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CALIFORNIA BROKER

VOLUME 39, NUMBER 7 Serving California's Life/Health Professionals & Financial Planners APRIL 2021

Diving into Fed Updates — it's tough to keep up!

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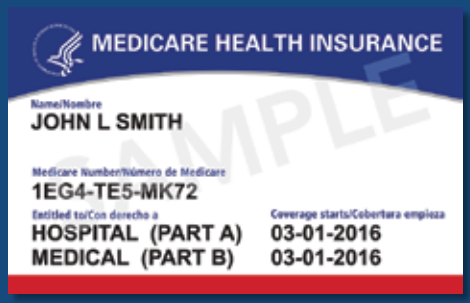

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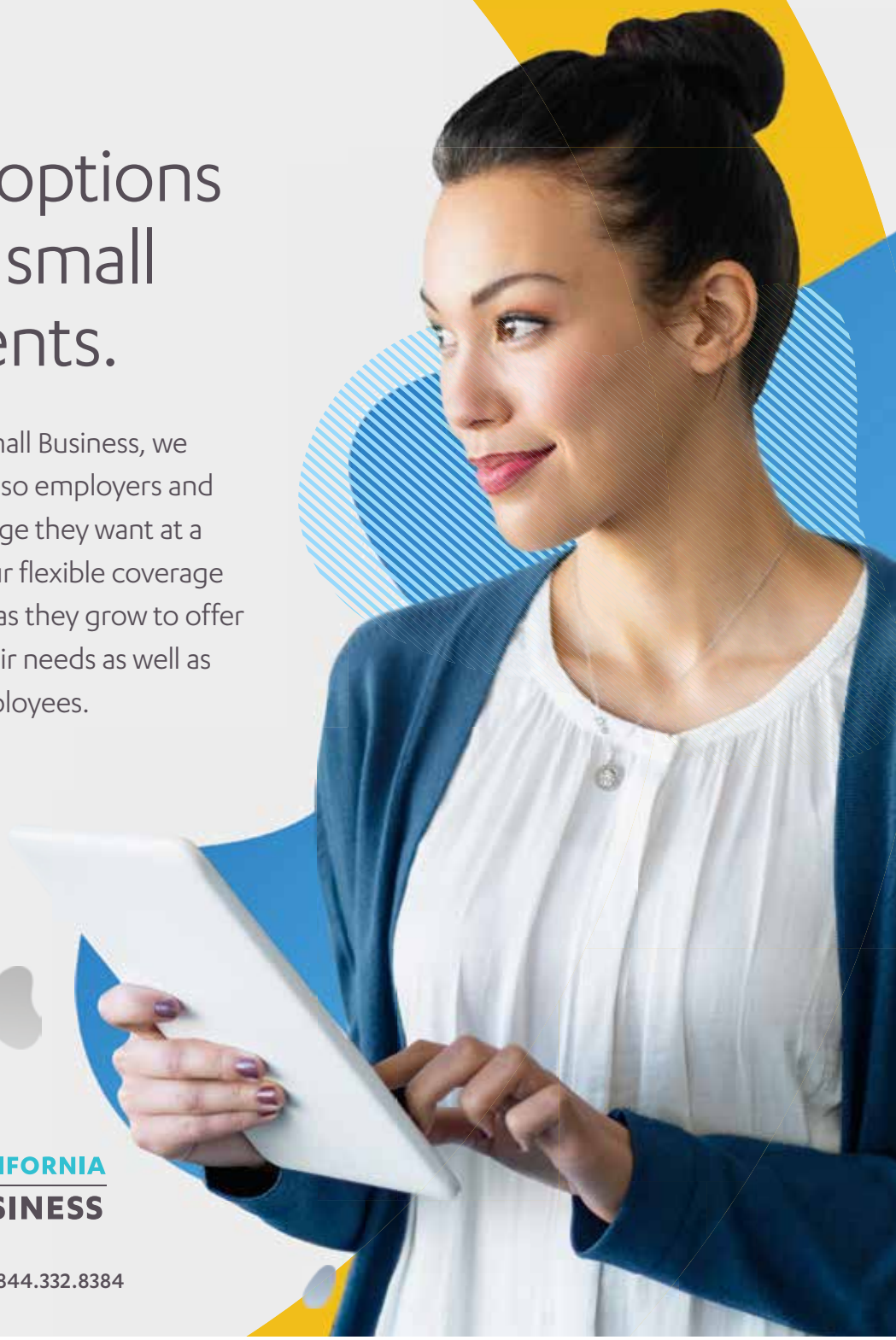

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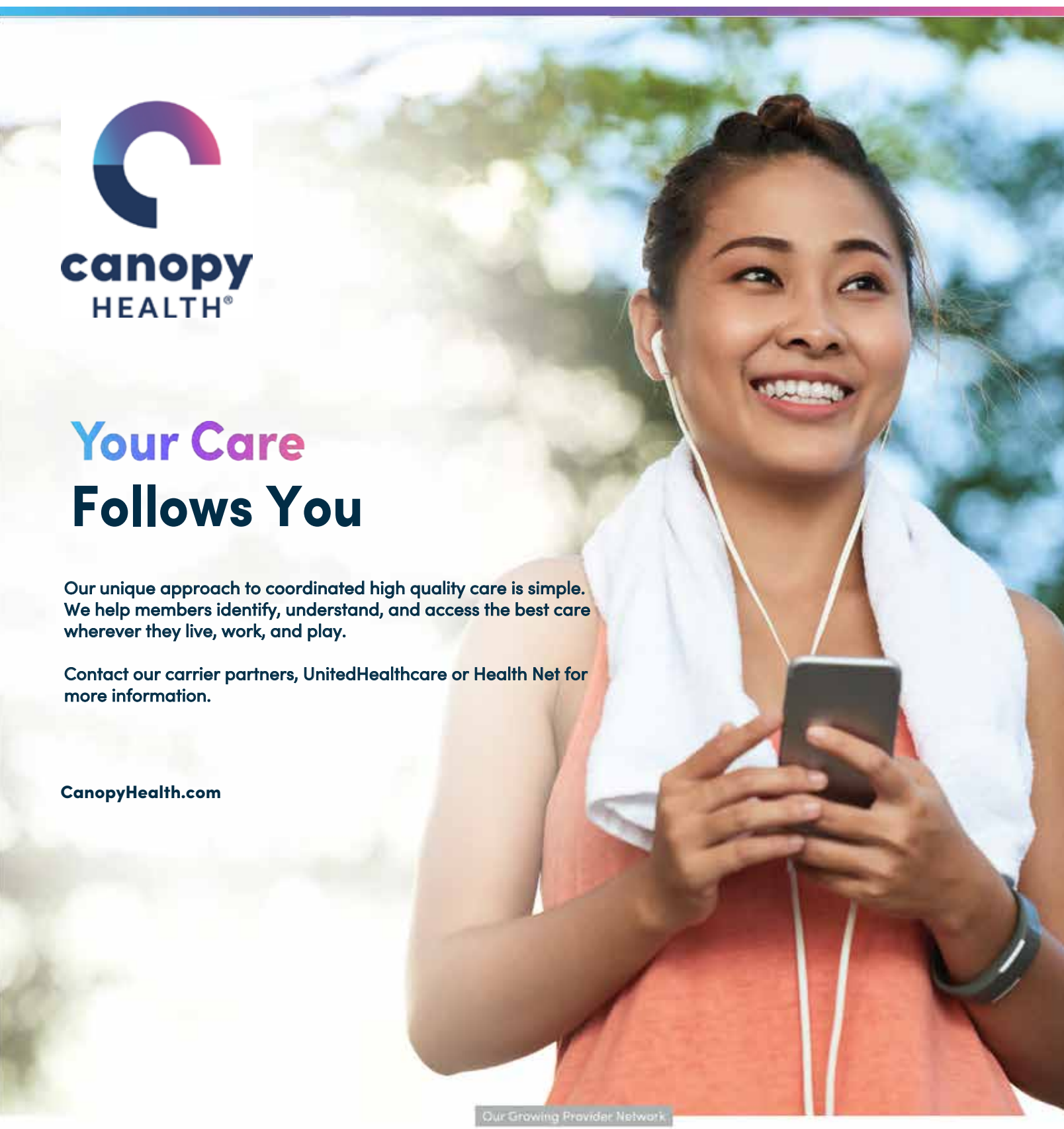

