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DISSECTING DIABETES

A ROADMAP FOR PREVENTING, MANAGING AND EVEN REVERSING A DECADES-LONG HEALTH CRISIS

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DISSECTING DIABETES

A ROADMAP FOR PREVENTING, MANAGING AND EVEN REVERSING A DECADES-LONG HEALTH CRISIS

Written By Bruce Shutan

While the world continues to wrestle with COVID-19's devastating impact on the health and welfare of citizens, another major public health crisis has been brought to the forefront – and self-insured employers are poised to do something about it.

"Diabetes, and frankly metabolic syndrome, has been this silent pandemic that we have been dealing with in this country for decades now," observes Lisa Moody, president and CEO of Renalogic. The Centers for Disease Control and Prevention (CDC) warns that having type 1 and 2 diabetes, as well as gestational diabetes, increases the risk of severe illness from COVID-19.

Although her company's focus is on chronic kidney disease, 60% of the patients she encounters have diabetes. She says the problem is that many of them are not seeking the treatment they need because they've been avoiding office visits with health care professionals.

Consequently, Moody says many primary care physicians and even endocrinologists are now recommending portable devices that allow patients to measure A1C and glucose levels from afar.

Lisa Moody

Her concern is that this growing segment of the population will require more clinical handholding, coaching and intervention than ever before until the pandemic is under control. The danger of unmanaged diabetes, which she labeled a clinical trend, is that it will spur more cases of chronic kidney disease because diabetes is a major precursor to that condition.

Since an A1C test cannot be done by a virtual visit, the pandemic could very well slow the rate of diabetes diagnoses and undermine existing cases because of reduced access to care, cautions Mark Wilcox, CEO of Partners Health Alliance. It's also important to note that labs are so overwhelmed with Covid testing that "they probably aren't effectively or accurately testing or being able to test as many people for A1C," he adds.

CRUSHING COSTS

Between obesity and type 2 diabetes, known within clinical circles as "diabesity" with 89% of those afflicted being overweight, concern is mounting about the state of the nation's health. More than 120 million U.S. adults are living with diabetes or prediabetes, according to the CDC. Also, people with diabetes are two to three times more likely to suffer from depression.

The American Diabetes Association (ADA) estimated the annual cost of diabetes at $327 billion in 2017 – the latest year for which statistics are available. This represents a 26% increase over the previous five-year period. Those with the disease, which afflicts more than 34 million Americans, cost far more those who don't have it.

Employers with an aging workforce are seeing more medical complications stemming from unmanaged diabetes, according to Ben Lonsdale, director of partnerships for Diathrive, a leading company on cost and diabetes disease management that works with medium and large organizations.

The annual cost of treating someone with diabetes is two or three times higher on average in the $6,000 to $9,000 range for health plans, whereas someone without diabetes who is healthy costs $2,000 to $3,000, he says.

Matt Edwards.

And with patients incurring higher out-of-pocket costs for their medications and doctor visits, he notes that both stakeholders must be incentivized to manage or reverse the effects of type 2 diabetes with healthier lifestyle choices.

Diabetes is among the top three to five most costly disease states "for every employer that I've run claims for," reports Matt Edwards, CEO of GEMCORE.

However, he says the good news is that it's reversable for patients who have the discipline to make and maintain lifestyle changes. Moreover, complications can be reduced with the help of sensing and blood glucose testing technology, as well as injectables and other medications.

His firm offers a program called On-Goal that targets every facet of reversing the complications of diabetes. Participants are coached by a health care professional who ensures that patients are refilling and taking their medication without disrupting the doctor-patient relationship.

They also help them through lifestyle modifications that could be as simple as suggesting people drink more water so they're not feeling as hungry during the day or consumer sparkling water if they're craving Coca-Cola.

"We're seeing 40% to 60% of people hitting their goals within six months," Edwards report, noting that program participants also have improved other parts of their health.

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DIFFERENCES BETWEEN TYPE 1 AND 2 DIABETES

What exactly is diabetes and what causes it? Type 1 diabetes develops when the pancreas no longer produces insulin, which is necessary to synthesize sugar into energy. Once that happens, the bloodstream becomes overrun with glucose that's not synthesizing into energy, damaging organs over time. People with type 1 diabetes require synthetic insulin, taken by self-administered injection or an insulin pump.

Those with type 2 diabetes, the most common form of this disease, develop a resistance to insulin. They produce natural insulin, but their body doesn't use it effectively, causing high blood sugar. Some people with type 2 diabetes need to take insulin injections to increase insulin levels, but most are able to manage blood sugar with dietary and lifestyle adjustments.

Since type 2 diabetes festers over years and complications usually don't show up until an individual's late 40s, 50s and 60s, it hasn't garnered as much attention as diseases with a more immediate impact, Lonsdale explains.

"Type 2 diabetes is compounding in growth," he reports. "One out of every five people has type 2 diabetes, but even more than that have it but don't know they have it."

Undiagnosed diabetes is certainly an issue. Wilcox believes there's a 25% or 35% chance that people don't even realize they have diabetes. Moreover, he says one-third of every workplace is probably prediabetic with an 80% to 90% risk of developing diabetes, while about 6% of his employer groups already have diabetes.

The cost of treating diabetes can be steep. Wilcox says the average estimated claim cost for someone with diabetes in his employer groups is just shy of $13,000 for every year moving forward, which is nearly $7,000 less than the ADA's latest national average and factoring in 5% medical trend for a 2020 projection. But they can soar to $50,000 to $60,000 when there are serious complications and could worsen in the future.

Since advances in medical science can significantly extend the life expectancy for someone with diabetes, he says that annual price tag for a 44-year-old multiplied by 25 years will quickly add up. Layer in increases in medical and Rx trend, as well as medical inflation, and those numbers can mount.

An early intervention strategy can slash the risk of developing diabetes to just 10% or 15% from as high as 90%, according to Wilcox. He says this strategy can help self-insured employers avoid $6,000 to $9,000 a year per case. The trouble is "there is no CPT code or treatment for prediabetes in the medical arena, so it's not recognized as an illness for the most part," he explains.

Recognizing this condition as a precursor to disease, his firm's proactive approach has helped mitigate that risk by using weight and body mass index to calculate risk. Another necessary tool is an A1C test that measures blood sugar over the previous three months for the most realistic view of what is happening inside

each individual. A fingerstick glucose or glucose reading isn't a reliable predictor of diabetes risk, he adds.

"What we find with individuals who have diabetes is that they'll behave the week or so before a screening and their glucose will be within normal ranges, and yet, the A1C will be totally out of whack," he cautions.

When a prediabetic trigger is met, Wilcox says steps are taken to mitigate risks by involving the appropriate health care professionals, who may include a nurse, dietician, medical nutritionist and even a mental health practitioner to address the emotional component.

Anyone who is overeating and gaining weight rapidly may need help to address the root cause of that behavior. Along with examining an individual's physical and mental roadblocks, patients also are taught to recognize wise choices and good behaviors. To help ensure lasting success, an additional free A1C test is given every six months to monitor how someone is progressing.

"Our data is showing that it's reducing the cost of care for people with diabetes who are engaged that way by about 50%," Wilcox reports. "About 70% of the time, those with prediabetes are changing back toward normal glucose levels."

USE OF DATA ANALYTICS

Data analytics is the key to diagnosing conditions, and ultimately improving health outcomes and lowering costs, according to Pamela Owen, a principal in the health and productivity practice of Buck who presented a case study on diabetes at SIIA's virtual 40th Annual National Educational Conference & Expo.

She explained to attendees how a self-funded employer in the health care space used was able to identify and target at-risk plan members and boost participation in an integrated disease management-health literacy initiative that resulted in fewer low-severity ER visits, reduced inpatient hospital stays and increased patients' medication adherence.

The result was a 1:3 return on investment for 5,000 covered members, 1,800 of whom were found to have diabetes that included catastrophic claims involving three end-stage renal failure patients. The employer enrolled 432 health plan members in a proactive educational program.

Knowledge, of course, is power, but Owen noted that applied knowledge helps manage costs. "People with low health literacy cost and extra $8,000 per year on average," she said, while half of patients in this category don't take their medication as prescribed and fail to understand what they've been told after a doctor's office visit. Moreover, she cited CDC statistics suggesting up to 80% of patients with diabetes do not monitor their blood glucose as recommended and 47% have uncontrolled A1C levels.

"In the past, disease management and wellness programs were implemented with a wish and a prayer," Owens observed. "Today we can use data analytics to substantially increase the chances for success… It's not a static reporting mechanism. It's dynamic. Every month as data and claims goes into the system, there should be insights coming out that are meaningful to your population and actionable, and we can make course corrections."

Ben Lonsdale

THE ROAD TO WELLNESS

The centerpiece of diabetes prevention is offering a wellness program with incentives for employees to exercise, eat healthy, and visit their doctor on a regular basis. But the challenge is that most people don't make a meaningful change until something painful happens. "We're very reactive," Lonsdale acknowledges.

Another issue to consider is that diabetes is a very fatiguing disease, which he says means patients will get tired of managing blood sugar and pricking their fingers or wearing an insulin pump.

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To combat this phenomenon, which is known as diabetes distress, Lonsdale says employers need to ensure that employees know where to turn for information, so they're not overwhelmed and where to go when they're diagnosed with diabetes. They also must remove as many cost barriers as possible so that patients will not ration or avoid necessary care.

"What employers need is a really affordable and effective way to help manage people with diabetes within their established care-network," he observes.

His firm provides coordinated care and real-time data that patients can share 24/7 with whoever they want. Price points are low enough for employers to cover all supplies at 100% for the patient. Diathrive can save 60% to 80% on glucose testing expenses alone.

