses incurred up through two months and fifteen days (2 ½ months) into the succeeding year. The second exception is a permitted "carryover" of a specified amount from one plan year to the next and is only applicable to Health FSAs. Also, a Health FSA cannot generally have both a carryover and a grace period except as noted below.

Notice 2020-29 provides a permissive extension of coverage, until December 31, 2020 for a grace period ending in 2020 or for a non-calendar plan year ending in 2020. For example, a 2019 calendar year plan with a grace period ending on March 15, 2020 may extend that grace period until December 31, 2020. As another example, a cafeteria plan with a plan year ending on June 30, 2020 may allow employees to use any remaining Health FSA or DCAP amounts at the end of the plan year for expenses incurred from July 1, 2020 to December 31, 2020 without regard to whether the Health FSA or DCAP has a grace period and even if the Health FSA has a carryover. These extensions would have no applicability for a 2019 calendar year Health FSA that did not have a grace period.

Remember, however, that enrollment in a general Health FSA will make an employee ineligible for health savings account (HSA) contributions for the entire period of coverage. In our examples above for a calendar year plan with a grace period ending March 15, an employee (if enrolled in a HDHP and otherwise eligible) would ordinarily become HSA eligible as of April 1. An employee in a cafeteria plan without a grace period with a plan year ending June 30 would (again if otherwise eligible) become HSA eligible on July 1. If the Notice 2020-19 extensions are adopted the employee would, however, be HSA ineligible until at least January 1, 2021.

Although beyond the scope of this article, HSA eligibility has a concept known as the "full contribution rule" which allows an employee who meets certain other conditions to make a full year's HSA contribution if he or she is otherwise HSA eligible as of December 1 of that year. Because of this rule, employers who are considering

extending eligibility may only want to do so through November 30, 2020 to preserve the possible use of the full contribution rule.

As with mid-year elections, if an employer wants to extend coverage for a grace period or non-calendar plan year an amendment is required by December 31, 2021.

COVID-19 Testing, Telemedicine and HDHPs

Notice 2020-15 was one of the IRS' earliest pieces of guidance on the COVID-19 pandemic and provided that an HDHP could provide medical care services related to testing for and treatment of COVID-19 with reduced or no cost sharing prior to the satisfaction of the applicable minimum HSA compatible HDHP deductible. Congress followed with the Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) which generally expanded coverage for testing and provided that telemedicine could be provided with reduced or no cost sharing prior to the satisfaction of the applicable minimum HSA compatible HDHP deductible. With respect to telemedicine those provisions were effective March 21, 2020 and only for plan years beginning on or before December 31, 2021.

Notice 2020-29 clarifies the prior guidance and legislation in several ways.

- As to testing, relief is provided for expenses incurred on or after January 1, 2020 and include "the panel of diagnostic testing for influenza A & B, norovirus and other coronaviruses, and respiratory syncytial virus (RSV) and any items or services required to be covered with zero cost sharing …" pursuant to the FFCRA and CARES Act.
- As to telemedicine relief is provided retroactive to January 1, 2020.

Notice 2020-33

As mentioned above, one exception to the "use it or lose it" rule for Health FSAs (but not DCAPs) is a permitted limited carryover from year to year. Since the inception of the carryover in 2013, that carryover amount had been limited to $500. Notice 2020-33 increases the carryover amount to $550 for plan years beginning on or after January 1, 2020. This will mean that the first time the increased carryover amount could be used is for a 2020 calendar year plan to be used in calendar year 2021. The carryover amount for a 2019 plan year remains at $500.

Notice 2020-33 also provides for future indexing of the carryover amount set at 20% of the maximum Health FSA contribution. The maximum contribution for a Health FSA for a plan year beginning in 2020 is $2,750 resulting in the maximum carryover amount of $550. If that maximum Health FSA contribution would, for example, increase to $3,000 for plan years beginning in 2021 the maximum carryover amount 2021 to be used in the next plan year would increase to $600.

Employers desiring to increase the maximum Health FSA carryover amount for the 2020 plan year to be used in the 2021 plan year must adopt an amendment by December 31, 2021 to be retroactive to the beginning of the 2020 plan year.

Conclusion

Again, the plan design/election changes set forth in Notices 2020-29 and 2020-31 are permissive. They provide an opportunity for employees to change their elections in light of changed circumstances related to COVID-19 (although employees need not establish that they were affected by COVID-19 at all). That said, there are procedural steps that an employer will need to take including conducting the new "open enrollment" and amending plan documents. As to conducting the enrollment, communication will be key Although there are extended deadlines for plan amendments communication to employees should be sent out as soon as practicable letting them know what is (and what is not) permitted and the deadlines for making any new or revised election changes.

Implementation of these changes will also require close coordination with any Health FSA/DCAP third party administrator. Coordination will also be crucial with any insurance carrier (including a stop loss carrier). Just because the IRS is permitting the change under a cafeteria plan does not mean the carrier must allow the change. The concern of changes enhancing adverse selection may be of particular concern with the carriers. Finally, most of these changes are only temporary and apply for just the 2020 plan year. ■

CAPTIVE REGULATORS STEPPING UP DURING THE PANDEMIC

Written By Karrie Hyatt

It's been five months since COVID-19 caused the federal and state governments to issue the "Safer-at-Home" orders causing havoc to businesses around the U.S. The pandemic is creating a protracted time of uncertainty and has the potential to be the slowest catastrophic event experienced in the insurance market.

The pandemic is changing the way many businesses operate and captives are changing as needed to provide support to their parent companies. With the contraction of the traditional market and the emerging risk of pandemic interruption coverage, captives are becoming and even better option for many businesses.

During this time of turmoil, captive regulators are showing that they can continue to provide top notch regulation while helping their captives, and their parent companies, through this time of upheaval. An informal survey of states shows that captive domiciles are helping their captives in myriad ways. Nearly all domiciles are offering regulatory filing extensions—either for all captives or on a case-by-case basis.