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Washington Hospital Healthcare System
WATSONVILLE COMMUNITY HOSPITAL

INDUSTRY NEWS

NEW STUDY ON MENTAL HEALTH CLAIMS FOR YOUNGER PEOPLE

In March and April 2020, mental health claim lines for people aged 13-18, as a percentage of all medical claim lines, approximately doubled over the same months in the previous year. At the height of the spring wave of the COVID-19 pandemic, this rise in mental health claim lines amounted to 97% in March and 103.5% in April. These are among the many findings in FAIR Health's new white paper, *"The Impact of COVID-19 on Pediatric Mental Health: A Study of Private Healthcare Claims, the seventh in its COVID-19 studies."* **www.FairHealth.org.**

LIMRA: Annuity Sales Down

U.S. annuity sales totaled $219 billion in 2020, 9% lower than sales in 2019, according to results from the Secure Retirement Institute® (SRI®) U.S. Individual Annuity Sales Survey. While total sales were down, the fourth quarter nonetheless didn't look bad. Annuity sales rebounded to pre-pandemic levels during this time.

NAAIA CELEBRATES 24 YEARS

Congratulations to the National African American Insurance Association (NAAIA) on their 24th Anniversary! Founded in 1997 by Jerald L. Tillman, NAAIA is the premier diversity, equity and inclusion focused organization for the insurance Industry. NAAIA's mission is to increase the numbers of African American insurance professionals and to support these members in their insurance industry careers. Find out more about this valuable organization at NAAIA.org.

New York Life Chairman and CEO Ted Mathas Joins NYDIG Board of Directors

TED MATHAS, *chairman and CEO of New York Life Insurance Company, must think this Bitcoin thing is going somewhere. NYDIG, a leading provider of investment and technology solutions for Bitcoin, announced Mathas will join its board of directors. New York Life Insurance Company is the nation's largest mutual life insurer with more than $700 billion in assets under management. NYDIG says Mathas' expertise and insights will be valuable as it continues to focus on "expanding the financial and technology services it delivers to institutional and individual clients alike."*

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Transamerica Introduces Transamerica Principal Optimizer

Transamerica recently unveiled the Transamerica Principal Optimizer, an annuity rider with guaranteed protection. The Transamerica Principal Optimizer℠ offers protection from market losses on an investor's principal and earnings, the potential of uncapped investment growth, and the ability to invest 70% of premiums into any investment option available within the annuity. For an additional fee, Transamerica Principal Optimizer variable annuity customers can have:

- Protection from market downturns, with up to 100% protection of principal and earnings growth, depending on the length of the benefit elected.
- Simplicity from a straightforward strategy with gains credited daily and dividends automatically reinvested.
- The flexibility to allocate 70% of all premiums as they wish from a menu of diverse investment options from well-known money managers. The remaining 30% will be allocated to the annuity stable value account that offers a guaranteed interest rate.
- An optional annual reset feature to lock in gains to their guaranteed future value.

Offered for waiting periods of either seven or ten years, Transamerica Principal Optimizer aims to offer investors the opportunity to protect premium and growth. Even if the policy value falls due to down markets, investors are guaranteed to receive 100% of their initial premium back if they elect and complete the 10-year waiting period. If an investor chooses the seven-year waiting period, they are guaranteed to receive 90% of their initial premium at the end of that waiting period. Optional annual reset is required to lock in earnings growth. At the time of an optional annual reset, this protection level percentage could drop as low as 80%.

More info at **transamerica.com.**

L.A. Broker Brings Showers to Those In Need

We all know that too many people in California are without a home and most of us would love to do something about it. Los Angeles broker Rachel Sunday of Playa Vista Insurance Services has. Three years ago, Rachel and family launched The Power of a Shower — a 501(c)3 nonprofit that focuses on providing their houseless neighbors in the Venice Beach area with access to personal hygiene. “I knew I wanted to do something but at first didn't know what,” explains Rachel. “One day I’d had a really horrible day, but after I took a shower I noticed how much better I felt. That’s really when I came up with the idea for The Power of a Shower.” Indeed, getting clean may not be the total solution, but it sure does help! Using mobile shower units, The Power of a Shower offers people without homes a chance to shower, use the restroom and change into fresh clothing. The Sunday family and volunteers set up shop Thursday mornings in the main parking lot of Venice Beach boardwalk, where they routinely have a long line of people who want a shower. They are able to provide showers for 30 to 50 people each week. Sunday says she loves the idea that helping people get clean is something almost anyone can get behind.

The organization is always in need of the following products:

Soap/body wash • Shampoo • Conditioner • Lotion •Toothbrushes • Toothpaste • Deodorant • Q-tips • Disposable gloves • Tampons

If you'd like to volunteer or make a donation, visit powerofashower.org.

Great work Sunday family!

INTEGRITY ACQUIRES ACCESS CAPITAL

Integrity Marketing Group, the nation's largest independent distributor of life and health insurance products, announced it has acquired Access Capital Group,LLC, a financing company for insurance agents and agencies. The companies say the partnership will serve the financial needs of America's agents and agencies, a vastly underserved market. As part of the transaction, Principals and Co-Founders Bryan Neary and Dave Emerton will also serve as Managing Partners with Integrity. Financial terms of the transaction were not disclosed. Access Capital provides financial solutions for insurance agents by leveraging future policy renewals to obtain capital today, while maintaining their client relationships for future product sales. Drawing from decades of insurance and actuarial experience, Access Capital uses proprietary data and actuarial models to project the value of an agent's future commissions across a limitless range of life and health products. Access Capital provides near real-time valuation services and an immediate capital payout to agents based on readily available information about their book of business. The ability for agents to convert their commissions into capital allows them to add staff, invest in leads or meet any number of life's unexpected obligations.

INDUSTRY NEWS

New Study: Patients Now Prefer Telehealth

A new study by Telehealth.com claims that a full 62% of Americans say will prefer telehealth post-pandemic. Highlights of the study include:

- Prior to the pandemic, 50% of people said they would have preferred an in-person doctors visit.
- Now only 43% said they would prefer an in-person visit, and only 23% say they will prefer in-person after the pandemic.
- 2/3 of millennials say they'd rather have a telehealth appointment than in an in-person appointment.

Almost 50% of people (47%) said they have used telehealth since the pandemic began.

- White, wealthier Americans were more likely to know about and to use telehealth services.

EVENTS

NAHU POWER HOUR

4th Wednesday of the month from 4-5 p.m. PST. Members and nonmembers welcome. Register at NAHU.org.

LAAHU DEI Book Club, discussing Miles McPherson's book, The Third Option, goes through September, Register at LAAHU.org.

CAHU WOMEN'S LEADERSHIP SUMMIT POSTPONED

Email questions to info@cahu.org.

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (NAIC)

Spring National Meeting, Virtual - April 7-9 and April 12-14. Register at NAIC.org.

INSURANCE ADVERTISING COMPLIANCE ASSOCIATION CONFERENCE

Virtual - April 22-23. Info at iadca.org.