What makes this approach so powerful, he says, is when high-risk patients who require the most attention are identified and given the services they need to avoid trips to the ER. That may involve custom alerts for abnormally higher blood sugar levels, as well as coaching or a direct primary care network of providers with whom they can meet anytime. Others, he suggests, may just need a better connection to their provider or cheaper way to test their blood sugar on a regular basis. His larger point is to empower patients and providers to do better.

Diabetes can lead not only to ER visits, but also neuropathy, blindness and amputation, adds Meredith D'Angelo, client relations manager at GemCare Wellness, which is part of GEMCORE, and whose focus is on preventing or delaying the onset of type 2 diabetes.

She notes that about 84 million adult Americans, or roughly 30% of the population, fall into this category. Since there are no signs or symptoms, D'Angelo says "about 9 out of 10 people don't even know they have it, and the only way they'll learn if they have prediabetes or not is by going to the doctor and getting a lab value, either that hemoglobin A1C or getting a blood sugar level to understand where their blood sugars are running."

GemCare Wellness' diabetes-prevention effort involves a research-based program certified through the CDC featuring in-person and virtual classes lasting an entire year. Enrollees are confined to those with prediabetes or people at high risk for developing type 2 diabetes.

Meredith D'Angelo

The first 16 weekly or biweekly hourlong classes address changes that need to be made with respect to nutrition, physical activity and lifestyle, while the remainder involves monthly classes featuring strategies to sustain the healthy changes that were made.

BEHAVIORAL HEALTH CONCERNS

Realizing self-worth and improving mental health are two top priorities for helping reverse diabetes or any chronic condition, according to Edwards. Experts agree it's also critically important to eliminate the disease's stigma.

But COVID has proven to be a roadblock, triggering greater consumption of alcohol and food while people have been sheltering in place and living socially distant lives, both of which can lead to depression. "A lot of times, the challenges we face are on that behavioral side," he explains. "You've got to help people with diabetes form healthy habits and think differently."

Unless self-insured employers are able to get a better handle on the cost of diabetes, more troubling outcomes lie ahead. "When we follow people who have abnormal A1Cs, we're hearing more often, that they had to choose to buy food or medication this month, so they bought food," Wilcox laments. "We spend a lot of time trying to help patients get assistance and make sure they can afford their medications, or steer them to programs that provide the medication for a lower cost or an additional cash rate that's cheaper than what their insurance plan will pay for." ■

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

The IRS Continues to BULLY "Microcaptives"

DESPITE A CALL TO WITHDRAW THE IRS IS STILL AGGRESSIVELY PURSUING MICROCAPTIVES

Written By Karrie Hyatt

This year, even as many businesses are suffering due to the COVID-19 pandemic, the IRS has increased its insistent examination of what the Service refers to as microcaptives—small to medium-sized captives that elect to take IRC 831(b).

From their request for information last March to their hostile release in October, the IRS is casting a wide net over microcaptives. This was followed in late October that the IRS is issuing another round of settlement offers.

Recently, a report was released by the Government Accountability Office (GAO) regarding offshore microcaptives that moderately supported the IRS's claims, yet it didn't take into account opinions outside the IRS. However, Congressional members have raised growing concerns as to why the IRS is so focused on these captives that provide legitimate forms of risk mitigation for their owners.

THE GAO REPORT

At the beginning of September, the GAO publicly released a report titled, "Abusive Tax Schemes: Offshore Insurance Products and Associated Compliance Risks" that, ostensibly, was meant to report on certain offshore captive and life insurance products that could be misused as tax shelters. However, the report casts aspersions over microcaptives in general.

The report is a poorly executed reiteration of the Service's party line. While the GAO purports to have spoken to industry professionals, the report hits on all of the IRS's key points regarding microcaptives without regard to outside opinons.

In a statement released by SIIA regarding the report, Ryan C. Work, vice president of Government Relations, said, "SIIA is disappointed in the one-sided nature of the report and the lack of industry background included. In many instances, the GAO simply duplicated verbatim past statements from the IRS that are broad sweeping in nature, rather than providing appropriate differentiation between abusive structures and non-abusive."

The report makes several mentions of "guidance" offered to the insurance entities in question by the IRS over the years, but, as stated in Appendix 1, makes no mention of guidance offered to microcaptives or insurance companies taking the 831(b) election.

This has long been a contentious issue. "As we have said in the past," said Work in SIIA's statement, "Congress gave the IRS rulemaking authority back in 2015 to curb certain abusive practices, which the Service has yet to take any action upon despite numerous industry and congressional requests. The GAO also fails to make mention of the tens of thousands of data filings and dozens of data requests the IRS has imposed on the industry. Time and time again the industry has provided that data, and the IRS has failed to provide additional clarity."

The report refers specifically to two recent Tax Court wins by the IRS. However, the second case it refers to, *Syzygy v. Commissioner*, is a case regarding a Delaware-domiciled captive. This mistake shows that the GAO either did very sloppy work on this report or that the report writers were more interested in proving the IRS's talking points than creating a nuanced look at offshore microcaptive tax abuses.

The report states, "IRS has said that the majority of micro-captive cases examined have been determined to be abusive." This statement is clearly meant to establish the Service's stance that all small to medium-sized captives are abusing the tax law.

"It is unfortunate that the report did not offer a balanced and accurate approach to the captive market, nor its importance in the current insurance market in general," the SIIA statement summed up.

According to John R. Capasso, president and CEO of Captive Planning Associates, LLC, "It concerns me that it seems as if the GAO is repeating the same IRS talking points—that all captives electing to be taxed as a small insurance company (IRC Section 831(b)) are bad, without providing evidence that it took the time to do the research necessary to come to an independent conclusion as to distinguish between an abusive captive structure verse an non-abusive captive structure."

IRS LETTER IR-2020-226

On October 1st, the IRS issued a formal letter that furthers their aggressive stance on microcaptives. The letter threatens expanded enforcement on "abusive microcaptive insurance schemes" and urges captive owners to fold their captive before the October 15 filing deadline. While the letter is hard-hitting, at the same time it is ambiguous. It offers no guidance on how an abusive microcaptive is structured, instead recommending consulting an independent tax advisor.

Bullying Continues

The report follows this recommendation with, "These taxpayers should seriously consider exiting the transaction and not claiming deductions associated with abusive micro-captive insurance transactions, just like many other taxpayers did who were contacted by the IRS in March and July 2020."

According to Work, "The IRS wants to scare as many business owners away from captives as possible. They're putting all captives into the same bucket—as abusive captives—rather than acknowledging there's a number of good captives out there."

"To me," said Jeffrey K. Simpson, partner with Womble Bond Dickinson (US) LLP, "Letter 2020-226 perfectly encapsulates the IRS' current strategy. That strategy is to threaten taxpayers into abandoning their [microcaptive] structures and to impose draconian penalties on anyone who tries to stick with it."

Continuing the critical tone, the IRS letter states, "For those taxpayers that do not exit the transaction and continue taking such deductions, the IRS will disallow tax benefits from transactions that are determined to be abusive …" Thus, taking an overly aggressive stance.

While the IRS is doubling down on its stance that all microcaptive structures are abusive, small to medium-sized captives are proliferating, with many states recommending businesses look into establishing captives in the wake of the current economic climate.

During the current COVID-19 pandemic, the IRS is trying to dismantle a legal and legitimate form of insurance when businesses are needing it most. Work said, "At a time when businesses are struggling, the IRS is working to scare away businesses from opportunities to mitigate real risk."

"The Service is taking the position that all micro-captives are bad," said Capasso. "In fairness to the Service, some of these micro-captives are not structured and operated in the true sense of an insurance company. That said, resorting to fearmongering to scare business owners into thinking they are guilty of operating an abusive scheme in the midst of a national pandemic is troubling. Especially so when considering that these captives, in some cases, are providing a life-line to businesses that insured for such a catastrophic risk."

"We are having this fight in the middle of the COVID crisis, where numerous [microcaptives] are being called upon to cover losses that are not being addressed by the commercial insurance industry," said Simpson. "Rather than recognize an example of the very reason [these captives] exist, the IRS is increasing its efforts to put them out of business."

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The October 1st letter appears to be a staunch reminder to microcaptives that, even while they were not named to the Service's "Dirty Dozen" list this year (which was instead filled with scams related to the pandemic), that they are still high on its list of abusive tax structures.

"The IRS has decided that while businesses remain shuttered during the COVID-19 national emergency, many helping their own communities, the IRS is flaunting the fact that it is embarking on even more purposefully onerous and unnecessary requirements, such as Letter 6336," said Work.

"What the IRS doesn't say, but their actions indicate, is that they've already decided that if you're [a microcaptive] you are abusive," said Simpson. "We are not seeing the IRS undertaking any kind of disciplined effort to understand and evaluate captives on a case-by-case basis. Instead, in every case, the audit summarily concludes that the ERC structure is not insurance for tax purposes and throws the burden back on the taxpayer to defend itself."

This is exactly what the IRS did at the end of October when it announced another round of settlement offers, this time with much more strict terms, which will be sent to some microcaptive insurance companies.

THE SENATOR'S LETTER

In late August, U.S. Senator Cory Gardner of Colorado sent a letter to Treasury Secretary Steven Mnuchin and IRS Commissioner Charles Rettig to express his concerns regarding

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the Service's continued scrutiny, especially in light of the current pandemic that is disrupting all levels of business.

He was especially critical of Letter 6336, issued in March to IRS-designated microcaptives. "Aside from poor timing given the fast-developing public health crisis, the letter also requested information, under penalty of perjury, that many may not be able to provide. More importantly, the Tenth Circuit is currently considering an appeal that will likely provide significant guidance for the industry," Gardner wrote in the letter.

The appeal he references is in the *Reserve Mechanical Corp. v. Commissioner* case, which was originally decided in favor of the IRS in June 2018 and which has been in the appeals process since. Gardner wrote, "The United States Tax Court's decision in *Reserve Mechanical Corp. v. Commissioner*, No. 014545-16, presents significant issues for the captive insurance industry.