Some domiciles are waiving the requirement for notarized affidavits or providing workarounds. In some cases, regulators are allowing for electronic signatures. According to Travis Wegkamp, captive insurance director with the Utah Insurance Department, "Due to the strains on companies from the pandemic, and everyone trying to adjust to teleworking while still trying to meet deadlines, we are being very liberal in granting extensions for filings of annual statements, audits, etc."

"We emphasized that during this time, we understand the disruption caused by the pandemic and will be accommodating and flexible as possible to our captives," said Andrew Kurata, the captive insurance administrator for the State of Hawaii Dept. of Commerce & Consumer Affairs, Insurance Division. "We encouraged captives to reach out and communicate to the Captive Insurance Branch, and we will work with captives on a case-by-case basis to resolve issues."

Domiciles are also waving in-state meeting requirements and meeting prospective captive owners through video conferencing. States that require an in-state captive representative are relying on that person to conduct board meeting through teleconferencing or video conferencing.

Several state insurance departments, such as North Carolina, had already switched to online submittal systems for filings which has made the process much more streamlined. According to Debra M. Walker, senior deputy commissioner of the Captive Insurance Companies Division of the North Carolina Department of Insurance, "Fortunately, through our online captive filing system or email, captive insurers were already electronically submitting applications, other filings and special requests to the NCDOI. With those processes in place, while our team was working remotely, we were able to timely review and respond to this information, just as we would from our office."

Regulators are keeping an eye on captive's capital, surplus, and solvency. The potential for large claims payouts, loans to the parent company, the fluctuating stock market, and an unsteady economy could have a detrimental effect on a captive's financial stability. "The overall majority of the captives are well-capitalized. As such, more than ever, we will need to monitor the capitalization and solvency of our captives due to the fluctuating stock market and economic downturn, but at the moment it is not a significant concern," said Kurata.

The key for captive regulators right now is flexibility, while encouraging communication from their captives and staying in close contact with captive managers. According to Walker, "Where we determine that issues exist or may be arising, we will more closely monitor those insurers. The manner in which we do that depends on the situation. We may require more frequent financial reporting, periodic calls and virtual meetings to discuss developments, conduct examinations, or take other actions commensurate with the magnitude of the issues."

For Steve Kinion, director of the Bureau of Captive Insurance Products for Delaware, staying on top of the situation has been crucial to helping captives in real time. During a webinar in June on the subject hosted by International Center for Captive Insurance Education (ICCIE), Kinion said, "We have seen some surplus reduction. We did have a couple of captives that reached minimal solvency threshold, actually just got below the minimal capital threshold … through weekly conference calls with captive managers, where we gathered information, we decided to allow them to wait out the market. The markets have recovered tremendously since March and that solvency issue solved itself."

PANDEMIC INTERRUPTION COVERAGE

Pandemic coverage will be the next big risk put into captives. Because of lack of actuarial data, pricing in the traditional market will be expensive, so many regulators foresee that captives will be used for this type of coverage. The captive sector was already in a position to grow in 2020 before the pandemic hit. Now that the insurance market has constricted and pricing is soaring, captives will be an important way for businesses to access pandemic risk.

Going hand-in-hand with pandemic coverage is business interruption, and the range of specific exposures that it encompasses. Examples of business interruption products are loss of key supplier, loss of key customer, employee loss, supply chain interruption, and political risk. Businesses that are experiencing losses right now are learning that pandemic triggers are excluded from their business interruption policies.

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More captive owners and potential captive owners will be looking to add insurance that specifically does not exclude pandemic risk.

While captives will prove to be a good solution to obtaining business interruption and pandemic risk insurance, regulators do have concerns about how and why pandemic risk will be covered in a captive. Concerns about conditions, coverage triggers, and pricing are at the top of that list.

For Kurata, "Like any other new, or unique risk, with limited historical data, in my opinion the most significant concern would be the adequacy and accuracy of the premium pricing and underwriting and reserving of the coverage."

In a second ICCIE webinar in June, David F. Provost, deputy commissioner of the Captive Insurance Division with Vermont's Department of Financial Regulation – Captive Division, was most concerned about what will be the triggering factors for pandemic coverage, if pandemic risk would be a good product for pooling, and putting limitations on how that money could be loaned back to the parent company.

According to Wegkamp, "I expect to see pandemic risk being put into captives as both a business interruption type policy and as a standalone risk. I have no objections to either; however, given this new type of coverage we will be taking a look at the proposed policies to ensure they are well defined with specific triggers, exclusions, etc. What I don't want to see are broad generic policies that would appear to be a 'catch-all' for any type of business interruption or loss of income event."

For David Piner, director of the Captive Program at the Michigan Department of Insurance and Financial Services, speaking on ICCIE's webinar, "It all comes down to the price. A captive can underwrite an unusual amount of coverage, as far as variety goes, so certainly if they want to do something akin to a business interruption policy that wouldn't exclude pandemics, that's fine, but let's see how much you are going to charge for that."

However pandemic interruption coverage is used, one positive thing the pandemic can offer is data towards a future similar incident. "It's a unique opportunity given that many of these companies that are interested in writing pandemic coverage is that they've experienced first-hand what their potential losses are and how it's going to affect their businesses. It's not multiple years of history but it is some experience," said Wegkamp.

WHAT THE FUTURE HOLDS

Going forward, reaction to the pandemic and a hard insurance market will mean growth for captives. The licensing and regulation of captives will not likely see any significant changes, but regulators might see some changes in how captive owners assess their risk. The pandemic caught nearly everyone off guard and will, hopefully, remind captive owners to assess their risks and coverage more often.

"As far as how the pandemic may change or improve captive operations," said Walker, "It seems that the pandemic (as well as the hardening commercial market) will likely lead to captive owners further evaluating their insurance program and assessing the benefits of using a captive insurer to determine if there are business risks that should be insured by a captive."