IICF INTERNATIONAL INCLUSION IN INSURANCE FORUM

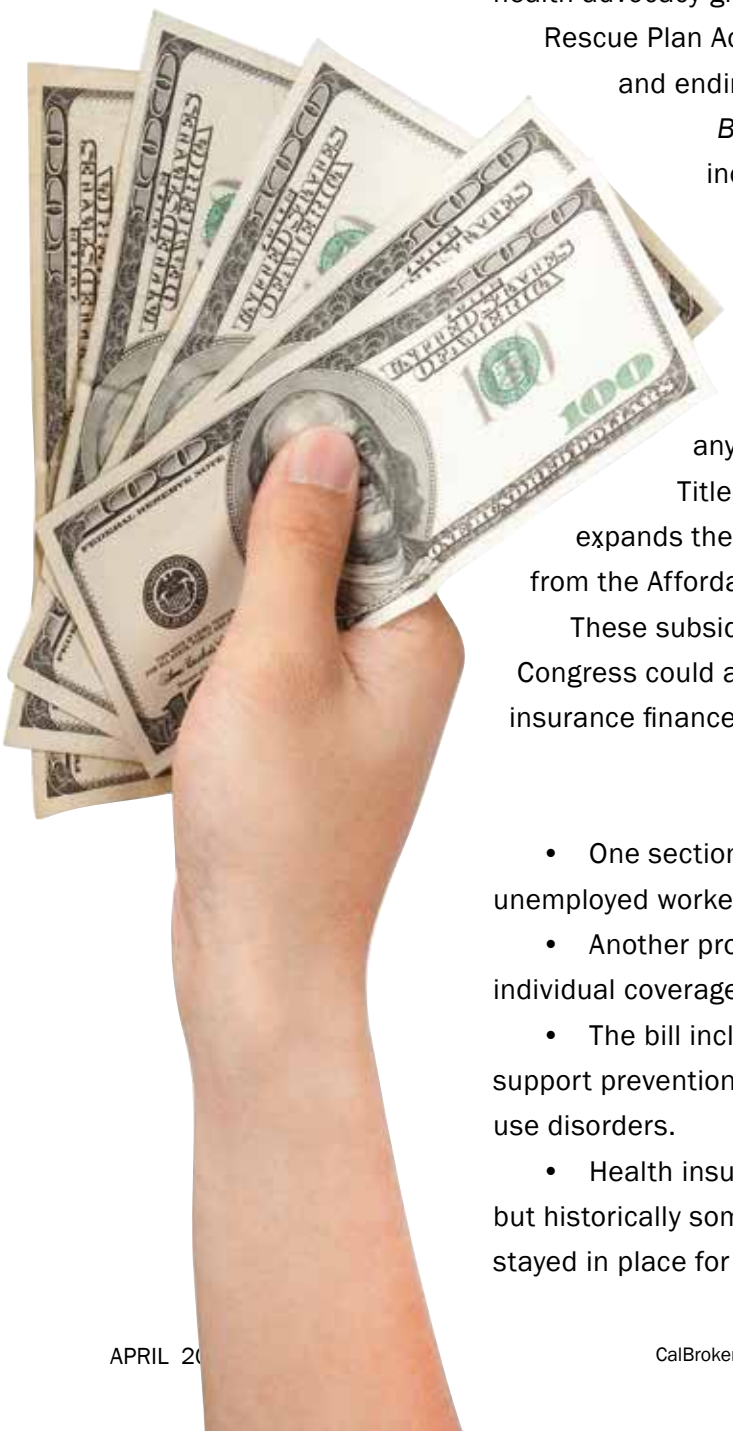
Virtual - June 15-17. The Insurance Industry Charitable Foundation (IICF) is convening insurance professionals, C-Suite executives, D&I leaders and other innovators from around the globe for the IICF International Inclusion in Insurance Forum, an action-oriented program with a unique focus on an inclusive future for the industry. Register at IICF.org.

AMERICAN ASSOCIATION FOR MEDICARE SUPPLEMENT INSURANCE

National Medicare Supplement Insurance Industry Summit - IN PERSON Sept 8-10 Schaumburg Convention Center, Chicago area. Info at medicaresupp.org.

BIGGEST NEWS:

Biden Signs American Rescue Plan



At press time, President Joe Biden had just signed the $1.9 trillion H.R. 1319, better known as the American Rescue Plan, into law. This clears the way for enhanced unemployment benefits, direct cash and other relief to millions of Americans.

Anti-poverty and unemployment experts heralded the plan and said the $1,400 checks that up to 85% of Americans could receive — as well as the extension of the $300 per-week extra unemployment benefits through Sept. 5 and an expansion of the low-income Child Tax Credit — will help families and lift children out of poverty. Non-partisan, nonprofit health advocacy group United States of Care called the American Rescue Plan Act of 2021 a "major step toward defeating the virus and ending the pandemic."

But what impact will it have on insurance? H.R. 1319 includes a provision (Title IX, Subtitle F) that helps those who lose employer coverage keep COBRA benefits in place through the end of September. The provision provides a tax credit that employers can use to pay to keep coverage for departing workers in place, without employees having to pay anything out of pocket for the coverage.

Title IX, Subtitle A, Part 7 drastically, though temporarily, expands the subsidies that people can use to pay for coverage from the Affordable Care Act health exchange.

These subsidies would expire by the end of 2022, but of course Congress could always decide to extend the time that the health insurance finance arrangements stay in place.

Stimulus Bill Need to Know

- One section calls for COBRA continuation benefits at no cost unemployed workers.
- Another provision caps what high-income people pay for individual coverage at 8.5% of income.
- The bill includes around $4 billion in funding for programs that support prevention of and treatment for mental health and substance use disorders.
- Health insurance subsidies are set to expire at end of 2022, but historically some temporary federal health finance provisions have stayed in place for many years.