As the amici curiae brief for various state agencies and the Self-Insurance Institute of America, Inc. makes clear, there is serious concern within the industry that the Tax Court's decision is contrary to established law and creates a marked change in the rules for the industry."

When the appeal is decided it should provide some guidance for captives regarding the 831(b) election and a decision that reverses the original Tax Court ruling would have an impact on the IRS's continued examination of small and medium-sized captives.

"While I support the IRS's goal of eliminating bad actors in the industry," wrote Gardner, "I respectfully request that the Service suspend its broad review of the industry until resolution of the current litigation in the United States Court of Appeals for the 10th Circuit."

The senator's letter was a result of discussions between SIIA members and Gardner. According to Ryan Work, there has been an uptick in interest from Congress regarding the IRS's fixation on microcaptives, which included a number of letters to the IRS from congressional offices asking why legitimate insurance companies are being burdened with IRS letters at this time.

"Instead of defining abuses, the Service has continued with duplicative data requests such as Letter 6336. I think members of Congress are getting wary of it. They are hearing more and more from constituents and businesses who are struggling. The last thing these businesses need right now is the IRS going after their legitimate insurance structure," said Work.

TAKING BACK THE NARRATIVE

The IRS is promoting a narrative that all microcaptives are abusing U.S. Tax law. Their rhetoric has included misinformation about how many of these captives are abusive. In October 2019, the IRS offered a global settlement to only 156 captives, with about 120 settling, yet, the IRS implies that the settlement offer was a large win.

There are thousands of captives operating in the U.S., so 156 is not a significant number. There is no indication at this time as to how many captives will receive settlement offers this year.

SIIA and other industry associations and professionals are working to wrestle back the story in support of captives. "The IRS is trying to frame microcaptives in their own way," said Work. "It's our job in the industry to cut through the IRS's narrative because it is not correct. The fact is, there are thousands of captives in this country operating within the law, yet the IRS is painting the whole industry as abusive."

According to Simpson, "Even though the current focus is on [microcaptives], the IRS has a long history of distrust of all captive insurance transactions, and has challenged them on a number of theories over several decades. They especially dislike [microcaptives] because they are novel and innovative, and the IRS simply doesn't believe that that innovation could be driven by anything other than tax motivation.

"Regarding the settlement offer from last year, the IRS cast a wide net hoping to get a few wins, but this exercise has become a very concerning expenditure of resources," continued Work. "They are using the limited time and resources of the Service to go after insurance companies that have

very low premiums. They have spent more on court cases alone than these captives will ever pay in taxes—even if they fold their cards and pay up. The IRS is spending millions of dollars to bring up these cases in court, which far outweigh any court penalties and taxes."

In addition, the IRS has focused on microcaptives that were formed more than ten years ago—when many microcaptives were just getting started. According to Work, "A captive established a number of years ago is going to look a lot different than ones that were established more recently."

As more microcaptives have been formed and captive domiciles become more sophisticated in regulating them, the whole industry has matured. While there were likely some bad players in the beginning, the legitimate professionals in the industry have worked to weed them out. Things like updating captive law in onshore domiciles, trade association educational forums, and SIIA's Captive Manager Code of Conduct, all of these have helped mature the industry.

Without formal guidance by the IRS, captive professionals have been working to create their own guidance—both formal and informal. "Captive professionals pay attention to what the IRS is doing and to court decisions," said Work. "They are changing captive management practices to do the best they can. That's the nature of any business, and I think our members want to do what's best for their client and they want to do it by the book. It's hard to do because that book hasn't been written."

The IRS has the tools at its disposal to issue guidance for microcaptives. Congress has asked it multiple times to issue this guidance, and yet, more than five years later, the Service still hasn't issued any. Instead, the IRS continues to demand extra information, to increase examinations, and to continue enforcement actions.

According to Capasso, "I am very much in favor of an open, honest dialogue to work towards resolving Congress's directive to the IRS to clarify parts of the PATH Act from 2015 on curbing specific abusive practices in life insurance and captives—which SIIA has previously brought forth certain proposals; and work on an industry-wide outline of 'Best Practices' of what constitutes the parameters of forming and operating a microcaptive."

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Bullying Continues

As Work said in his letter to SIIA members after the most recent letter issued by the IRS, "American taxpayers, including captive owners, deserve a fair process, one in which the IRS should set out clear guidance to provide. We have asked for that over and over again, as has Congress. Let's stop the fear-mongering press releases and have a productive conversation with the IRS and industry about what can be done to solve the impasse."

"Thankfully," said Simpson, "SIIA is there to help give us a voice in the press, in the Department of the Treasury, and in Congress. The great news is that many captive owners are now finding the forum and opportunity to tell their success stories and those stories are having an impact. But we have to continue telling them and we have to amplify them because this is an uphill battle and the IRS is a resourceful opponent." ■

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.

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.

VENDOR CREDITS—APPLICATION OF THE CREDITS AND GUARDRAILS

As mentioned in last month's article, it has become quite common for insurance carriers and service providers to offer employee benefit plans and their employer plan sponsors certain "credits" that can be used to pay for items such as employee benefit plan communications, benefit administration system improvements, or in certain instances unspecified future special administration projects. Although the terminology for these credits varies (e.g. innovation fees or credits, communication credits, technology credits etc.) we will use the term innovation credits as a catch-all for purposes of this article.

Last month we described the various ways innovation credits "flow" from a carrier or service provider back to a plan or plan sponsor and the different methods used to calculate the credits. Innovation credits are typically generated by "voluntary benefits" that are funded, often in substantial part, through participant premiums or contributions.

United States Department of Labor ("DOL") guidance, indicates that, although situations can differ, if innovation credits are generated from sources where the premiums or contributions are paid entirely by employees, the entire innovation credit would likely be considered a plan asset under ERISA. In instances where both the employer and the employees pay the premiums or contributions, then a pro-rata share of the innovation credit would likely be a plan asset.

We then discussed the ERISA fiduciary and prohibited transaction implications arising from these innovation credits as plan assets under ERISA including the fiduciary duty to only use plan assets for providing benefits or defraying reasonable expenses of administering the plan. Further it is a prohibited transaction for an ERISA plan fiduciary to:

- Deal with plan assets for the fiduciary's own interest or account;
- Act on behalf of a party whose interests are adverse to the plan; or
- Receive any consideration for the fiduciary's own personal account from any party dealing with such plan in connection with a transaction involving plan assets.

In this month's article we explore permitted uses of innovation credits where they are determined to be plan assets under ERISA. This analysis includes a discussion of what is the "plan" and what are permissible plan expenses.

A. IDENTIFYING THE PLAN

A fiduciary decision to take the innovation credits generated by the assets of one plan and apply them to the administrative expenses of another ERISA plan would likely be a fiduciary breach.

Indeed, in instances where medical loss ratio rebates from insurers are plan assets DOL flatly stated that: "[T]he use of a rebate generated by one plan to benefit the participants of another plan would be a breach of the duty of loyalty to a plan's participants." Technical Release 2011-04 ("T.R. 2011-04").

So, let's take an arrangement where the innovation credit comes from a vision or dental carrier and the benefit is funded completely by participant contributions. Those innovation credits are likely plan assets under ERISA, but what is "the plan"?

What if the credit is used to fund a benefits administration system or publish a benefits guide? Would a plan fiduciary be required to determine what percentage of the cost of the benefit administration system or benefits guide is attributable to the dental or vision benefit? Based on DOL guidance discussed later in this article that might be the case if each benefit is considered to be its own ERISA plan.

Many employers, however, use a "wrap plan" document to combine all welfare plan benefits into a single plan. The motivation behind a wrap plan document is typically unrelated to innovation credits but rather it is to reduce the number of "plans" for Form 5500 filings and to include any required ERISA language


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that might be missing from underlying documentation.

Still, that wrap plan may also serve to simplify the ERISA analysis for innovation credits. If all ERISA covered benefits are part of a single plan, then innovation credits generated by one benefit could be applied to the administrative expenses related to another benefit since it would be the administrative expense of the same "plan."

In other words, the innovation credit generated by the dental or vision carrier could be used to offset the administrative expenses of any benefit that was "wrapped." Therefore, when included in the same wrap plan. the innovation credit could be used for the expenses associated with producing a benefits booklet or wrap SPD that included medial, dental and vision benefits or a benefits administration system that included those benefits.

Even here, however, experienced benefits counsel should be consulted because with respect to payments associated with insurance demutualization proceeds, we have anecdotal experience of DOL asserting that proceeds should be used to benefit the participants who are or were enrolled in the specific benefit generating the credits even if a wrap document existed.

In the T.R. 2011-04 guidance on MLR rebates, DOL also stated that where a plan provides "benefits under multiple policies" this "benefit by benefit" approach was the preferred application of MLR rebates provided it was prudent overall.

B. PLAN EXPENSES AND EMPLOYER/SETTLOR EXPENSES

Last month we concluded that, where plan assets are involved, the use of innovation credits by an employer for its own purposes unrelated to plan administration would be a fiduciary breach and a prohibited transaction.

ERISA generally provides that he assets of an employee benefit plan shall never inure to the benefit of any employer and shall be held for the exclusive purpose of providing benefits to participants and beneficiaries and defraying reasonable expenses of administering the plan.

Also, DOL has stated that even for expenses related to the plan there are certain "settlor" functions that cannot be paid from plan assets such as certain actions establishing, amending or terminating a plan. Other activities that are expressly the responsibility of the employer or are non-benefit related are also settlor functions.

These would include preparation, distribution and filing of Forms 1094-C and 1095-C under the ACA; facilitating payroll deductions etc. In addition, administrative expenses related to non-ERISA benefits could not be paid from plan assets. Those expenses could include, for example, dependent care assistance account plans, transportation spending account plans, and health savings accounts (HSAs).