Kurata agrees, "I think it is a strong reminder of the importance of prudent regulation of captives in that it is important to monitor the solvency of captives and that they are properly capitalized and not overly reliant on investment rates."

While the pandemic is an adverse event, captives are showing their capability to insure unusual risks. "The captive industry is a unique and inventive one; the owners and parent companies of these captives, like everyone else, have experienced an event like none we've ever faced before," said Wegkamp. "I'm certain there will be many changes and/or improvements proposed and experimented with to mitigate the effects of a possible similar event in the future." ■

Karrie Hyatt is a freelance writer who has been involved in the captive industry for more than ten years. More information about her work can be found at: www.karriehyatt.com.

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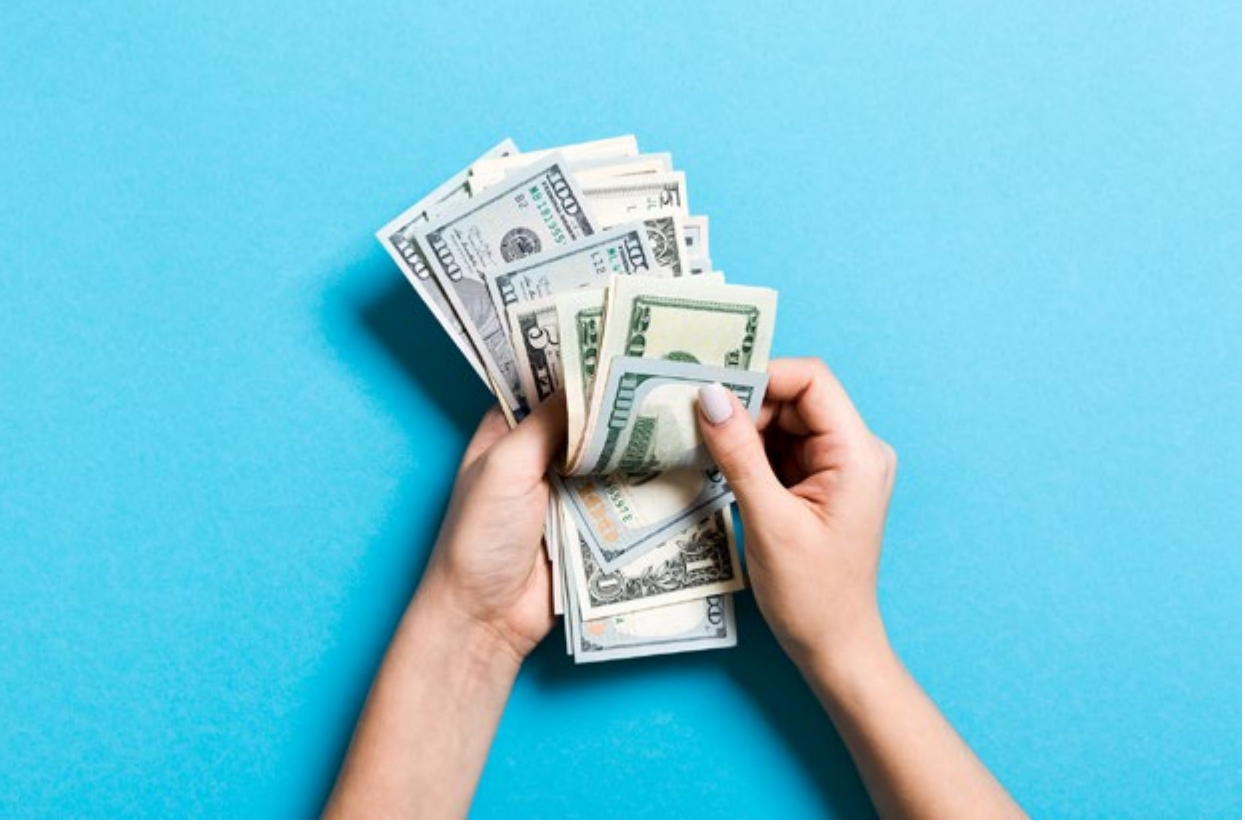

SUBROGATION: THE OLDEST AND MOST EFFECTIVE FORM OF COST CONTAINMENT

Maribel Echeverry McLaughlin, Esq.

For many health plans, the first interaction with any type of cost containment method usually comes about when they begin to utilize subrogation as a way to keep plan costs low, and recover monies owed to them by third parties. It is one of the original, yet consistently effective, cost containment concepts that, as of recently, tends to get overlooked when discussing new and more innovative ways to enhance plan savings.

The history of subrogation can be traced back to as far as the origins of the Court of Chancery in the Elizabethan period. The English Court of Chancery had jurisdiction over all matters in equity, such as trusts, land disputes, the estates of lunatics and guardianship of infants. In this period, subrogation was a common equitable remedy, where one party was permitted to assume a third party's legal right to collect a debt.

In the present day, when plans pay for claims that are owed to them by third parties, they naturally expect to be reimbursed for those costs. However, during the COVID-19 crisis, many states were locked down, and people were forced to stay home; which meant less car accidents, less elective treatments due to statewide bans, and thus less money paid out by plans for medical claims.

According to information released by UC Davis, traffic accidents and crash-related injuries and deaths decreased by 50% during the first three weeks of California's shelter-in-place order. The or-der began on March 20 and the university estimates that the decrease saved the state about $40 million each day.

In other words, the state saved $1 billion in three weeks by having to respond to fewer car accidents. The department found that the state's reduction in accidents was paired with up to a 55% reduction in traffic and a 40-50% decrease in serious injuries for drivers, pedestrians, and cyclists[1].

While motor vehicle accidents have been less frequent, ironically the drivers that are on the road daily have become increasingly more reckless. According to the National Safety Council's President and CEO, Lorraine M. Martin, "disturbingly, we have open lanes of traffic and an apparent open season on reckless driving," causing more fatal accidents in many states.