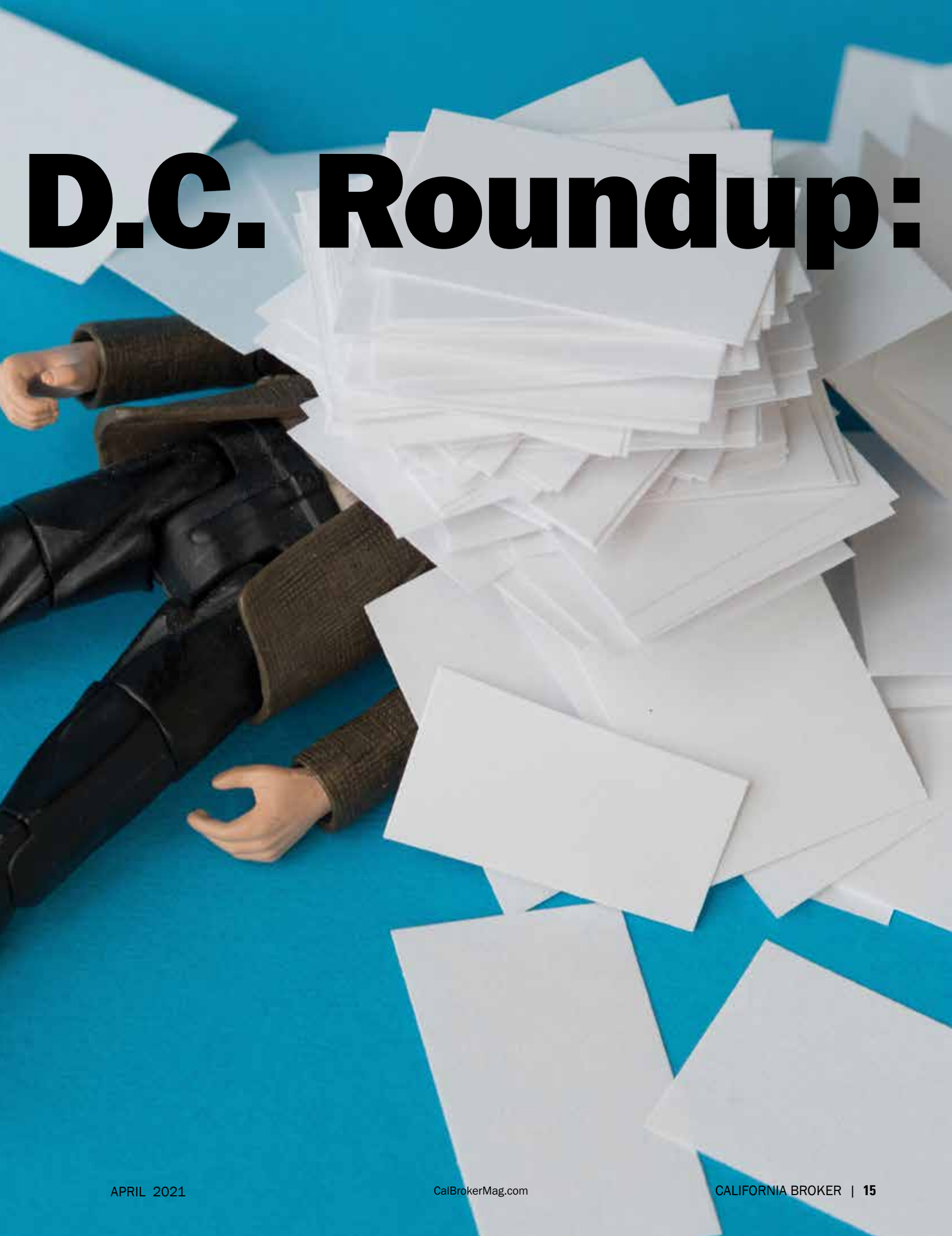
Washington,

Diving Into Federal Updates, Including COVID-19, the New Stimulus Bill, Agent Disclosure Requirements and Grandfathered Health Plan Rules

By Dorothy Cociu

There has been so much going on in Washington, D.C. that it's definitely hard to keep up. Just after I finish writing a lengthy article on something important, more of course happens, meaning that more lengthy articles are waiting to be written — 2020 and now 2021 have definitely kept us all busy!

D.C. Roundup:



COVID-19 UPDATES AND REMINDERS

As a reminder, there are some important deadlines from previous COVID-19 legislation (pre-CAA). Paid leave under the Families First Coronavirus Response Act (FFCRA) expired on December 31, 2020. This was a hard stop.

In California, AB 1867, which had many of the same provisions of FFCRA but applied to groups with over 500 employees (FFCRA applied to groups with fewer than 500 employees), also ended on December 31, 2020. Although if someone were in the middle of a leave on Dec. 31, that leave could continue until completed. Keep in mind, California AB 1867 did not have tax credit provisions. For paid leave under FFCRA, employers are reminded to disclose in box 14 of the W-2 form, the amount of qualified wages paid under FFCRA. The IRS has updated its FAQs and items 25, 25a and 31-36 focus on the tax credit provisions of FFCRA.

Under the CARES Act, over-the-counter medicines used for medical care, as well as menstrual products, may be reimbursed by an HSA, health FSA, HRA, or Archer MSA, and applies to expenses incurred and amounts paid as of Jan. 1, 2020. You should be sure to have plan amendments in place and coordinate with your TPA. Mid-year cafeteria plan election changes implemented during the 2020 calendar year require a plan amendment by Dec. 31, 2021. In addition, Health FSA carryover provisions were increased to $550, and also require a plan amendment by Dec. 31, 2021.

Furthermore, the mandate to provide COVID-19 testing without cost sharing was recently extended another 90 days, so it now expires on April 21, 2021, unless further extended. This was part of the HHS Public Health Emergency.

COVID-19 vaccines are required under Section 3203 of the CARES Act for non-grandfathered group and individual health plans. The cost of a coronavirus vaccine must be with no cost-sharing 15 business days after the vaccine is recommended as preventive care. Grandfathered plans and excepted benefits are not subject to this mandate but may voluntarily comply. In addition, during the Public Health Emergency (as of the writing of this article it was through April 21, 2021 but we consider this subject to potential additional extensions), vaccines must be provided without cost-sharing. This whether they are provided by an in-network or out-of-network provider, including multi-dose vaccines and the cost of administering the vaccine. Reimbursements for out-of-network providers must be made at a "reasonable rate." You should also review, of course, OSHA, EEOC and state guidance on vaccines and workplace issues related to COVID-19.

As a reminder, under the FFCRA and CARES Act, during the HHS Public Health Emergency, all group and individual health plans, including fully-insured, self-funded grandfathered or non-grandfathered plans, must cover testing (not treatment) for the detection or diagnosis of COVID-19, and related items and services. These include in-person visits, telehealth, urgent care and ER visits without cost sharing (no co-pays or deductibles), and they cannot require prior authorization or medical management. Tests that must be covered include at-home testing, multiple COVID-19 tests, and antibody tests. *Testing for employment purposes, however, is not covered*. Therefore, if an employer requires a COVID-19 test before you return to work, those tests are not required to be covered at no-cost under the FFCRA and CARES Act, so an employee could be billed for those services. Employees and employers should coordinate to determine who will pay for required COVID-19 tests to return to work.

TIME FRAME EXTENSIONS (FOR PLAN PARTICIPANTS, BENEFICIARIES, OR CLAIMANTS) – THE OUTBREAK PERIOD END DATE

If you'll recall, time frame extensions were granted in 2020, which stated that for plan participants, beneficiaries or claimants, the:

- Outbreak Period, beginning March 1, 2020, was disregarded in connection with the period to request HIPAA Special Enrollment
- 60-day election period for COBRA coverage
- date for making COBRA premium payments
- 60-day period for individuals to notify the plan of a COBRA-qualifying event or determination of disability
- date to file a benefit claim
- date to file an adverse benefit determination
- date for a claimant to file a request for an external review after the receipt of an adverse benefit determination or final adverse benefit determination, or
- date for a claimant to file information to file a request for external review upon finding that the request was not complete.

To keep you up to date, after I initially wrote this article, very important information was released by the Department of Labor in EBSA Disaster Relief Notice 2021-01. So that you understand the original information plus the update, I am going to attempt to frame this with "THEN and NOW" information, to be sure that you're not confused (at least as much as possible) with conflicting information that is out there. Of course it's confusing... it all changed with one notice release!

According to ERISA sections 518 and Code Section 7508A, the Secretary may, notwithstanding any other provision of law, prescribe, by notice or otherwise, a period of up to 1 year which must be disregarded in determining the date by which any action is required or permitted to be completed under this chapter. The IRS/DOL guidance states that subject to the statutory duration limitation in ERISA section 518 and Code Section 7508A, all group health plans, disability plans and other employee welfare benefit plans, and employee pension benefit plans subject to ERISA or the Code must disregard the period between March 1, 2020 until 60 days after the announced end of the National Emergency or such other date announced by the Agencies in a future notice (the "Outbreak Period").

What this means (or meant) is that with the March 1 start date in 2020, the period of one-year period defined in ERISA and the Code ended February 28, 2021, which, unless further extended by an agency extension, emergency order or other, means that the Outbreak Period should've ended on Feb. 28, 2021. This means anyone with pending COBRA elections and premium payments would be asked to pay up.

Because I heard so little talk about this in the industry, I asked two attorneys to tell me their thoughts on the ending of the Outbreak Period (again, this was prior to Notice 2021-01, so **THEN**). In a recent conversation with John Hickman, attorney from Alston & Bird in Atlanta, John responded, "While generally not well known, and absent further agency action, the Outbreak Period tolling should expire by statute, on Feb. 28, 2021. This means that any affected tolled periods (COBRA election period or premium payment period or claims submission period) will begin to run again, with any previously tolled periods tacked onto the end. The Outbreak Period is kind of like Groundhog Day. You wake up on March 1, 2021 and all tolled periods start to run again."

Marilyn Monahan of Monahan Law office felt the same. In a recent podcast we discussed this topic, where Marilyn stated "... the duration of the Outbreak Period would be subject to a one-year limitation that's contained in Section 518 of ERISA ... That being the case, based on a strict reading of the regulations, the Outbreak Period should end on Feb. 28, 2021." Marilyn continued, "However, events are changing rapidly these days in Washington, so keep your eye out about whether this period might be extended by the government."