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Finally, plan documents should be consulted because while plan assets can never be used to pay a settlor expense there may be provisions in those documents providing that all or part f the plan administrative expenses are to be borne by the employer.

In Advisory Opinion 97-03A, DOL looked at "settlor" expenses in a series of hypotheticals In one of those hypotheticals an employer produced a twelve page booklet that included summary information about all the employer's benefit plans (health, dental, vision), as well as one full page devoted to non-ERISA covered benefits (e.g., the physical fitness center, limousine services) and employee activities (e.g., annual picnic, Holiday party, etc.).

The cost to prepare and distribute the booklet was approximately $125,000 annually. In analyzing whether the cost of the booklet could be paid from plan assets, DOL stated:

> "[A] portion of the $125,000 for preparation and distribution of the benefit booklets may also be a permissible plan expense. Clearly, the plan sponsor should pay that portion (1/12) of the costs of the booklet that relates to non-plan matters (i.e., physical fitness center, limousine services, picnic, etc.). In addition, a plan may pay only those reasonable expenses relating to that plan, and therefore, each of the plans should pay their proportionate share of the expenses of the booklet.

So, using this hypothetical, could innovation credits be used to pay the total cost of a benefit administration system or a wrap SPD? Likely not if the wrap SPD contained an explanation of HSAs, a dependent care assistance plan, buying and selling paid time off etc.

Also a benefit administration system would need to be examined to determine whether it performs settlor functions like production of 1095-C forms, aspects of payroll processing, enrollment in non-ERISA benefits or other non-ERISA HR functions.

If it is determined that settlor functions are implicated, then an allocation would need to be made to settlor functions similar to the DOL hypothetical above. Of course, for expenses such as a benefits administration system, the analysis is going to be far more complex that the preparation and distribution of a benefits booklet as in the hypothetical.

Further complicating the analysis is that the decision on how to allocate that expense between the employer and a plan is a fiduciary decision in itself. And, if the employer stands to benefit from the allocation then there are further prohibited transaction issues.

C. OTHER POTENTIAL COMPLIANCE ISSUES

Other issues to be addressed with counsel include whether the innovation credits might trigger a trust requirement or certain Form 5500 reporting such as additional Schedule C forms. Additionally, outside the scope of this article, are potential insurance rebating concerns that could arise for the insurance carrier and/or its brokers.

D. APPROACHES AND GUARDRAILS

One approach may be to use insurers or vendors who do not generate innovation credits. This might trigger a savings on premiums or other beneficial aspects of the coverage. Of course, employers, understandably, do not want to "leave money on the table" and if there is no ascertainable benefit to using an insurer or vendor that does not provide innovation credits over one that does then an employer will likely select the insurer or vendor that provides the credit.

Then, if innovation credits are involved the employer will need to decide whether it will take a benefit by benefit approach or the more aggressive plan-wide "wrap" approach. In the benefit by benefit approach is taken, the first step would be to see whether the innovation credit could be locked down, so it only pays the legitimate plan expenses for that benefit.

If the innovation credit is used for the expenses related to multiple benefits and/or settlor expenses, then an allocation would need to be made on what percentage of that expense is related to the benefit. If the innovation credit is greater than the expense then, because of exceptions from ERISA's trust requirement for plan assets held by an insurer, it is better for the insurer to hold any excess credits.

The plan-wide wrap approach would essentially be the same except the analysis would be whether the innovation credit could be used exclusively for plan rather than settlor expenses. If the expense represented both settlor and plan expenses, then there would need to be an allocation between the two.

In both approaches any plan fiduciary should avoid making the allocation decision. For example, for a benefit administration system it would be preferable for the vendor for that system to provide the allocation percentages and analysis.

E. SUMMARY

As detailed in this month's and last month's articles innovation credits raise a number of complex ERISA issues. DOL is aware of these types of arrangements and has raised concerns so care should be taken to document that any innovation credits are being used exclusively for legitimate benefit or plan expenses. ■

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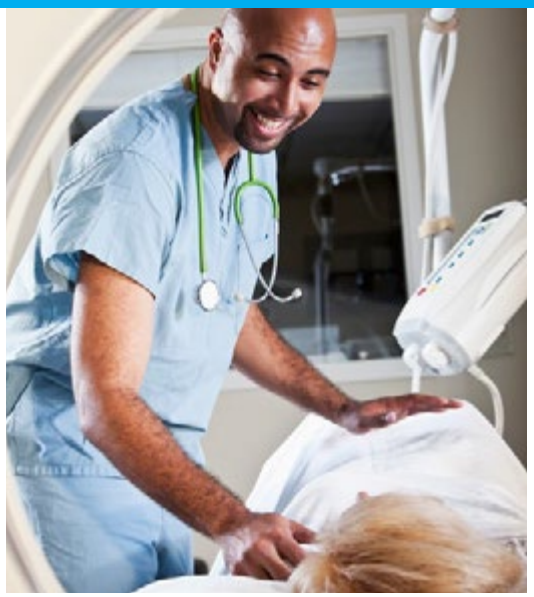

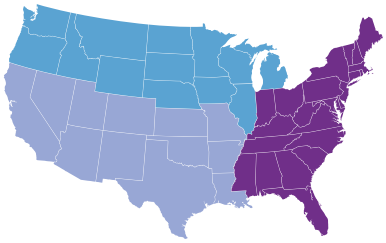

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COBRA COVERAGE AND COVID-19

Written by Kevin Brady, Esq.

It is an unfortunate, but well-known, fact that the COVID-19 pandemic has had a significant impact on the U.S. economy. With the unemployment rate reaching a high of 14.7% in April, it is no surprise that many hard-working Americans lost their jobs.

Given that many Americans rely on those jobs for their health plan coverage, the loss of income, combined with the loss of health coverage, has been and could continue to be catastrophic for many.

On the (somewhat) bright side of things, those who lose their jobs are not always left optionless, as most individuals who lose their employer-sponsored health coverage will generally be eligible for continued coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

COBRA provides workers and their families the option to continue group health plan coverage (for a limited period of time) under certain circumstances which cause a loss in group health plan coverage. Further, the employee, rather than a combination of the employee and employer, bears the full cost of coverage when enrolled in COBRA.

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From the individual's perspective, the cost alone, especially in the midst of the pandemic and the resulting economic uncertainty makes COBRA a tough sell for former employees, especially those who have other coverage options available.

From an employer's perspective, administering COBRA coverage effectively- and most importantly, correctly is a difficult task. Employers have strict obligations under COBRA. They must provide adequate notice of a "qualifying event" to ensure that their former employees and their dependents are offered coverage.

What makes things even more complicated, is that employers who self-fund their health plan coverage actually serve as both the employer under COBRA (subject to certain obligations), and the plan administrator (subject to a distinct set of obligations) as well.

This nuance only adds to the multitude of obligations and the resulting confusion that an employer must contend with. As is this case with a great many other things, those obligations have become even more difficult to understand and satisfy in the wake of the COVID-19 pandemic.

As mentioned above, COBRA provides the opportunity to continue group health plan coverage if certain criteria are satisfied. Private employers who employ 20 or more workers, are generally subject to COBRA if they offer if a group health plan. COBRA must be made available for the "covered employees" of the employer, and their dependents, if they experience what is known as a qualifying event.

The COBRA regulations provide that a qualifying event may be any of the following occurrences:

- Voluntary or involuntary termination of the covered employee's employment other than by reason of gross misconduct;
- Reduction of hours of the covered employee's employment; Divorce or legal separation of the covered employee from the employee's spouse;
- Death of the covered employee;
- A dependent child ceases to be a dependent under the generally applicable requirements of the plan;

- A covered employee becomes entitled to benefits under Medicare; and
- An employer's bankruptcy, but only with respect to health coverage for retirees and their families.

While the situations and occurrences which are considered qualifying events may be widely known, what is often overlooked is that the qualifying event must also cause a loss of coverage under the plan. Therefore, if plan coverage does not terminate as a result of the qualifying event, then the individual does not become eligible for an offer of COBRA coverage from the employer.

One instance where this principle is becoming more and more relevant, relates to employees who are furloughed or laid off. Given the economic uncertainty surrounding the COVID-19 pandemic, an unprecedented number of employers have turned to workforce reduction measures such as furloughs and/or layoffs to ensure business continuity.

On the surface, a layoff or furlough may appear to be a qualifying event which triggers an offer of COBRA coverage to the affected individuals. While it may very well be a qualifying event, it very much depends on the facts and circumstances of the given case.

For example, many health plans choose to continue plan coverage in the event of a leave of absence, or even a temporary layoff or furlough. This approach is actually quite common. Although typically outlined within an employer handbook or policy manual, effectively outlining the instances in which plan coverage will be continued within the plan document can mitigate the risk of a potential dispute with the stop loss carrier.

In essence, the employer must review the plan document to determine whether it properly allows for continued coverage while an individual is furloughed or laid off. If the plan outlines said continuation, then the individual has not experienced a qualifying event and the employer's obligation to offer COBRA coverage has not been triggered.

Of course, the individual may become eligible for COBRA continuation coverage if they do not ultimately return to work or if their continued plan coverage expires during the maximum coverage period of COBRA.

If that is the case, the employer's obligations would then be triggered, and the employer would be required to offer coverage in accordance with COBRA's requirements. Fortunately for employers, there is some flexibility in the timeframe in which the offer of coverage must be made.

The Internal Revenue Service (IRS) along with the Department of Labor (DOL) issued final rules which extend a number of important benefit plan timeframes. As

it relates to COBRA, plan administrators do have some flexibility as it relates to their obligation to notify the individual of COBRA coverage.