Fatalities caused by car accidents increased in Massachusetts and Minnesota[2], with the latter seeing deadly accidents more than double typical rates. Other states like Nevada and Rhode Island experienced an increase in pedestrian accidents[3].

You would think that during a pandemic, plan spending would increase as the injuries in motor vehicle accidents get worse and the cost of a hospital admission for patients with COVID-19, the disease caused by coronavirus, can top tens of thousands of dollars. Especially as there were over a hundred thousand hospitalizations just in the early months of the pandemic.

Eventually, we can expect new additional costs to plans when an effective pharmaceutical treatment is identified, or hopefully a vaccine becomes widely available. However, social distancing measures, concerns over hospital capacity, and fears of contracting the virus are leading to other critical healthcare services being delayed or forgone.

For example, providers have delayed elective surgeries during the pandemic, thus having a downward effect on health costs, at least in the short term. Taken together, this data shows that there has been an abrupt and sizable decrease in healthcare utilization, at least in the early months of the pandemic.

The exception has been telehealth, which has experienced an increase; however, the increase so far in telehealth was not enough to offset the decrease in in-person office visits.

In the first quarter of 2020 (January through March), spending on health services was relatively flat overall. Across all health care services, which excludes prescription drugs and social services, spending was down about -0.4% relative to the first quarter of 2019.

Spending was up on nursing homes (5.9%), physician offices (3.9%), outpatient care centers (1.1%), but spending on medical labs (-2.7%) and hospitals (-4.1%) was down in the first quarter of 2020 compared to last year.

Federal spending data from the BEA are reported monthly on an annualized basis. If sustained for a year, the drop in personal consumption expenditures on health care services seen in April would total roughly $1 trillion dollars over a 12-month period[4].

Property and casualty insurers are also reporting a 40 to 50% drop in claims volume for personal automobile claims and a 30 to 40% reduction for commercial claims due to the COVID-19 pandemic[5]. It is too soon to say whether the drop-in frequency will fully offset the rebates that many auto-mobile insurers have been extending to consumers, which the Information Insurance Institute estimates will amount to $10.5 billion.

With all this information, it is easy to conclude that health plans are also saving money in not paying for motor vehicle accident related claims. According to the National Highway Traffic Safety Administration (NHTSA), U.S. motor vehicle crashes in 2010 cost almost $1 trillion in loss of productivity and loss of life[6].

The Centers for Disease Control and Prevention (CDC) said in 2010 that the cost of medical care and productivity losses associated with motor vehicle crash injuries was over $99 billion, or nearly $500, for each licensed driver in the U.S[7].

In 2015, the CDC reported that the average cost for a treatment for motor vehicle accident was $2,314. Which means, if a health plan has 100,000 employees, and roughly one in 150 lives will be involved in one motor vehicle accident per year, then a plan has a potential exposure of 600 lives with accident-related claims that year. If 600 lives have an average of $2,314 in costs, a plan could have had an expense of approximately $1.3 million in costs that year.

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It is easy to conclude then, if accidents approximately decreased by 50%, then the plan's expenses may have also decreased by 50%, thus saving a plan approximately an excess of $690,000, this year alone. The Phia Group boasts their recoveries for established clients total an average of $30 recovered per employee per year[8]. That could translate, for a 100,000-employee plan, into a $3,000,000 recovery on a good year.

It is apparent, by way of current events in this country, that this new normal will be here for quite some time. It is probable that when social distancing rules become more relaxed, people will feel more comfortable going back to provider's offices and having elective surgeries, thus increasing plan expenses. But until the virus is under control, and an effective treatment is found, we can only assume that we will continue in this pattern of uncertainty.

Plans more likely than not, will see less expenditures this year in claims paid for members. This will allow for next year's premiums to stay low and provide exceptional benefits to members at a low cost.

A plan could determine that not paying claims is less lucrative than getting claims reimbursed back to them. But the only way a plan would get any claims reimbursed to them, would be if they paid the claims in the first place. Even though subrogation tends to be the main form of cost containment for plans, it is safe to say that the best form of cost containment is to not have to pay those claims at all. ■

Maribel E. McLaughlin joined The Phia Group as a subrogation attorney in 2016. Previously, she was a plaintiff's attorney, representing clients in medical malpractice and personal injury lawsuits. She is licensed to practice in the Commonwealth of Massachusetts and in the United State District Court for the District of Massachusetts.

References

1 Fell, A., Kushman, R., Oskin, B., Perez, T., & Bankston, E. (2020, June 09). California COVID-19 Traffic Report Finds Silver Lining. Retrieved July 10, 2020, from https://www.ucdavis.edu/news/california-covid-19-traffic-report-finds-silver-lining

2 Wilson, K., Aued, B., Hertz, D., & Cuba, J. (2020, April 10). COVID-19 Cuts Car Crashes - But What About Crash Rates? Retrieved July 10, 2020, from https://usa.streetsblog.org/2020/04/09/covid-19-cuts-car-crashes-but-what-about-crash-rates/

3 Have Car Accidents Decreased During the COVID-19 Crisis? (n.d.). Retrieved July 10, 2020, from https://www.hhrlaw.com/blog/2020/may/have-car-accidents-decreased-during-the-covid-19/

4 Twitter, C. (2020, May 29). How have healthcare utilization and spending changed so far during the coronavirus pandemic? Retrieved July 10, 2020, from https://www.healthsystemtracker.org/chart-collection/how-have-healthcare-utilization-and-spending-changed-so-far-during-the-coronavirus-pandemic/

5 N. (2020, April 15). Auto Claims Decline 40 to 50% as Consumers Stay Home, Snapsheet Says. Retrieved July 10, 2020, from https://www.claimsjournal.com/news/national/2020/04/15/296565.htm

6 Vi.chilukuri.ctr@dot.gov. (2020, July 06). National Highway Traffic Safety Administration. Retrieved July 10, 2020, from http://www.nhtsa.dot.gov/

7 Centers for Disease Control and Prevention. (n.d.). Retrieved July 10, 2020, from http://www.cdc.gov/

8 Services. (n.d.). Retrieved July 10, 2020, from https://www.phiagroup.com/Services/Save-Claims-Recovery-Subrogation-Services

LOSS PORTFOLIO TRANSFERS FOR SELF INSURED WORKERS COMPENSATION LIABILITIES

Written by John West

Loss Portfolios Transfers (LPT) are one of the financial transactions that are available to self-insured employers to reduce their liability. An LPT is a financial transaction which enables a company to transfer their known and unknown liabilities to other, qualified carriers. This transaction is separate from the excess insurance policies which they may have in place.