I asked Hickman if the federal agencies would or could extend this Outbreak Period. Or could the new Biden Administration extend it by Executive Order? Is this something Congress can do? John responded: "Congress most certainly could extend the Outbreak Period, but it would take a hastily enacted law. The agencies are also currently considering their options. We understand that at least one of the tri-agencies believes that they are constrained by the 12-month period, because it is used for other statutory requirements as well. They will need to get creative to find a way to extend the relief."

As a former TPA executive, I have to think of the administrative considerations of the end of the Outbreak Period. I asked Hickman if he felt that health plans or their COBRA Administrators need to send notices to participants and COBRA qualified beneficiaries. "Much of the notice obligation will depend on the approach taken with regard to the Outbreak Period," he explained. "Was coverage continued (unlikely) or merely made available if an election/payment was made (generally the case)? Look at what was communicated previously and determine what should be communicated now. Back in mid-2020 neither the agencies nor TPAs considered the Outbreak Period would continue for a full 12 months. Under current COBRA law, some notices will most likely be required: coverage termination notices, premium contribution notices, etc., because situations vary based on past notices and practices, TPAs should seek the advice of counsel on these issues."

How does the end of the Outbreak Period impact Health FSA run out periods? Can plans voluntarily extend it? Hickman had this response: "In most cases the runout period for 2019 and 2020 plan years will resume (along with any tolled days) as of March 1. This means that the FSA TPA may have 3 separate years against which to process claims – 2019-2021."

So here is where it gets crazy!

Now we move on to the **NOW**... On Feb. 26, 2021, the DOL issued Notice 2021-01, which offered their very important and much needed interpretation of prior guidance. Under the new notice, the one-year limitation discussed above provides the ability to extend the deadlines through regulatory action to basically apply on an individual-by-individual basis! In the notice, the DOL interprets the Tolling Period to end the earlier of one year from the date the deadline would have begun running for that individual or 60 days from the end of the National Emergency. As we all know, the national emergency has not yet ended.

"Congress most certainly could extend the Outbreak Period, but it would take a hastily enacted law. The agencies are also currently considering their options."

— John Hickman

Let's dig into this a bit further... *What this means is that every person has his or her own "tolling period." So, the extension begins on the date that the clock would have started for a particular deadline, on a rolling basis.*

The DOL provided examples to illustrate the duration of the relief under the notices:

If a qualified beneficiary (QB) would have been required to make a COBRA election by March 1, 2020, the Notice delays requirement until Feb. 28, 2021, which is the earlier of 1 year from March 1, 2020 or the end of the Outbreak Period (still ongoing). Similarly, if a QB would have been required to make a COBRA election by March 1, 2021, the notice delays that election requirement until the earlier of one year from that date (i.e. March 1, 2022), or the end of the outbreak period. Likewise, if a plan would have been required to furnish a notice or disclosure by March 1, 2020, the relief under the Notices would end with respect to that notice or disclosure on Feb. 28, 2021. The responsible fiduciary would be required to ensure that the notice or disclosure was furnished on or before March 1 2021. In all of these examples, the delay for actions required or permitted that is provided by the Notices does not exceed one year.

"While the relief can be important in cases where 2020 FSA amounts remain unused, many employers have already incorporated the May 2020 IRS FSA relief and allowed an extended grace period for years ending in 2020, and for 2020 elections. So, whether the enhanced grace period/carryover relief is appealing to an employer will very much depend on whether unused amounts will still remain after any 'normal' or '2020 extended' grace period or carryover. Also, employers with HSA programs and HDHPs should take extreme care in coordinating their HSA eligibility with any enhanced grace period or carryover."

— John Hickman

So, what does all this mean for your TPAs, insurers or others when administering all of this? Think about it. They literally only had two days' notice (expected end date was Feb. 28 and the notice was released on Feb. 26, 2021). **So it's highly unlikely that they would have had time to do necessary programming to accommodate these changes! They will literally have to create custom COBRA, special enrollment and claims deadlines on a person-by-person basis.**

The DOL stated in the Notice that plan administrators or other fiduciaries "should consider affirmatively sending a notice regarding the end of the relief period." In addition, they stated, "plan disclosures issued prior to or during the pandemic may need to be reissued or amended if such disclosures failed to provide accurate information regarding time in which participants and beneficiaries were required to take action, e.g. COBRA election notices and claims procedure notices." They also encouraged plans to ensure that participants and beneficiaries losing coverage are made aware of other coverage options, such as marketplace coverage.

Marilyn Monahan was kind enough to give me an updated comment on these changes. "The new guidance will complicate plan administration, particularly with regard to COBRA, but also with regard to claims processing for medical benefits and health FSAs. Good record keeping, and working closely with your TPA and COBRA administrator, will be essential." Regarding the notices, Marilyn commented: "Implementing the new guidance will have to start with creating and distributing any necessary notices to explain when the Outbreak Period will end and participants will have to act."

I'm guessing a lot of extensions will need to be made, which is going to make this a very confusing, very difficult process, so stay tuned!

THE NEW STIMULUS BILL – CONSOLIDATED APPROPRIATIONS ACT OF 2021 (CAA)

The new CAA is extensive, with HR 133 containing 2,124 pages of bill text alone. The entire Act is 5,593 pages in length. For the purposes of this article, I will focus only on the employer plan sponsor and benefits perspective. Keep in mind, at this point we only have bill text. So, we have the "what" but until we have regulations and guidance, we do not have the "how." I'm sure some of the "how" will be released in the next few months.

CAA PROVISIONS TO EXTEND FFCRA - OPTIONAL

First, CAA has some provisions to extend provisions of the FFCRA related to paid leaves. As mentioned above, the two paid leave provisions in the FFCRA expired as of Dec. 31, 2020, which means that employees no longer have a right to paid leave and employers are no longer obligated to provide such leave in the event of a COVID-19 diagnosis. The CAA, however, gave employers the option to provide paid sick leave and receive a tax credit through March 31, 2021, under the terms and conditions set forth in the FFCRA. Note that this provision does not include any additional sick days. In short, employers had the choice of paying the applicable mandatory paid sick and family leave through Dec. 31, 2020, as previously required by FFCRA. Or they could've extended payment eligibility through March 31, 2021, subject to all other obligations under FFCRA. This also applies to self-employed individuals. **If employers should elect to extend the FFCRA paid sick leave provisions through March 31, 2021, they could then also extend the business tax credits for emergency paid sick leave or expanded family medical leave through that March 31, 2021, date.** (This would have otherwise ended on Dec. 31, 2020).

I would like to add as a personal comment that although CAA offered the option to continue the FFCRA leaves, employers hopefully didn't feel obligated. Let's face it; many employers had a terrible financial year in 2020 due to COVID-19 shutdowns, etc., and although they will get a tax credit for continuation of 2021 leaves through March, they still had to put the money out first, and many just simply couldn't afford that.

For self-employed individuals, they may now elect to use earnings from the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prior taxable year rather than the current taxable year for emergency paid sick leave or expanded family medical leave.

CAA PROVISIONS FOR CAFETERIA PLAN CHANGES — FSAS AND DCAPS — SUMMARY

The CAA provides for temporary relief for Health FSAs and Dependent Care Accounts, which allow participants to carry over any unused FSA funds from plan years ending in 2020 or 2021. Prior to this provision, DCAPs could not have a carry-over feature, and FSA accounts had a $550 limit. In essence, Health FSA and DCAP balances that are unused in 2020 may be carried over into 2021, and unused balances in 2021 may be carried over into 2022. This came about because people put off surgeries, overestimated dependent care amounts, etc. due to COVID-19. Note that the temporary relief provisions can be found in Pub. L. No. 116-260, Div. EE Section 214 (2020). You should also review 2020 relief under IRS Notice 2020-29.