On the other hand, the rules also extend the period in which individuals can elect COBRA coverage, as well as the period of time in which an individual must pay their premiums. These extensions are sure to make administering COBRA eligibility another difficult task for the foreseeable future.

Any way you look at it, COBRA continuation coverage generally imposes a number of obligations on employers, plan administrators, and those who would enroll in COBRA coverage as well.

Determining what those obligations are, how to apply them, and who may be eligible for them is no small feat even without the regulatory and economic uncertainty of the COVID-19 pandemic factored in.

In order to avoid potential compliance issues, as well as mitigating the risk of reimbursement issues down the road, plan administrators should pay special attention to these COVID-19 related issues.

Review the plan document to determine whether individuals furloughed and laid off are eligible to continue coverage under the plan, or alternatively under COBRA. Until the economic consequences of the pandemic dissipate, the complications and nuances associated with COBRA continuation coverage are sure to persist along with it. ■

Kevin Brady, Esq. joined the Phia Group Consulting team as an attorney in the summer of 2019. As a member of the consulting team, Kevin works on general consulting, plan document compliance, contract gap reviews, and general compliance issues.

Kevin attended Oakland University in Rochester, Michigan graduating with his B.A. in History. He earned his Juris Doctor from Michigan State University College of Law in East Lansing, Michigan. While at MSU, Kevin was a member of the Journal of Business and Securities Law and worked in the MSU College of Law Immigration Clinic. After law school, Kevin worked as an attorney representing several healthcare providers in the Midwest. He is currently licensed to practice law in the State of Michigan.

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SIIA intends for this to be a "safe" environment with regard to employment solicitations. In this regard, we ask that attendees refrain from approaching any of mentors regarding employment opportunities with their companies and that mentors likewise not engage in employment discussions with any attendees. For more information visit www.siia.org.

The following list of mentors have confirmed their participation. As you will see, they represent all segments of the self-insurance marketplace (group health, captives & workers' compensation) and each of them have been very successful in their respective careers as well as being highly involved with SIIA in various capacities. Additional mentors may be announced closer to the date, so please check www.siia.org periodically to see the latest line-up.

Les Boughner
Chairman
Advantage Insurance Management (USA) LLC

Les entered the insurance business in 1977. He held senior positions with FM Global, AIG, CNA, Zurich and Willis prior to joining Advantage Insurance Management (USA) LLC. He holds a Bachelor of Mechanical Engineering (with Distinction) from Carleton University, Ottawa, Canada, and an MBA from York University, Toronto, Canada.

As Chairman of Advantage Insurance Management (USA) LLC, Les is

responsible for developing Advantage's captive insurance and related businesses globally, including its direct underwriting activity at Lloyd's reinsured by Advantage Property & Casualty Company SPC. In his role as Managing Director of Willis Global Captive Practice, Les was responsible for the profit and growth of "The Americas" Practice with offices in Barbados, Vermont, Cayman, Bermuda and Hawaii. He is Past Chairman of the Captive Insurance Companies Association (CICA), is on the Program Committee of the World Captive Forum and Chairman of the Self Insurance Information Association (SIIA).

Pat Campola
Presisent, Campola Consulting
Director, New Business Development
Windsor Strategy Partners, Inc.

Pat Campola is a Principal at Windsor Strategy Partners, Inc. as well as President of Campola Consulting and Intermediary Services. Pat has 30 years of senior management experience in the insurance industry. He is Past President of several organizations that include Alden Risk Management Services, a John Alden Insurance Co. subsidiary, Lincoln Re. Risk Management Services, a Lincoln National Insurance Co subsidiary, and John Alden International.

Jerry Castelloe
Principal
Castelloe Partners

Jerry Castelloe founded Castelloe Partners, LLC in January 2015. As a foundation for his consulting practice, Jerry has used his expertise, relationships and experiences in the self-funding industry to assist clients with a variety of strategic endeavors. He has assisted a variety of clients, including employers, high performance networks, cost management specialists and claims administrators with strategic planning management, product development, talent identification, mergers and acquisitions, and ACA compliance.

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Jerry gained valuable experience in all aspects of healthcare and self-funding during 31 years of leadership at CoreSource, Inc., a large national Third Party Administrator. During his tenure at CoreSource, Jerry provided leadership to all functional and geographical areas. Most recently, as Regional President, he led the SouthEast region and was responsible for business development, client management and administration for the clients in the region. In addition, Jerry provided strategic consulting advice to several of CoreSource's major national clients, including the establishment and relationship management of CoreSource's State High Risk Pool strategy.

Richard J. Fleder
President and CEO
ELMC Risk Solutions, LLC

Which he co-founded in 2013. ELMC is the latest venture in a series of successful insurance related entities he has created including Comprehensive Benefits (CBSC), in 1978, and Thesco Benefits, LLC, in 1995. Since 2013 Richard has built ELMC through the acquisition of best-in-class MGUs with funding partnership from the international investment firm J.C. Flowers & Co. Richard is a graduate of Franklin & Marshall College.

He is a member of the Board of Directors of Unimerica Insurance Company of New York (Executive Committee member). Richard is a past member of the HMO Board of Directors of Oxford Health Plans and the National Advisory Councils of Aetna, CIGNA, HealthNet, and UnitedHealthcare. He is a former member of the Legislative Council of NAHU and the founder of the Empire State Healthcare Coalition.

Liz Mariner-Ford
Senior Vice President, National Health Care Practice
Risk Strategies Company

Liz brings to Risk Strategies over 25+ years of insurance and reinsurance experience. She is skilled in health, life, disability, the worksite market and a wide range of accident products, on both a group and individual basis. Well known for her talent in advising and collaborating with clients on growth strategies, product diversification and

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risk management techniques, Liz is equally recognized for her strong relationships within global reinsurance markets.

Liz started her career in 1982 at General Reassurance, the former life division of General Re, as an Account Manager in the Financial Reinsurance Unit and last held the position of Vice President of Treaty Operations for all individual and group life, accident and health lines of business for its successor company, Life Reassurance Corporation of America, subsequently acquired by Swiss Re.

In 1992, Liz joined Towers Perrin, where she became a Principal and held the position of Vice President responsible for business development in the Risk & Financial Services' Life, Accident and Health Reinsurance Practice.

Liz is currently the Chair of the SIIA International Committee and a former Director of SIIA, holds an MBA from the University of Connecticut, a Bachelor of Science Degree in Pre-Med from Boston College, and professional designations as a Chartered Financial Consultant (ChFC), a Chartered Life Underwriter (CLU), a Health Insurance Associate of America (HIA), a Certified Employee Benefit Specialist (CEBS), and a Fellow of the Life Management Institute (FLMI).

Rob Gelb
Chief Executive Officer
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As an accomplished executive leader with a consistent record of strategic and tactical success across his 30+ year career, Rob excels at identifying and developing talent within scaling organizations and achieved exponential growth and results for all stakeholders.

His diverse background includes direct experience in healthcare, managed care, network development, banking and finance, mergers and acquisitions, and property/casualty insurance. Rob is a CPA, earning his public accounting degree from Hofstra University in 1989, and has held leadership positions at several prestigious firms, including York (now Sedgwick), Coventry (now CVS/Aetna), CIGNA and PNC Bank.

Laura Hirsch
Cofounder & co-CEO
Aither Health

Laura Hirsch is a visionary and innovative senior executive who has more than 30 years of experience in self-funding business strategy, private labeled business process outsourcing (BPO) services, mergers & acquisitions, operational excellence and business development.

Deborah Hodges
President and CEO
Health Plans, Inc.

As President, Deb leads the company's diversification growth strategy and represents the organization to parent company, Harvard Pilgrim Health Care (HPHC). Deb works with the board of directors and senior management of both companies to develop long-range goals, strategies, plans, and organizational policies.

Deb has held a number of senior executive positions over the past two decades and was a key participant during our acquisition by HPHC in 2005. Her experience and skills have directly impacted product marketing, business development, sales revenues and strategic planning, and the company's recent risk management growth endeavors.

Deb joined Health Plans in 1993 to build our self-funded sales team as regional sales executive, serving as development architect as Health Plans transitioned operations to primarily administer self-funded health plans. Deb has since served numerous roles in the sales area including Vice President of Sales and Marketing. As Senior Vice President, Deb's other responsibilities included Care Management and Health strategies, Reporting and Analytics, and Operations.

Earlier in her career, Deb served as an Underwriting Manager for R.E. Moulton, Director of Marketing at Mt. Vernon Associates, and was a member of the sales team at Blue Cross/Blue Shield Massachusetts.

She works closely on HPHC's self-insured line of business strategy, serves on the Executive Leadership Committee

for HPHC and is a Government Relations Committee Member for the Self Insurance Institute of America, Inc. (SIIA).

Deb holds a Bachelor of Science degree in Health Care Administration.

Steve Kelly
Co-founder and CEO
ELAP Services

Steve Kelly is the Co-founder and CEO of ELAP Services, a leading healthcare solution for self-funded employers based in Wayne, Pa. He is a recognized expert in the insurance, employee benefits and risk management industry, bringing more than three decades of experience solving his clients' complex healthcare challenges.

Kelly has expertise in the nuances of the healthcare and benefits industry, an unyielding passion to bring transparency and fairness to medical costs, and the desire to empower employers to be good stewards of healthcare and benefits programs.

Kelly has presented at the World Health Congress and other notable industry events and has been featured as an expert commentator for National Public Radio, Newsweek, FOX Business, The New York Times, and several other media organizations.

Most recently, Kelly was recognized as a winner of the 2019 EY Entrepreneur of the Year Award in Greater Philadelphia and was named a national finalist in the Financial Services category.

Liz Midtlien
Vice President, Emerging Markets
AmeriHealth Administrators, Inc.