Companies who have retained liability for certain claims exposures will begin to understand that there is a clear difference between claims which are more recent than those which have been in existence for a period of time.

When a self-insured employer has determined the amount of risk they will retain per claimant or in the aggregate, they will also have determined the amount which will flow into their excess insurance carrier, if they have purchased that cover. After a few years, those liabilities which have been retained by the employer will grow and accumulate. Given the duration and predictability of the workers compensation liability tail, owning those claims for 20 to 30 years may become daunting.

LPTs are basically reinsurance agreements where employers (risk bearers) can transfer their liabilities to another carrier. That assuming carrier will take on the financial and legal responsibility of those liabilities through closure. As with any other workers compensation carrier, those assuming carriers are obliged to manage those claims in accordance with the laws in the relevant state(s) to the claims.

The proposition of transferring liabilities does not mean that an employer needs to consider transferring their entire block of claims. The process can be extremely surgical. As an example, imagine that an employer is in the business of building homes.

They operate in three states and have employees of all ages performing a variety of tasks; construction, administration, and management.

Over time, claims will be submitted for head injuries, back strain, fractured vertebrae and burns (among others). Some of these injuries will heal and the employees will return to work. Others, whether severe or not will continue for many years.

Some of these claimants were relatively young and some were older when they were injured. At some point the employer will begin to think about the amount of time, money and energy that will be spent on these long tail claims. The employer is comfortable that the company (a third-party administrator - or TPA) who was hired to manage these claims has been doing so properly.

However, the employer is still looking at a payout on claims and related expenses for an additional 15 years or so.

It is at this point that the employer has two options;

- continue to fund and manage the claims. By doing so, they risk the chance that the claimant's prognosis will worsen and medical costs will escalate.

- Pursue a loss portfolio transfer where they can carve out some or all of these claims and transfer them to another carrier.

The employer is now at a point where they can review their loss runs and decide the best route forward.

Imagine that the loss run has 500 claims on it. These claims have loss dates spread over the last 10 years. The nature of the injuries on these claims varies, as does the age and prognosis of the claimants. Even though the employer has set aside enough money to pay these claims, she realizes that some of that capital could be utilized for other things (not to mention her time).

The employer can now take the loss run and carve it up for further review. She can look at all claims by loss or injury code. She can look at all claims incurred between the first and seventh year of the program. She can also separate claims by state. By performing this exercise, the employer has now adjusted the risk horizon and decided what part of that is no longer of interest to her.

Once the employer has decided that all back-injury claims that occurred over 3 years ago are no longer ones she wants to retain, she can place those on a separate list and begin discussions of transferring them through an LPT.

HOW DOES THE LPT PROCESS WORK?

Buyers of runoff liability are each unique. Some are focused on larger and more complex lines of business while others are focused on very specific lines and dollar thresholds. It is important that the buyer be comfortable that the counterparty is appropriate. The intent of the transaction will be to relieve the seller of any ongoing liability for those claims which are being transferred. In exchange, the seller will transfer the corresponding assets along with the liabilities at issue. The buyer will usually require a risk premium.

After both parties have agreed and signed a Non-Disclosure Agreement, the initial due diligence process begins. An introductory call between buyer and seller will allow for a better understanding of the seller's intention.

It will also allow for any questions about the size and complexity of the portfolio, as well as the timeline to accomplish everything from start to finish.

Over the next few weeks, the buyer will review the claims run as well as payment history and reserve calculations. The excess cover wording will be examined as well. Recent actuarial reports and claims audits will be reviewed.

When the buyer has reached a comfort level with the portfolio, they will submit a non-binding offer. This will give the seller an indication as to whether the transaction will provide the solution they require for a reasonable price.

Once the non-binding offer has been understood and found to be acceptable by the seller, the buyer will then continue with a more thorough due diligence process. In addition to a detailed claims audit, where relevant, the buyer will interview the claims adjusters, law firms, investigators, large case managers and pose additional questions to the employer.

Actuarial triangles which have been provided by the seller will be reviewed and compared to the buyer's own actuarial analysis. This entire process may take a few months.

After a complete review, the buyer will propose a final and binding offer to the seller. This is typically limited to some contingencies, including a window of time.

Once agreed, the buyer will submit a contract for the transfer of the liabilities.

It should be noted that whereas an LPT may relieve one of financial obligations regarding noncore or aged liabilities, they almost always have a cap, or maximum aggregate limits on what they will pay out. There are well known market examples of where that cap has been reached, and the continuing liabilities then reverted to the original carrier. The carrier chosen as reinsurer may have to put up large trust funds to provide 'credit for reinsurance' security for your balance sheet, should they not already be sufficiently accredited.

Finally, you would need to be as confident as possible in the solvency of your chosen reinsurer, for under an LPT, insolvency on the part of the reinsurer would cause those liabilities to bounce back onto your balance sheet. Consequently, the assertion can be made with confidence that an LPT provides financial relief (up to the level of the cap in the agreement), but not legal finality.

As mentioned before, since buyers each have their unique ability and appetite when it comes to various loss portfolios, companies who are considering an LPT should research which company is best for their potential LPT. ■

John West began his career working in A&H, excess workers compensation and Medical Stop Loss. He then move over to P/C in 2000. Managing a team of 35 consultants, his focus was on exposure analysis and reinsurance collections. Transitioning to runoff liability transactions, John worked for companies in London, Paris, and New York. He is currently a partner in his company, Apetrop.