Grace periods were also extended in the CAA for FSAs and DCAPs. Prior to the CAA, grace periods could extend for 2 1/2 months. Under CAA, for plan years ending in 2020 or 2021, the plan may extend their grace period to 12 months after the end of the plan year. Keep in mind, these selections are optional, and you should adopt Plan Amendments for all applicable CAA selections. The Relief Act does not address whether the extended grace period can be limited by plan design in amount or duration. Grace period guidance pre-COVID-19 allowed plan sponsors to limit their carryovers to a specified amount (such as no more than $1,500, or no more than $2,000). The 12-month grace period extension appears to be flexible, and employers may be able to adopt an extension less than the 12-month allowance. (Please consult with your legal counsel).

"The new guidance will complicate plan administration, particularly with regard to COBRA, but also with regard to claims processing for medical benefits and health FSAs. Good record keeping, and working closely with your TPA and COBRA administrator, will be essential."

—Marilyn Monahan

FSAs can have a carryover or grace period, but not both. Your carryover or grace periods can impact HSA eligibility in the following year.

Another important provision is that ongoing grace period coverage in a general-purpose health FSA would make an individual ineligible for an HSA for the entire period of coverage. This also applies to the carryover.

Health FSAs have post-termination reimbursement provisions under CAA. If an employee terminates participation in a health FSA during the 2020 or 2021 calendar year, the individual may continue to receive reimbursements from unused FSA account balances through the end of the plan year, including any grace periods.

In the CAA, the DCAP plan may change the age of a "qualified individual" for DCAP reimbursement purposes. For dependents who have aged out of eligibility during the COVID-19 pandemic, plans may extend the maximum age limit to age 14 (previously it was age 13). This applies during the last plan year with a regular enrollment period ending on or before January 31, 2020. The same relief applies for the next plan year, but only for unused grace period amounts from the 2020 plan year or other amounts carried over into the 2021 plan year.

In my recent conversation with Hickman, we discussed the extent of provisions on FSA relief, carryover, post termination FSA spend-downs, expansions of eligible DCAP from age 12 to 13, as well as election changes in plan years ending in 2021 under the CAA. He discussed "Points to Ponder" in a recent update he did on the CAA. I asked if he would share his thoughts on whether Amendments should be adopted, timing considerations and TPA capabilities. "Sure," stated John. "While the relief can be important in cases where 2020 FSA amounts remain unused, many employers have already incorporated the May 2020 IRS FSA relief and allowed an extended grace period for years ending in 2020, and for 2020 elections. So, whether the enhanced grace period/carryover relief is appealing to an employer will very much depend on whether unused amounts will still remain after any 'normal' or '2020 extended' grace period or carryover. Also, employers with HSA programs and HDHPs should take extreme care in coordinating their HSA eligibility with any enhanced grace period or carryover."

STUDENT LOAN REPAYMENT EXTENSION

The Internal Revenue Code (IRC) allows for employers to set up an educational assistance program under section 127 of the Code. Prior to the CARES Act, this program could only be used for tuition reimbursement. The CARES Act allowed employers to also reimburse for student loan debt, but that provision has since expired (as of January 1, 2021).

The CAA extends the CARES Act tuition assistance program change through December 31, 2025. The maximum is $5,250 for both tuition and student loan repayment, allowing the employer to contribute up to the $5,250 on student loans on a tax-free basis, and such payment would be excluded from the employee's income. This change has captured the interest of tech companies and other companies; particularly those that tend to hire engineers or other tech positions straight out of college. Some of these companies may not be able to compete with other firms on salary, but offering to reimburse for student loan debt could help in their recruiting efforts.

This provision applies to any student loan payments made by an employer on behalf of the employee after the date of enactment and before Jan. 1, 2026.

In order for an employer to use this provision, they must first set up a written Section 127 Plan Document and follow the applicable rules established by the IRC.

SURPRISE BILLING

Surprise billing in the No Surprises Act, which was part of the CAA, seeks to protect patients from surprise medical bills in situations where patients have little or no control over who provides their care. This includes non-emergency services provided by out-of-network (OON) providers and in-network facilities, emergency services provided by OON providers, and facilities, and air ambulance services. Surprise billing practices are commonly known to undermine the control and affordability of a health plan, take advantage of people when they are the most vulnerable, and jeopardizes the overall satisfaction of the employer sponsored health plan. In these circumstances, plan participants/patients should not be penalized for the services that were provided outside of their control, such as an ER physician, an anesthesiologist, or lab work that could not be completed in a PPO lab and was sent elsewhere. Previously we had the No Surprises Act of 2019, and 17 states now have passed laws on balance billing. The applicability is for plan years on or after Jan. 1, 2022, for group health plans and group health insurers. It applies to grandfathered and non-grandfathered health plans, but does not apply to excepted benefits or retiree health plans.

The No Surprises Act mandates that in-network cost sharing applies to out-of-network services in the following circumstances:

- Emergency services at a hospital emergency department (ED)/freestanding ED*
- Ancillary services provided by an out-of-network provider at an in-network facility*
- Non-emergency services performed by an out-of-network provider in an in-network facility (exceptions apply if provider provides notice and individual consents to using an out-of-network provider, or not applicable to ancillary services or services arising from unforeseen, urgent medical needs)*
- Cost sharing counted as if in-network
- In-network coinsurance is based on the "recognized amount"
- Providers may not balance bill the amount in excess of the in-network cost sharing for the services listed above.

Under this Act, "certain services*" includes emergency medicine, anesthesiologist, pathology, radiology, neonatology, assistant surgeon, hospitals, intensivisits, diagnostic services (x-ray/lab) services for which there is no in-network provider available, and other services as directed by the Secretary.

The No Surprises Act requires plans to make an initial payment or make an initial denial within 30 days; the provider or health plan must open negotiations regarding any cost dispute within the 30 days of receiving an initial payment or denial. If negotiations fail, a 30-day cooling off period happens, followed by a "baseball-style" independent arbitration, where each side submits a payment offer and the arbitrator chooses which side is acceptable.

In the event of an air ambulance service, similar rules will apply (not applicable to ground ambulances). The air ambulance must report to HHS/DOT, and plans must report to DOL/HHS/IRS.

The No Surprises Act requires advance EOB disclosures. Upon receiving notice from a provider or facility of scheduled services or a request form a participant or beneficiary, the plan must notify the participant or beneficiary within the applicable timeframe, and provide the following information:

- Whether the provider/facility is in-network or OON
- A good-faith cost estimate of the amount the plan will pay and the amount of the individual's cost-sharing
- A good faith estimate of the amounts the individual has incurred towards financial limitations such as deductibles and out-of-pocket accumulations
- A disclaimer if a medical management technique is applied
- A disclaimer that this is just an estimate
- Other pertinent or relevant information

Consumer Protection Provisions in the No Surprises Act include transparency for all patients, consistent with the Transparency in Coverage Rules, which I discussed in detail in a previous article.

In general, the consumer protection provisions include transparency for in-network and out-of-network provisions and out-of-pocket provisions, the maintenance of a price comparison tool (see my prior Transparency in Coverage article for details), provider directory information (web-based), and disclosure of billing protections within your state.

BROKER/AGENT COMPENSATION DISCLOSURE

The CAA also includes significant broker compensation disclosure requirements, effective one year from enactment, or Dec. 27, 2021. This disclosure provision modifies ERISA to add a disclosure requirement of both direct or indirect compensation by brokers or consultants, if they enter into a contract or arrangement with a group health plan, or reasonably expect broker services or consulting compensation to equal $1,000 or more per year (group health plan insurance commissions would likely count toward the $1,000 threshold in all cases). Compensation includes anything of monetary value, but does not include non-monetary compensation valued at $250 or less, in aggregate, during the contract term. The broker and consultant disclosure requirements include health plans, which would include excepted benefits like stand-alone dental and vision, health FSAs, EAPs, and HRAs.

Disclosure is required under Section 408(b)(2) of ERISA and is very similar to retirement plan disclosures that have been required since 2012.

In summary, the broker/consultant must provide in advance of the contract date to the employer/plan sponsor all expected compensation, and communicate any changes no later than 60 days from the date the broker is aware of the change, or upon written request. Brokers/consultants will be required to provide a disclosure notice to each client.