Elizabeth (Liz) Midtlien has spent nearly 30 years as health insurance industry professional. Liz has built, influenced, and led multi-disciplined teams across multiple domains, including sales, marketing, strategy, underwriting, and operations. In her current role leading Emerging Markets development for AmeriHealth Administrator, Liz is responsible for developing, executing, and overseeing programs that support diversified revenue streams through partnerships, joint ventures, and acquisitions. Based in AmeriHealth Administrators' Minnesota office, Liz also leads activities related to strategy development, service model optimization, and client and partner relationships in MN and across the country.

Before joining AmeriHealth Administrators, Liz most recently served as Senior Vice President at HM Insurance Group, where she led diverse teams focused on managed care reinsurance, product development, project management, and integrated marketing and communications. Her experience also includes roles as a Chief Marketing Officer and Sr. VP of Sales for the Starline Group, a leading Managing General Underwriter. She has also served as Vice President Employee Benefits Producer at a leading national brokerage firm and held leadership positions with nationally known health reinsurers and a large national third-party administrator.

Liz received her Master of Arts in industrial relations from the University of Minnesota and her Bachelor of Arts in business administration from the University of Wisconsin – River Falls. She is active in the Self-Insured Institute of America (SIIA) and a participant and volunteer in showing her American Quarter Horses. She resides in MN and is supported in all her endeavors by her husband Jim and adult son Jack.

Lisa Moody
President and Chief Executive Officer
Renalogic

Since 2008, Lisa has been President and CEO for Renalogic. Lisa is responsible for overseeing and directing all strategic initiatives as they relate to People, Process and Product, while ensuring the strength of our organizational health. Lisa places a high priority on our ability to demonstrate and carry out the Renalogic mission and vision. She has been instrumental in leading the development of core values that reflect our commitment to our clients and to the industry. Lisa consistently works to create a diverse and satisfying work experience for our growing employee base. A second generational family-owned company, Lisa has been with Renalogic since its inception in 2002. She encourages and leads the disruptive entrepreneurial spirit for positive change that continues to drive the evolution of Renalogic today.

Lisa has been a longstanding member of SIIA (Self-Insurance Institute of America, Inc.) and was instrumental in promoting Renalogic, as she was one of the first cost containment consultants for SIIA Diamond members. She is also a long standing member of HCAA (Health Care Administrators Association) and an active advocate and supporter within the self-insured community to help promote industry initiatives. Lisa graduated from the University of Massachusetts Dartmouth and is a highly respected leader for change management in the health care industry.

Mark Schmidt
Head of TPA & Payer Solutions and Workers' Compensation
Prodigy Health Group

Mark Schmidt is the head of TPA & Payer Solutions, which includes Meritain Health, American Health Holding, First Health and Aetna Signature Administrators specialty businesses, and Workers' Compensation.

Mark joined Aetna in 2007 to lead the insurer's Strategic Resource Company (SRC), which provides limited health and related employee benefits to part-time and hourly contract workers. In 2009, he joined the Local Employers and Customers segment where he served as a local market head with oversight and responsibility for the Arkansas, North Carolina, South Carolina and Tennessee markets.

Prior to Aetna, Mark spent 13 years with CoreSource, the last 10 years as president. While serving as president at CoreSource, he also held the role of executive vice president for Trustmark, the parent company of CoreSource, leading both its operations and large group medical business. Additionally, Mark served two terms on the Board of Private HealthCare Systems (PHCS) including one term as chairman. Prior to his time at CoreSource, he spent 12 years in various financial roles with multiple insurance companies.

Harry Tipper, III
Chief Operating Officer – Insurance
CaptiveOne Advisors LLC

Harry Tipper, III currently is the Chief Insurance Operating Officer for CaptiveOne Advisors LLC (a financial services firm focused on and with the expertise required to assess, develop, and manage captive insurance and reinsurance companies successfully).

Harry previously was a founder of and former President and Chief Executive Officer of Lyon's Gate Reinsurance Company, Ltd. ("Lyon's Gate Re") a Class III, Bermuda reinsurance company licensed under the Act and the Segregated Accounts Act to offer reinsurance and segregated account (or rent-a-captive) cells and served on the Board of Directors of Su Vino Holdings, Inc. (an insurance and reinsurance consulting firm affiliated with ISG Group, Ltd.).

In order to keep registration cost low for our younger attendees, we invite SIIA member companies to consider becoming an event sponsor. This a perfect involvement opportunity who don't typically sponsor/exhibit/advertise through SIIA but want to support a great cause and want to be recognized for it. Contact Justin Miller at jmiller@siia.org for details. ■

AmWINS Group Benefits

ON YOUR TEAM.

At AmWINS Group Benefits our team of specialists wakes up every morning committed to bringing your team innovative solutions to the opportunities and challenges you and your self-funded clients face. That's the competitive advantage you get with AmWINS Group Benefits.

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NEWS FROM SIIA MEMBERS

2020 NOVEMBER 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.

Delaware

Advantage

- Delaware takes captive insurance company licensing to a new level that Speeds to Market the licensing process.
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- Delaware's conditional certificate of authority means receiving a license to conduct insurance business the same day of submitting the application to do business.

STEVE KINION, DIRECTOR
Bureau of Captive & Financial Products
Department of Insurance

ICCIE TRAINED iccie ORGANIZATION

Trinidad Navarro
Insurance Commissioner

Insurance Commissioner of the State of Delaware

BUREAU OF CAPTIVE & FINANCIAL INSURANCE PRODUCTS
Delaware Department of Insurance
1007 Orange Street, Suite 1010
Wilmington, DE 19801
302-577-5280 | captive.delaware.gov
Trinidad Navarro, Insurance Commissioner

DIAMOND MEMBERS

RENALOGIC EXPANDS PROGRAM OFFERING WITH KIDNEY HEALTH LABS

PHOENIX, AZ – Renalogic, the leader in comprehensive kidney care and dialysis risk management, will now offer Kidney Health Labs as a part of its Kidney Dialysis Avoidance Program (KDAP) for self-funded employer groups and their employees.

Renalogic Kidney Health Labs is a new, proactive tool to help employer groups and their KDAP members take control of their health. The program offers easy access to regular lab testing so members can better monitor and understand their kidney function. It provides insight into their health and underlying signs of chronic disease–leading to measurable changes in behaviors and a healthier lifestyle.

"Our mission has always been to help as many people as possible avoid kidney disease," said Jim Wachtel, Executive Vice President of Sales and Marketing. "Routine lab work is the best barometer of kidney health. By removing the barriers to regular testing, patients can keep track of how well their kidneys are performing and create an action plan to improve their health."

KDAP Kidney Health Labs are planned around members' convenience with start-to-finish guidance from a Renalogic Health Nurse Coach. Members of the program have access to consistent pricing and incur no fees, deductibles or additional co-pays, which typically come from repeated office visits.

Through Kidney Health Labs, employers can leverage aggregate health data to better help employees in the early stages of disease–saving time and reducing healthcare costs. The data can also be used to guide health plan decisions and measure future risk and potential high claims costs.

About Renalogic

Renalogic has been the industry leader in dialysis risk management and cost containment for nearly 20 years and continues to innovate through the impact of its Kidney Dialysis Avoidance Program (KDAP) and Kidney Disease Prevention Program. The company leverages innovation to revolutionize dialysis risk management while reducing the dialysis incident rate in every population it touches. Every chronic condition leading to kidney disease is manageable and even preventable when identified early. Contact Mark Schaefer, Marketing Manager, at mschaefer@renalogic.com and visit www.renalogic.com.

SUN LIFE LAUNCHES COVID-19 OUTBREAK COVERAGE TO STOP-LOSS OFFERINGS

WELLESLEY, Mass. -- Sun Life U.S. has added three COVID-19 insurance products to its stop-loss offerings, including coverage for outbreaks, providing risk protection for self-funded employers if employees become infected.

Sun Life research shows that employers are focused on keeping their employees healthy while also concerned about the potential costs of COVID-19 in the workplace. More than a quarter of employers would consider benefits that provide additional protection against COVID-19, according to brokers surveyed by Sun Life.

"The needs of our clients have evolved significantly over the past six months," said Jen Collier, senior vice president of Stop-Loss & Health for Sun Life U.S. "These new solutions will allow our self-funded clients to stay focused on creating a safe working environment for employees while letting us provide more protection for higher than expected plan costs associated with the diagnosis, testing, and treatment of COVID-19. For employers that self-fund their own health plans, these products provide meaningful coverage that offers financial protection and also gives them continued peace of mind, allowing them to focus on running their businesses during these challenging times."

Stop-Loss insurance protects self-funded employers when they encounter high-dollar medical claims or higher-than-expected medical costs over the course of the year.

The new Sun Life Stop-Loss suite of COVID-19 coverages provides employers who self-fund their health plans with options for additional financial protection depending on their needs, including:

Outbreak coverage – If a certain number of employees test positive for COVID-19, the employer receives a benefit payment for eligible diagnosed employees once a pre-determined threshold has been met.

Specific benefit – If an employee receives a COVID-19 diagnosis resulting in hospitalization costs that reach the employer's stop-loss deductible, the benefit increases the amount of reimbursement to the employer.

Aggregate benefit – If the amount of claims for COVID-19 cause health plan claims to exceed the employer's aggregate stop-loss attachment point (the aggregate deductible), the attachment point will be reduced, resulting in a larger reimbursement for the employer.

Self-funded employers are eligible for Sun Life COVID-19 protection as long as they are using an approved workplace monitoring program to help manage the return-to-work process, maintain a safe workplace, and prevent the spread of the disease.

The first approved program, Collective Go, is a comprehensive COVID-19 screening, testing and monitoring solution developed by Sun Life partner Collective Health. Collective Go™ offers an evidence-based approach, with an adaptive scientific protocol developed by in-house medical experts and reviewed by former FDA Commissioners and researchers from leading academic and public health institutions.