Apetrop provides risk transfer mechanisms and related services to self-insureds, captives and RRGs and traditional insurers. We provide effective runoff liability solutions. We are also an approved captive manager in Vermont.

SIIA ENDEAVORS

SIIA UNITES WITH CAPTIVE INDUSTRY ON U.S. SUPREME COURT CASE

As part of an unprecedented captive insurance industry coalition, the Self-Insurance Institute of America, Inc. (SIIA) has joined with nearly two dozen captive insurance organizations to file an amicus brief before the U.S. Supreme Court in the case of CIC Services LLC v. IRS ('CIC'). CIC Services, a SIIA member, is a Knoxville, TN-based captive manager.

This diverse coalition formed with the goal of expressing broad captive insurance industry concerns through a U.S. Supreme Court amicus brief supporting the CIC Services case to overturn a decision by the 6th Circuit Court that challenged IRS authority under Notice 2016-66 ("the Notice").

SIIA has been active in opposing the administrative burden of the Notice since its implementation, discussing concerns with the U.S. Department of the Treasury and a number of congressional stakeholders.

The Notice imposes requirements and potential penalties on owners, advisors and managers who participate in certain captive transactions, going back up to 10 years.

These taxpayers are being forced to comply with the Notice regardless of whether their captive insurance arrangement contained any of the characteristics of concern identified by the IRS, and were offered no meaningful opportunity to provide comment or feedback prior to the Notice's immediate implementation in 2016, nor the ability appeal the filing requirements until paying a penalty.

The coalition amicus brief focuses on three key arguments at issue in the CIC case. First, that the Court should consider the heavy regulatory burden and harm being caused to taxpayers, namely the captive insurance industry.

The Notice requires taxpayers to report duplicative information and imposes an undue financial burden to small- and medium- sized businesses, all for little to no benefit to the IRS. These requirements have come at a tremendous cost to taxpayers.

Second, the Administrative Procedures Act ("APA") requires federal agencies to allow for a meaningful opportunity for public comment on proposed rules. The industry brief argues that the IRS did not comply with the APA, rather issuing the Notice without offering public comment and review.

Despite the lack of a formal comment and review process, SIIA and other coalition members nonetheless provided comments to the IRS that went unheeded.

Third, the coalition argues that the Anti-Injunction Act ("AIA") prohibition on preventing challenges to the IRS should not extend to reporting requirement, such as are imposed by the Notice.

A link to the full coalition brief can be found here.

While SIIA continues to support appropriate IRS actions to curb abusive practices, it objects to the unnecessary regulatory burdens being imposed on taxpayers without a formal rulemaking or appeal process, contrary to law and Congressional intent.

"SIIA has been a leading advocate against the regulatory burdens being imposed by the IRS under Notice 2016-66, among other actions, and applauds CIC Services for bringing this case before the court," stated SIIA President & CEO Mike Ferguson. "In joining with a number of industry partners, this brief demonstrates our ongoing commitment to advancing captive insurance through education, reducing regulatory burdens, and allowing American businesses to self-insure risk."

SIIA looks forward to the U.S. Supreme Court hearing this case during the upcoming session, beginning in November, and appreciates the opportunity to file an amicus brief to the Court. It is important to note that while the CIC case is specific to captive insurance companies electing under IRC 831(b), the unnecessary and over broad regulatory actions of the IRS are of concern to both the broader captive insurance industry, and to U.S. business in general.

In addition to SIIA, the broad industry coalition is comprised of 22 other national, state and territorial captive domicile associations, including: Alabama, Arizona, the Captive Insurance Company Association (CICA), Connecticut, Delaware, the District of Columbia, Georgia, Hawaii, Kentucky, Missouri, Montana, Nevada, New Jersey, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, Utah, the U.S. Virgin Islands and Vermont. ■

For more information, please contact Ryan Work, SIIA vice president of federal government relations, at rwork@siia.org.

NEWS
FROM SIIA MEMBERS

2020 AUGUST MEMBER NEWS

SIIA Diamond, Gold & Silver Member News

SIIA Diamond, Gold, and Silver member companies are leaders in the self-insurance/captive insurance marketplace. Provided below are news highlights from these upgraded members. News items should be submitted to membernews@siia.org. All submissions are subject to editing for brevity. Information about upgraded memberships can be accessed online at www.siia.org. For immediate assistance, please contact Jennifer Ivy at jivy@siia.org. If you would like to learn more about the benefits of SIIA's premium memberships, please contact Jennifer Ivy at jivy@siia.org.

DIAMOND MEMBERS

TPAC UNDERWRITERS WELCOMES JOHN NELSON AS PRESIDENT

Minneapolis, MN – TPAC Underwriters, Inc. (TPAC) is pleased to announce John Nelson has joined the company as its new President. As President, Nelson will be responsible for the total operations of the company and execution of corporate goals and initiatives. Michael Meloch will remain with TPAC as its Chief Executive Officer to focus on long-term strategy and product development.

"John is a strong leader who understands the industry and shares the values TPAC holds dear," said Meloch. "He brings a broad perspective of the industry, which will enable TPAC's continued delivery of the exceptional level of service that our partners expect."

Nelson has over 30 years of healthcare insurance industry experience, including 8 years at Risk Solution Resources working as Vice President of Underwriting under Meloch. Much of his experience has been in employer stop loss, holding executive positions in the direct carrier, HMO, MGU, TPA, and reinsurer segments.

"I am excited to join TPAC at such a pivotal time in its growth," Nelson said. "Their position in the industry has always been as innovators, from Spaggregate to SmartShare, and I look forward to supporting TPAC's commitment to building strong relationships with its partner companies."