CONTENT OF DISCLOSURE

In general, the CAA Broker compensation disclosure notice must include:

- A description of services (what are you doing for your client?)

- A statement indicating if the broker/consultant plans to offer fiduciary services to the plan, if applicable (yes or no – in most cases, this should be NO for most brokers)
- All direct compensation, in the aggregate, or by service
- All indirect compensation, including vendor incentive payments, a description of the arrangement under with the compensation is paid, the payer name, and any services for which compensation will be received
- Any transactional-based compensation, for example, commissions, finder's fees for services and the payers and recipients of the compensation
- A description of any compensation expected with regard to the contract's termination

Note that bonuses and overrides, etc. were not clearly specified in the bill text. The coming regulations/rules/guidance should give us more clarity on this.

SERVICES INCLUDED

In general, the services you provide to your clients must be included in your disclosure notice. Examples of services include, but are not limited to:

- Development or implementation of plan design, insurance or insurance selection
- Recordkeeping services
- Medical Management vendor
- Benefits Administration (including dental and vision)*
- Stop-loss insurance placement or recommendations
- PBM services
- Wellness program services
- Transparency tools and vendors
- Group purchasing organization preferred vendor panels
- Disease management vendors or products
- Compliance services
- EAP Programs
- Third Party Administration (TPA) services *

Consulting services are nearly identical to the brokerage services, but do not need to involve the actual broker services. At this time, it is unclear whether "consulting" just involves brokers serving in a consulting capacity (for example, consulting for a self-insured employer in a self-funded health plan), or other service providers who "consult" such as TPA consulting on plan design or implementation. We assume that further guidance will be coming soon.

I'd like to point out that in many states, including California, administration services (indicated by the asterisks above) require a license, and in many cases, providing administrative services that would be covered under that license as a broker could be considered prohibited transactions under ERISA (but that is a topic for another article on another day). I also wanted to mention that in California, the Department of Insurance issued a bulletin some time ago that basically states that for insured products, if you're getting a commission, you cannot also take a fee, unless you are doing other services. So please check with your legal counsel to determine what you can and cannot charge fees for (self-funded plans with ERISA jurisdiction are separate and fees and stop loss commissions are acceptable and common).

Direct compensation is defined as compensation from the plan itself, through plan assets. Amounts paid by the plan sponsor/employer would not be considered plan assets, but participant contributions, keep in mind, are always plan assets.

Indirect compensation is generally amounts received from anyone other than the plan or the employer/plan sponsor. For example, if a consultant receives compensation from an insurance carrier, an industry vendor, or TPA not in the form of commissions.

I know that many brokers are in panic mode about these disclosure requirements. I, however, welcome them. I guess that is because I have worked in

I would recommend that brokers/ consultants begin now to identify all group health plans where broker or consulting services are provided, to determine all sources of direct and indirect compensation, and determine all compensation that meets the $1,000 threshold. Then, you should begin to design your disclosure notice and determine the best way to produce this to your clients.

the ERISA world for all of my career, where disclosure is already required in most cases (particularly over 100 lives). I believe that this disclosure requirement is actually a way to show your value as a broker and consultant. If you provide fewer services than many other brokers, this could alarm you, but if you are providing a number of services for your clients, this should be a way to prove your worth to your clients.

I would recommend that brokers/consultants begin now to identify all group health plans where broker or consulting services are provided, to determine all sources of direct and indirect compensation, and determine all compensation that meets the $1,000 threshold. Then, you should begin to design your disclosure notice and determine the best way to produce this to your clients. For most, particularly large agencies, this would be easier if automated, so that timely disclosures can be provided at the end of the year.

"The new guidance will complicate plan administration, particularly with regard to COBRA, but also with regard to claims processing for medical benefits and health FSAs. Good record keeping, and working closely with your TPA and COBRA administrator, will be essential."

—Marilyn Monahan

TRANSPARENCY

There are four significant provisions of Division BB of the CAA, Gag Clauses (effective Jan. 1, 2021), Compensation Disclosure (effective Dec. 27, 2021), Mental Health Parity (effective Feb. 10, 2021, and Pharmacy Benefit & Drug Cost Reporting (effective Dec. 27, 2021). The gag clause section states that health plans may not enter into an agreement with a provider, TPA or other service provider that would restrict the plan (directly or indirectly) from providing provider-specific cost or quality of care information or data, electronically accessing de-identified claims and encounter information, and sharing such information with a business associate. I discussed the compensation disclosure in the broker disclosure section. The Mental Health Parity section states that group and individual plans that provide medical and surgical benefits and mental health/substance abuse benefits must perform and document comparative analysis. The pharmacy benefit section requires plans to disclose the cost of commonly prescribed medications annually. These are only simple explanations of the transparency requirements in the CAA.

UNEMPLOYMENT PROVISIONS

The CAA includes an extension and phase-out of unemployment benefits, including extending benefits to current recipients with benefits remaining to March 14, 2021, including relief for governmental entities and nonprofit organizations.

The CAA provisions limit unemployment assistance to any week prior to April 5, 2021, and increases the number of weeks from 39 to 50. In addition, it adds additional unemployment funding of $300 per week for weeks of unemployment beginning on or after Dec. 26, 2020, and ending before March 14, 2021.

GRANDFATHERED HEALTH PLANS – FINAL RULES

On Dec. 11, 2020, the U.S. Departments of Labor, Health & Human Services, and Treasury released the final rule for Grandfathered Health Plans. The final rule amends the requirements for grandfathered group health plans and grandfathered group health insurance coverage to preserve their grandfathered status.

The final rule provides greater flexibility to increase cost-sharing amounts without loss of grandfather status; for example, you could increase the deductible of a HDHP to comply with HSA limits, or you could use a new standard for calculating increases in co-pays. The final rule applies to plan changes that are effective on/after 6/15/21.

Grandfathered plans are subject to the ACA's requirements, such as the prohibition on pre-existing conditions and prohibitions on waiting periods that exceed 90 days, the prohibition on lifetime or annual dollar limits, the prohibition on rescissions, and the requirement for plans that offer dependent coverage of children do so up to the age of 26, but grandfathered plans are exempt from certain other requirements.

The final rule clarifies that grandfathered group health plans that are High Deductible Health Plans (HDHP) may increase fixed-dollar amount cost sharing requirements, such as deductibles, to the extent necessary to maintain its status as a HDHP, without losing grandfathered status.

The final rule provides for an alternate method of measuring permitted increases in fixed-amount cost-sharing that allows plans and issuers to better account for changes in the costs of health coverage over time.

Provisions in the 2015 final rules specify circumstances which changes to terms will cause the plans to cease to be a grandfathered plan, including the elimination of all or substantially all benefits to diagnose or treat a particular condition; any increase in a % cost-sharing requirement (such as co-insurance), any increase in a fixed-amount cost-sharing requirement (other than a co-payment), such as a deductible or OOP Maximum that exceeds certain thresholds, any increase in a fixed-amount co-payment that exceeds certain thresholds, a decrease in contribution rate toward the cost of coverage of any tier of coverage for any class of similarly situated individuals by more than 5%, and the imposition of annual limits on the dollar value of all benefits for group health plans and insurance coverage that did not impose such a limit prior to March 23, 2010.

High Deductible Health Plan (HDHP) Changes: The 2020 final rules include amendments to the 2015 Final Rules for HDHP limits, including: an increase to fixed-amount cost-sharing requirements effective on/after 6/15/21 will not cause the plan to relinquish its grandfather status—but only to the extent such increases are necessary to maintain its status as an HDHP under IRC section 223.

● IRS Example: A grandfathered HDHP had a $2,400 deductible for family coverage on 3/23/10. The plan is amended after 6/15/21 to increase the deductible limit by the amount that is necessary to comply with the requirements for a plan to qualify as an HDHP under section 223(c)(2)(A). This change exceeds the maximum percentage increase under the Grandfathered regulations.