The Collective Go™ Protocol identifies external factors and determines a series of necessary measures including frequency of testing, screening, and compliance

monitoring to help organizations reduce risk as employees return to the workplace. With the easy-to-use Collective Go™ app, workers complete a daily symptom and exposure checklist and manage their COVID-19 testing. Those who pass the protocol requirements receive Compliance Certificates.

In Sun Life's recent survey, brokers estimated that about 50 percent of their employer clients were considering implementing a workplace monitoring program.

Since the start of the pandemic, Sun Life has swiftly introduced innovative product features and services to meet the growing and evolving needs of employer clients around the country, including fully virtual benefits enrollment, COVID-19 coverage for critical illness plans and COVID-19 compliance and regulatory expertise.

About Sun Life

Sun Life is a leading international financial services organization providing insurance, wealth and asset management solutions to individual and corporate Clients. Sun Life has operations in a number of markets worldwide, including Canada, the United States, the United Kingdom, Ireland, Hong Kong, the Philippines, Japan, Indonesia, India, China, Australia, Singapore, Vietnam, Malaysia and Bermuda. As of June 30, 2020, Sun Life had total assets under management of C$1,122 billion. Visit www.sunlife.com.

In the United States, Sun Life is one of the largest group benefits providers, serving more than 60,000 employers in small, medium and large workplaces across the country. Sun Life's broad portfolio of insurance products and services in the U.S. includes disability, absence management, life, dental, vision, voluntary and medical stop-loss. Sun Life and its affiliates in asset management businesses in the U.S. employ approximately 5,500 people. Group insurance policies are issued by Sun Life Assurance Company of Canada (Wellesley Hills, Mass.), except in New York, where policies are issued by Sun Life and Health Insurance Company (U.S.) (Lansing, Mich.). Visit www.sunlife.com/us.

BERKLEY ACCIDENT AND HEALTH INTRODUCES COVID-19 TELEHEALTH SERVICE FOR EMPLOYER STOP LOSS POLICYHOLDERS

Hamilton Square, NJ – As individuals return to school, work, and other aspects of their daily lives this fall, Berkley Accident and Health, a Berkley Company, has introduced a COVID 19 Symptom Checker and Physician Access service for Stop Loss policyholders.

This innovative new service lets employees and their dependents check their symptoms and connect virtually to a physician who is board-certified in emergency medicine. The COVID-19 service provides a tangible benefit to policyholders, in a time when employee safety is a top concern.

"The need for remote services during the pandemic has increased. With this in mind, we're providing an innovative online tool designed to help policyholders keep their workers healthy and safe," said Brad Nieland, President and CEO of Berkley Accident and Health. "Berkley Accident and Health is committed to helping clients better manage the risks facing their self-funded health plans, and this value-added service demonstrates our continued commitment."

"Before the COVID pandemic, many patients were skeptical about the effectiveness of telehealth. But now, adoption rates have skyrocketed, as patients have looked to the convenience and speed of virtual care," explained Lee Davidson, Senior Vice President, Stop Loss Division, Berkley Accident and Health. According to a recent McKinsey survey, there has been a massive acceleration in the use of telehealth during the COVID-19 pandemic, with 46% of U.S. consumers now using virtual health care visits.

Individuals displaying symptoms of COVID can speak via phone or video 24/7 to a board-certified physician, who can recommend the best course of action. This secure, virtual service allows them to remain safely at home, without risking additional exposure to the virus.

The COVID-19 Symptom Checker and Physician Access service is provided by MedCall Advisors, a leader in tele-emergent care, and their in-house physicians.

Employer Stop Loss insurance protects employers with self-funded plans from catastrophic claims over a predetermined level. MedCall's services may not be available to all employers or in all states.

For more information, contact your Berkley Accident and Health representative.

For your convenience, Berkley Accident and Health is providing access to MedCall to its policyholders for medical assistance/information, but Berkley Accident and Health does not endorse the use of MedCall or the information, products, or services (including, but not limited to, the appropriateness or suitability of any diagnosis, course of treatment, or medical advice) provided by or accessible through MedCall.

Access and use of MedCall, including the information, products, and services on or available through MedCall, is solely at your own risk, and Berkley Accident and Health makes no representations or warranties, express, statutory, or implied, with respect thereto.

Berkley Accident and Health is not responsible or liable for any damage or loss caused, or alleged to be caused, directly or indirectly, under any theory of law, by or as a result of the use of or reliance on any information, products or services accessible from MedCall.

BERKLEY ACCIDENT AND HEALTH IS NOT RESPONSIBLE NOR LIABLE FOR ANY ADVICE, COURSE OF TREATMENT, DIAGNOSIS OR ANY OTHER INFORMATION, PRODUCTS OR SERVICES THAT YOU OBTAIN FROM MEDCALL. The MedCall COVID-19 Symptom Checker and Physician Access will collect personal information that will be kept confidential according to MedCall's Privacy Policy.

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. Visit www.BerkleyAH.com.

About MedCall Advisors

MedCall Advisors is the nation's leading tele-emergent care provider that immediately connects patients to in-house physicians board certified in Emergency Medicine. MedCall focuses on immediate consults with physicians experienced in acute illnesses and injuries. Providing virtual information and immediate connection to an emergency physician allows employees get care conveniently and quickly, as individuals and businesses return to school, work, and other key aspects of their daily lives. Patients connect to physicians in a secure environment through phone, computer, or tablet portals available 24/7 and in multiple languages. MedCall offers an online COVID-19 screening tool that identifies risks and gives at-risk patients the option to speak to an ER physician for further analysis. Visit www.MedCallAdvisors.com.

GOLD MEMBERS

AMPS ANNOUNCES NEW LEADERSHIP FOR CLIENT SERVICES

PHOENIX – Advanced Medical Pricing Solutions (AMPS), a pioneer in cost management for the self-insurance industry, appoints Jeannette Flowers as Senior Vice President of Client Services.

AMPS continues its commitment to service excellence with the appointment of Mrs. Flowers to lead and grow its Client Services team across the Nation. The ideal

executive to lead this critical part of AMPS continued expansion, Jeannette brings 35 years of expertise in the healthcare and employee benefits space, combined with a focus in self-funding and an in-depth understanding of employer groups, brokers and TPAs.

Jeannette's previous roles included leadership of Account Management at UMR/UHP; leadership of Client Service at Pomco, one of the largest independent TPAs in the US; and Vice President of Sales Operations and Director of Account Management at Lifetime Benefit Solutions, in upstate New York. Jeannette has also held positions with Prepaid Health Plan, Univera Healthcare and Excellus Blue Cross Blue Shield.

"Jeannette brings AMPS a wealth of client service experience and tremendous leadership skills which will benefit all AMPS clients across the nation" said Lawrence Thompson, AMPS Chief Revenue and Strategy Officer. "I have had the pleasure of working with Jeannette in the past and her commitment to clients is unequalled".

Jeannette will manage AMPS teams in Atlanta, Phoenix and throughout the US and will be responsible for all aspects of AMPS client service delivery model.

"As employers seek alternatives to the ever-increasing costs of healthcare, AMPS is experiencing unpanelled growth. Jeannette's first-hand experience in leading the client services team at one of the largest independent TPAs in the country will help TPAs, Brokers and AMPS better serve our joint customers as we together grow the self-insured market" added Kirk Fallbacher, CEO and President of AMPS.

About AMPS

Advanced Medical Pricing Solutions (AMPS) provides market leading healthcare cost containment services for self-funded employers, public entities, brokers, TPAs, and reinsurers. AMPS mission is to help clients attain their goals of reducing healthcare costs while keeping members satisfied with quality healthcare benefits. AMPS leverages 15 years of experience in auditing and pricing medical claims to deliver "fair for all" pricing both pre-care and post-care. AMPS offers innovative dashboards and analytics to provide clients with insights based on Plan performance. Visit www.advancedpricing.com.

SILVER MEMBERS

TMS RE WELCOMES DOUG DEANGELIS AS REGIONAL SALES VICE PRESIDENT, WEST REGION

Andover, MA - TMS Re is pleased to announce that Doug DeAngelis recently joined the Company as Regional Sales Vice President. For the past seventeen years, Doug served as the Senior Vice President and Producer at USI Insurance Services in Eugene, OR.

He built and maintained a successful stop loss portfolio as part of his responsibilities with USI in the Pacific Northwest market. Doug's primary responsibility at TMS Re will be to drive profitable sales growth through the development of brokers, consultants and TPA's in the Western United States.

"We are excited to have someone with Doug's extensive sales experience and knowledge of the stop loss industry join TMS Re" says Travis Micucci, President and COO. "Doug's experience as a broker provides us with insight to better serve our stop loss producers and clients."

"I am excited to be joining the team at TMS Re and helping grow the employer stop loss business." said Doug. "In my most recent role, I worked as a broker/consultant, so I'm excited about this new opportunity."

"We continue to explore opportunities to expand our business and serve the stop loss market by hiring talented individuals", says Michael Shevlin, CEO. "Doug's track record of success will help us achieve our growth objectives."

Doug can be contacted via email at ddeangelis@tmsreinc.com.

About TMS Re, Inc.

TMS Re is one of the largest and most experienced medical stop loss MGUs in the market today. TMS is committed to delivering excellent service, unparalleled expertise, and creativity in our product and service solutions for our customers

TMS Re, Inc. provides comprehensive excess loss products and services tailored to the insurance needs of your employer and provider groups. Established as Cairnstone, Inc. in 1996, the Company was acquired by one of the world's largest reinsurers, and in July 2018 was purchased through a management buyout. Our team of highly experienced underwriting, actuarial, claims, and medical management professionals work closely with you to understand your long-term objectives and design the optimal stop loss solution to minimize your risk. Call (978) 933-4009, email Info@TMSReInc.com and visit www.TMSReInc.com.