About TPAC

TPAC Underwriters, Inc. is a Managing General Underwriting firm located in Minneapolis, Minnesota. In business since 1991, TPAC works to protect employer's self-funded plans by providing reliable and creative stop-loss solutions such as Spaggregate®, Specific, Aggregate and SmartShare® through Third-Party Administrators and fully-funded capitated drug card programs. With nearly 30 years in business, we take pride in finding original solutions to the problems our partners face. Visit tpac.com.

BERKLEY ACCIDENT AND HEALTH INTRODUCES HR SUPPORT TO HELP EMPLOYERS NAVIGATE COMPLEX HR ISSUES

Hamilton Square, NJ – Berkley Accident and Health, a Berkley Company, has introduced a new innovative service, called Berkley Accident and Health HR Assist, to help clients navigate complex HR and compliance issues.

The service provides a tangible, immediate value to clients nationwide by connecting them to an unlimited "ask an attorney" service, online resources, and solutions. Berkley Accident and Health HR Assist, provided in conjunction with Enquiron, helps clients stay ahead of changing regulations and is available immediately to all of Berkley Accident and Health's Group Captive members and their broker consultants.

"Today's HR landscape has grown increasingly complex for self-funded employers," said Brad Nieland, President and CEO of Berkley Accident and Health. "Companies are facing benefit, employment, and compliance challenges on a daily basis, often with limited time and resources. We're excited to offer HR Assist to our clients and reduce the burden on HR departments. We are committed to helping clients better manage the risks facing their self-funded health plans, and Berkley Accident and Health HR Assist demonstrates our continued commitment."

Berkley Accident and Health HR Assist includes:

- "Ask an Attorney" Service

Clients can ask ERISA and employment law attorneys questions about benefits, ERISA, ACA, work from home, sick time, employment law, and more. Clients will receive documented, confidential answers to their specific questions.

- Robust online portal with valuable tools and resources

An online portal provides valuable content, including a state-specific employee handbook and policy builder, on-demand training courses, COVID-19 and workplace emergency and disaster resources, best practice guides, and a job description builder.

- Live and recorded webinars

Webinars cover a wide range of employment topics, many with CE credits for HR personnel.

- Personalized email alerts

Clients can receive proactive regulatory updates, based on their selected preferences.

Berkley Accident and Health's Group Captive members are employers who self-fund their employee health benefits. Rather than buy traditional health insurance, they self-fund with Stop Loss protection and then join together to share risk through a Group Captive arrangement, potentially giving them greater control, transparency, and stability.

"We are excited to bring a new solution to Berkley Accident and Health's clients," said Mike Naclerio, President and CEO of Enquiron. "Berkley Accident and Health HR Assist can help employers manage human resource, employment law, ERISA health care, and plan fiduciary issues. We look forward to engaging Berkley Accident and Health's clients and demonstrating the significant new value Berkley Accident and Health is delivering."

To learn more, please visit BerkleyAH.com/hr-assist/.

Berkley Accident and Health HR Assist services are provided by Enquiron. Berkley Accident and Health assumes no responsibility or liability for any advice or resources provided by Enquiron. Berkley Accident and Health HR Assist may not be available in all states.

About Berkley Accident and Health

Berkley Accident and Health is a member company of W. R. Berkley Corporation, a Fortune 500® company. Berkley Accident and Health provides an innovative portfolio of accident and health insurance products. It offers four categories of products: Employer Stop Loss, Group Captives, Managed Care (including HMO Reinsurance and Provider Excess), and Specialty Accident. The company underwrites Stop Loss coverage through Berkley Life and Health Insurance Company, rated A+ (Superior) by A.M. Best. Not all products and services are available in every jurisdiction, and the precise coverage afforded by any insurer is subject to the actual terms and conditions of the policies as issued. For more information, please visit www.BerkleyAH.com.

About Enquiron

Enquiron, headquartered in Boston, Massachusetts, provides consultative business solutions to employers in all 50 states, across various industries, sectors and sizes. Since 1996, Enquiron has revolutionized the way that services impacting Human Resources, Employment Law, Healthcare, Retirement, Cyber Security and more are delivered to and utilized by employers. Enquiron has locations across the United States and is a trusted partner to organizations who need specific answers to specific questions. Follow us on LinkedIn and Twitter.

GOLD MEMBERS

BERKSHIRE HATHAWAY SPECIALTY INSURANCE MEDICAL STOP LOSS ADDS WARREN THREADGILL AND BRAD ERICKSON

Warren Threadgill has joined the Berkshire Hathaway Specialty Insurance Medical Stop Loss team as Sales Director for the South-Central Region at Berkshire Hathaway Specialty Insurance. Warren has been in the group insurance industry working with self-funded employers since 2009.

He has significant experience across multiple product lines including health plans, group life and disability, voluntary products, wellness offerings, medical stop loss and RBP solutions. Besides his strong experience, Warren's dedication to a spirit of collaboration and service makes him the perfect fit for his new role. He is a Based in Dallas, TX. You can reach Warren at warren.threadgill@bhspecialty.com.

Brad Erickson has joined the Berkshire Hathaway Specialty Insurance Medical Stop Loss team as Assistant Vice President, Underwriting. Brad brings significant experience in underwriting from Voya Financial, where he spent the past seventeen years as a Stop Loss Underwriter with increasing levels of underwriting authority and leadership responsibility. Brad's expertise and collaborative spirit make him a great fit with his new BHSI team. Contact Brad at 917.830.2320 or brad.erickson@bhspecialty.com.

About BHSI

Berkshire Hathaway Specialty Insurance (BHSI) provides medical stop loss, commercial property, casualty, healthcare professional liability, executive and professional lines, surety, travel, programs, accident and health, and homeowners insurance. It underwrites on the paper of Berkshire Hathaway's National Indemnity group of insurance companies, which hold financial strength ratings of A++ from AM Best and AA+ from Standard & Poor's. Based in Boston, Berkshire Hathaway Specialty Insurance has offices in Atlanta, Boston, Chicago, Houston, Indianapolis, Irvine, Los Angeles, New York, San Francisco, San Ramon, Seattle, Stevens Point, Adelaide, Auckland, Brisbane, Cologne, Dubai, Dublin, Hong Kong, Kuala Lumpur, London, Macau, Madrid, Melbourne, Munich, Paris, Perth, Singapore, Sydney and Toronto. Contact Ruth Weaver at Ruth.Weaver@bhspecialty.com and visit www.bhspecialty.com.