DEERWALK ANNOUNCES LATEST RELEASE OF PLAN ANALYTICS

Deerwalk's announces its September release of Plan Analytics, the flagship population health analytics and reporting application. The new release incorporates several new and enhanced features in version 10.4. Plan Analytics is fully integrated with our clinical workflow platform, Care Manager.

New and Enhanced Features

New Machine Learning Model: Medication Adherence

We've released our 7th machine learning model - Medication Adherence. This model helps users identify opportunities

to increase medication adherence in a population(s). Using a number of factors, the model predicts the likelihood that a member will adhere to a newly prescribed medication over the next year.

You can pair the results from this model with the Quality Metrics Report (gaps in care) that are related to medication adherence to gain an even deeper understanding of a member's overall risk.

This information can also be very useful as you look to manage health and control costs for members taking medication to treat chronic disease. Having these insights will allow clients to intervene early on, which is essential as initial adherence or non-adherence to a new medication is often indicative of a member's future adherence patterns.

This model makes the below fields available from within the Member Search Module:

- "Medication Adherence Class 1" field contains data on the therapeutic class to which the new medication belongs.
- "Medication Adherence Probability 1" field indicates the probability that a member will adhere to a medication from that therapeutic class.
- In the event a member has two newly prescribed medications, "Medication Adherence Class 2" and "Medication Adherence Probability 2" fields will be populated.

New Custom Value Fields Available In The Create Module

Within the custom reporting Create Module, you can now access custom value fields to enhance the metrics used to generate charts, tables, and widgets. We've added several calculated fields, including "Inpatient Paid Amount," "Outpatient Paid Amount," and "Office Visit Paid Amount" for even greater reporting flexibility beyond just a single "Paid Amount" field.

New High Cost Members Monthly Claims Report

We've added a report that gives users another way to look at high cost members. Just like the High Cost Members Report and the Shock Claimants Report, the High Cost Members Monthly Claims Report allows users to generate a list of members whose total paid amounts are above a user defined dollar threshold.

This new report takes it a step further, returning the paid amounts (for both medical and pharmacy claims) for each member trended across each month within the reporting period. Accessible from Report Manager, this report can be exported in multiple formats (Word, PDF, and Excel), scheduled, and included in reporting bundles.

Data Type Accessibility Controls

Within the Settings panel, Admin users now have the flexibility to enable/disable data types for users with different levels of access. From the Administration tab in the Settings panel, we've added a category called "Data Types" that allows Admin users to simply check a box to set data type permissions by user tier.

Disabling certain data types will restrict users' ability to drill down into that data type from anywhere within the application but will not restrict their ability to view that data type in aggregate form in reports and dashboards.

New Look & Feel - Comparison & Search Modules

With the phased rollout of the usability and user interface redesign, we've made improvements to certain interface elements in the Data Search Modules and Comparison Module. We've adjusted fonts for readability, the appearance of pop-up windows have been updated across the Search and Comparison Modules, and trending population labels have been updated within the Comparison Module.

Predictive Modeling Quarterly Upgrade

We've completed the quarterly maintenance upgrade of the Milliman Advanced Risk Adjusters (MARA) to MARA Version 4.3.3.2.

About Deerwalk, Inc.

Deerwalk is an innovative population health management, data management, and healthcare analytics software company based in Lexington, Massachusetts. Founded in 2010, Deerwalk is privately held with over 300 employees worldwide, including a technology campus in Kathmandu, Nepal. Deerwalk Partners with industry leaders responsible for making

decisions for the health of a population to optimize costs and improve the quality of care. Deerwalk offers a complete population health management suite built on a foundation of data integrity that delivers reliable data insights and actionable intelligence. Contact Leslie Ricci, MBA, BSN, RN, Director of Sales, Care Management, at lricci@deerwalk.com and visit www.deerwalk.com.

D.W. VAN DYKE ANNOUNCES DISTRIBUTION OF MEDICAL STOP LOSS INDUSTRY PERSISTENCY AND NEW BUSINESS SURVEY

Joe Sabol, Senior Vice President at D.W. Van Dyke & Co., Inc., announced that results for the recently completed Medical Stop Loss Industry Persistency and New Business Survey will be distributed the week of September 21st to the 27 participants (MGUs and Direct Carriers) representing over $7.4B in annualized Stop Loss Premiums.

The July 2020 results reflect an uptick, as compared to the July 2019 Survey results, in both New Business written and Renewal Premium Persistency resulting in overall premium growth of just over 2.0% which is also slightly higher than the July 2019 survey results.

New to the survey this year, DWVD added an additional question covering the topic of Cell & Gene Therapy. The results reflect that almost half of the participants expect costs associated with Cell & Gene Therapy will comprise more than 5% of large claims over the next twelve months.

Stop Loss MGUs and Carriers interested in learning more about DWVD's Industry surveys and services should contact Joe Sabol at jsabol@dwvd.com, Chris Koehler at ckoehler@dwvd.com or Michelle Marzella at mmarzella@dwvd.com.

About D.W. Van Dyke & Company

Founded in 1978, DWVD provides intermediary and advisory support for reinsurance placements, distribution, product development consulting and direct brokering services on behalf of institutional clients. DWVD works throughout the Life, Accident & Health space, most prominently in the stop loss business. DWVD's customers and markets include Insurance Companies, Reinsurers, TPAs, MEWAs, Cooperatives, MGAs, distribution companies and others. Contact Walt Roland at wroland@dwvd.com and visit www.dwvd.com.

GILSBAR COACH OFFERING COACH-TO-MEMBER VIRTUAL CALL CAPABILITIES

COVINGTON, LA -- Gilsbar Coach is an engagement app designed for quick and secure clinical messaging between Gilsbar personal health coaches and nurses and Gilsbar members. Gilsbar health coaches and nurses communicate on topics specific to members' individual health objectives with the goal of creating actionable steps to improve overall health.

Gilsbar is focused on finding better ways to engage with our members and creating happier constituents and healthier bottom lines. We're excited to share Gilsbar Coach will offer secure, virtual face-to-face clinician services, starting in 2021.

Paul Johnson, Senior Director of Population Health Management, shared

"Due to COVID-19, many people are spending more time inside their homes and less time interacting with their health care providers. This new feature gives our clinicians the ability to communicate face-to-face with members via Zoom at their convenience. It's a great new addition that allows us to provide an even higher level of service to improve the health of our members."

Gilsbar Coach and our Population Health Management program provides your organization with a combination of proactive educational and personalized solutions. Both are key features—and they work in tandem to create a fully-integrated approach. Our strategic outreach plan addresses the entire healthcare continuum, improving all risk categories: acute, chronic, diagnosed, and healthy/at risk. The personal outcomes—and related cost savings—speak for themselves.

About Gilsbar, LLC

Established in 1959, Gilsbar, LLC® is one of the largest privately-held insurance services organizations in the United States. Recognized as a catalyst for creating healthy businesses, Gilsbar, LLC® offers self-funded and fully-insured benefit plan management services, along with Wellness, Advocacy, and overall Population Health Management. Gilsbar, LLC®'s integrated delivery model improves the health and well-being of its members, resulting in significant health plan savings for its clients. Gilsbar, LLC® has been honored by Inc. magazine for its sustained growth, Modern Healthcare and Business Insurance magazines as a Best Place to Work, and WELCOA and the American Heart Association for its proven wellness methodology. Visit Gilsbar.com.

SCM PROMOTES CRAIG CLEMENTE TO PRESIDENT

Doylestown, PA – Specialty Care Management (SCM), a company concentrated on saving significant healthcare dollars for the self-funded marketplace, is pleased to announce that Craig Clemente has been promoted to President.

This move merges Clemente's prior title and responsibilities of COO with that of President. Adding to his oversight of day-to-day operations, he will direct the overall marketing efforts, all aspects of sales/promotion, and assume additional strategic planning and financial responsibilities.

Clemente assumes the position with 12 years of experience at SCM. Most recently, he has spearheaded and negotiated SCM's new Dialysis+ program, and expanded operations of nurse underwriting services, its extensive cancer management programs, as well as the company's comprehensive CKD-ERSD (chronic kidney disease-end stage renal disease) programs, the main aspect of SCM's business.

Robert Clemente, SCM Founder and CEO, said, "I am delighted to announce Craig's promotion to President. Craig has earned this position through hard work, dedication, and his proven capabilities to create and maintain mutually beneficial relationships in the marketplace. Further, he has flourished in part through his keen awareness of the ever-changing self-funded healthcare industry. Craig's experience coupled with understanding of the intricate synergies between SCM, our business associates, and clients, will enable this company to move forward and take advantage of challenges

and opportunities facing us."

At SCM, Clemente has been COO since 2015. A respected leader in the self-funded industry, in 2018 he had been appointed as inaugural Chairman of the Future Leaders Committee of the Self-Insured Institute of America (SIIA).

He has been a noted speaker at multiple industry events, and he is recognized as an industry resource.

Prior to joining SCM, he had worked stints in the hotel and bond trading industries. In 2012, Clemente earned his MBA with a concentration in healthcare from Northeastern University. He received his BA in Economics from Drew University.

Clemente is an avid sports enthusiast who enjoys hiking in the Adirondacks, playing basketball, and water and snow skiing. He resides with his wife and two children in Doylestown, PA.

About SCM

Based in Doylestown, PA, SCM is a national company which pioneers value-added strategies for the self-insured healthcare industry. A leader in managing and significantly reducing the high cost of catastrophic healthcare claims, the company specializes in minimizing the extraordinary costs and managing risk of renal dialysis, and cancer care. With some of its key executives working together in this healthcare niche since 2002, SCM was created in 2006. Visit specialtycm.com. ■

SIIA 2020

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NOVEMBER 2020

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