SILVER MEMBERS

H.H.C. GROUP WELCOMES FARZAN KHAJEHNOORI AS ITS NEW GENERAL COUNSEL

H.H.C. Group is proud to announce the addition of Farzan Khajehnoori as its new General Counsel. Immediately prior to joining H.H.C. Group, Farzan served as an Associate at a Maryland law firm handling a broad range of legal matters for both businesses and individuals. Farzan is a graduate of the University Of Baltimore School Of Law and earned his undergraduate degree from the University Of Maryland Robert H. Smith School Of Business. He is a Maryland native.

"We are very pleased to welcome Farzan to the H.H.C. Group team," said Dr. Bruce D. Roffé, HHC's President and CEO. "I'm confident that his knowledge and broad range of experience will enable him to quickly become a major contributor to the company's continued success."

About H.H.C. Group

H.H.C. Group provides containment solutions for Insurers, Third Party Administrators, Self-Insured Employee Health Plans, Health Maintenance Organizations (HMOs), ERISA and Government Health Plans. H.H.C. Group utilizes a combination of highly skilled professionals and advanced information technology tools to consistently deliver targeted solutions, significant savings and exceptional client service.

H.H.C. Group's services include Claim Negotiation, Claim Repricing, Medicare Based Pricing, DRG Validation, Medical Bill Review (Audit), Claims Editing, Medical Peer Reviews/Independent Reviews, Independent Medical Examinations (IME), and Pharmacy Consulting. H.H.C. Group is an URAC accredited Independent Review Organization for Internal and External Reviews. Visit www.hhcgroup.com and Bob Serber at rserber@hhcgroup.com or 301-963-0762 ext. 163. ■

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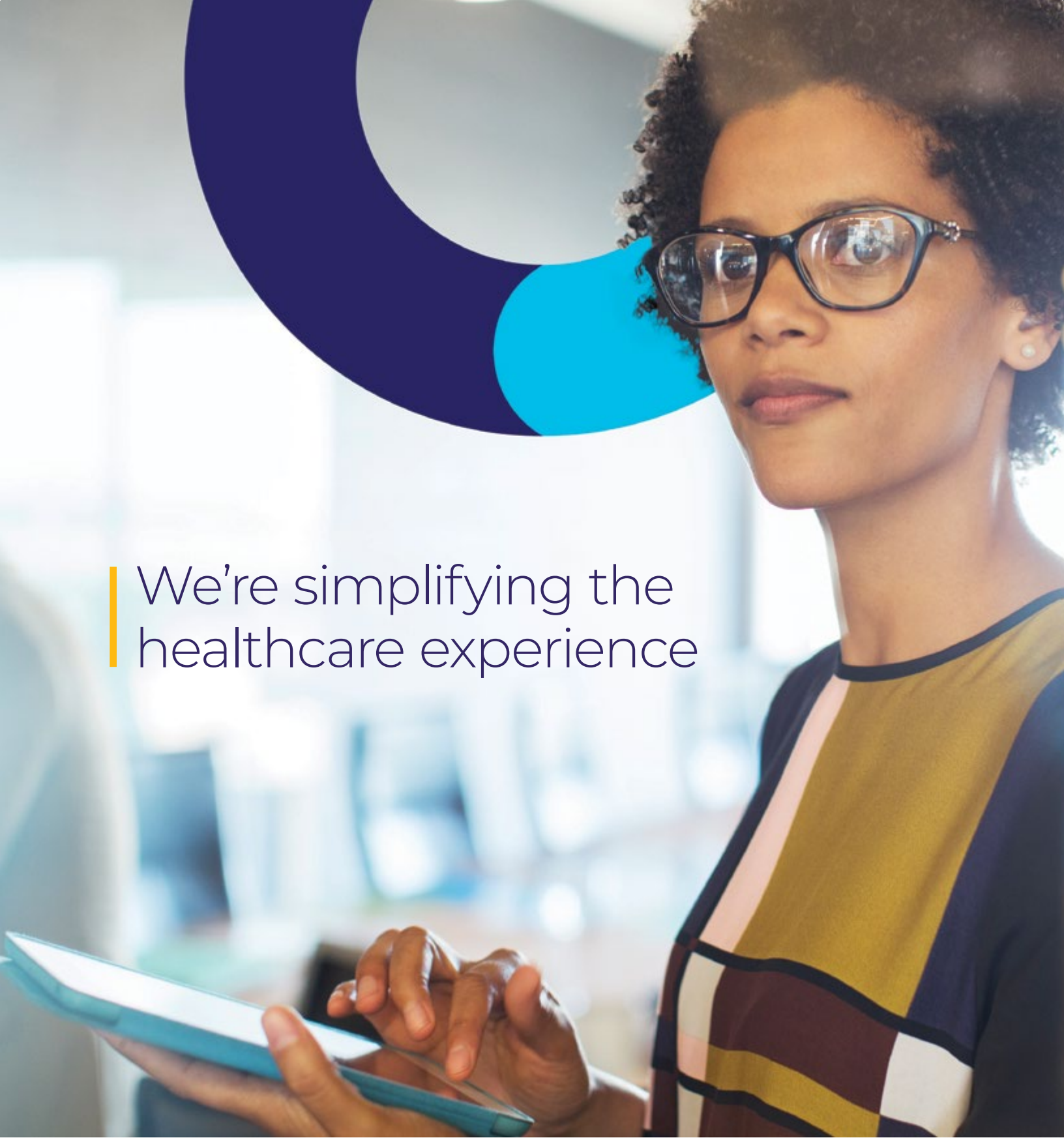

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