● IRS Conclusion: The increase in the deductible at that time does not cause the plan to cease to be a grandfathered health plan because the increase was necessary for the plan to continue to satisfy the definition of an HDHP under section 223(c)(2)(A).

An important note related to this provision: *The annual cost-of-living adjustment to the required minimum deductible for an HDHP has not yet exceeded the maximum percentage increase that would cause an HDHP to lose grandfather status—but it may in the future, causing participants to lose HSA eligibility—and that is the reason for the change in the regulations.*

AMENDMENTS TO THE 2015 FINAL RULES:

There was a new definition of maximum percentage increase provided in the final rules, which allowed for a new Fixed Amount Cost-Sharing provision. Under the 2015 rules, there is a formula for plans used to determine if the fixed cost-sharing amount exceeds certain limits; if the plan exceeds the limits, the plan uses status. The formula relies on the "maximum percentage increase." Under the 2015 rules, the maximum percentage increase is medical inflation from 3/23/10 (tied to CPI-U) plus 15 percentage points. Under the new rules, on or after 6/15/21, the maximum percentage increase is the greater of (a) the current standard or (b) the change in the premium adjustment percentage plus 15 percentage points. So why the change? In essence, according to Monahan, the alternative standard is considered a better reflection of the cost of group coverage.

In other amendments to the 2015 Final Rule, a new Definition of Maximum Percentage Increase was defined. To best describe the new definition of maximum percentage increase, I'm going to use two of the examples from the regulations, and the analysis done by my benefits attorney, Marilyn Monahan (with her permission) in a recent webinar we did jointly, which was modified slightly for educational purposes.

● Example 4—Facts: On 3/23/10, a grandfathered plan charges a copayment of $30 per office visit for specialists; this is later increased to $40. The plan subsequently increases the $40 copayment requirement to $45 for a later plan year, effective before 6/15/21. Within the 12-month period before the $45 copayment takes effect, the greatest value of the overall medical care component of the CPI–U (unadjusted) is 485.

● Conclusion: The increase in the copayment from $30 to $45, expressed as a percentage, is 50% (45 - 30 = 15; 15 ÷ 30 = 0.5; 0.5 = 50%).

● Medical inflation from March 2010 is 0.2527 (485 - 387.142 = 97.858; 97.858 ÷ 387.142 = 0.2527).

● The increase that would cause a plan to cease to be a grandfathered health plan is the greater of the maximum percentage increase of 40.27% (0.2527 = 25.27%; 25.27% + 15% = 40.27%), or $6.26 (5 × 0.2527 = $1.26; $1.26 + $5 = $6.26).

● Because 50% exceeds 40.27% and $15 exceeds $6.26, the change in the copayment at that time causes the plan to cease to be a GR health plan.

● Example 5—Facts: Same facts as Example 4, except the grandfathered group health plan increases the copayment to $45, effective after 6/15/21. The greatest value of the overall medical care component of the CPI–U (unadjusted) in the preceding 12-month period is still 485. In the calendar year that includes the effective date of the increase, the applicable portion of the premium adjustment percentage is 36%.

● Conclusion: In this Example 5, the grandfathered health plan may increase the copayment by the greater of: Medical inflation, expressed as a percentage, plus 15 percentage points; or the applicable portion of the premium adjustment percentage for the calendar year that includes the effective date of the increase, plus 15 percentage points. The latter amount is greater because it results in a 51% maximum percentage increase (36% + 15% = 51%) and, as demonstrated in Example 4, determining the maximum percentage increase using medical inflation yields a result of 40.27%. The increase in the copayment, expressed as a percentage, is 50% (45 - 30 = 15; 15 ÷ 30 = 0.5; 0.5 = 50%). Because the 50% increase in the copayment is less than the 51% maximum percentage increase, the change in the copayment requirement at that time does not cause the plan to cease to be a grandfathered health plan.

Note: The percentages used are hypotheticals.

I've obviously shared a lot of information, which may take you a bit of time to absorb. The best thing I can tell you is to stay tuned, because the way things are changing, this could all be modified in the coming weeks and months, as new rules, technical releases, guidance and FAQs are released. Until then, to everyone out there, stay safe and stay healthy!

Author's Note & Disclaimer: I'd like to thank attorneys Marilyn Monahan of Monahan Law Office and John Hickman of Alston & Bird for their assistance with this article. The information contained in this article is informational only and should not be construed as legal advice. We always recommend that you work with your legal counsel as situations vary.

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Boosting Your Workforces' Productivity and Wellness: It Starts With Vision

BY JONATHAN ORMSBY

Workplace wellness initiatives are not a new trend, but they are on the rise. According to a recent report by Allied Market Research, the global workplace wellness industry is expected to hit $74 billion by 2026. While workplace wellness includes many initiatives—such as catered healthy food options, standing desks, paid or discounted gym memberships and more—one initiative that is being overlooked is healthy vision.

Comprehensive eye exams identifying common problems with vision—such as trouble seeing up close or far away—are also a way to detect eye diseases and serious overall health issues while it's still early enough to seek treatment and save on medical costs.

The 2020 Transitions Optical Workplace Wellness survey found that half of employees say the top way to improve their overall productivity and quality of work would be encouragement by employers to take breaks to rest their eyes and prevent eye strain. However, only one-third of their employers are actually implementing this. With employees saying that workplace eye health is so important—and particularly younger generations who are making up an increasing portion of the workplace—now is the opportunity to arm employers with the tools they need to implement a successful workplace wellness program, including offering comprehensive vision benefits plans that cover premium eyewear options.

GIVING A PRODUCTIVITY AND HEALTH BOOST TO EMPLOYEE EYES

In the Workplace Wellness survey, not only did employees say that resting their eyes is something that would help productivity and quality of work, but half also said that it would improve their overall health. And they're right, considering that the American Academy of Ophthalmology (AAO) notes that staring at screens and digital devices for long periods of time may cause dry and tired eyes, as well as blurry vision, fatigue or eyestrain. Employees in the survey validated this, as almost three-quarters of those surveyed say they frequently experience digital eye strain in the workplace—with eight in 10 saying they experience negative symptoms from looking at a screen all day including eyestrain, back, neck and shoulder pain and headaches. When employees can't see well, they can't work well. The AAO suggests taking regular breaks using the "20-20-20" rule: every 20 minutes, moving eyes to look at an object at least 20 feet away, for at least 20 seconds.

Not only does poor vision impact work, but it also impacts overall health. In addition to comprehensive eye exams identifying common problems with vision—such as trouble seeing up close or far away—exams are also a way to detect eye diseases and serious overall health issues while it's still early enough to seek treatment and save on medical costs. The Workplace Wellness survey revealed nine in 10 employees say they're likely to get a comprehensive eye exam in the next year—but only half of Gen Z employees are very likely. With these workers showing interest in eye health (88% of Gen Z employees noted the importance of resting eyes at work), now is the time to keep them informed on the benefits of a comprehensive eye exam, which could detect common eye diseases like cataract, glaucoma and age-related macular degeneration, as well as serious and costly health conditions such as diabetes and hypertension (also known as high blood pressure).

ADDITIONAL WAYS TO PROTECT EYES WITH PREMIUM BENEFITS

In addition to implementing a workplace wellness program that includes encouraging breaks to protect and rest eyes, employers should also offer comprehensive vision benefits plans that cover premium eyewear options to alleviate common visual problems, followed closely by ongoing education about the importance of sight-enhancing eyeglass lens options.

Employees not only need vision benefits—they want them, and they're more likely to engage with employers who offer them. In fact, nearly two in three employees say they would be more likely to accept a job offering vision benefits. Brand name matters, as well. Eight in 10 employees say they'd be more likely to enroll in or keep a vision plan that covers eyewear options like Transitions® Light Intelligent Lenses™. And, seven in 10 say it's important to have authentic Transitions® brand lenses covered by their company's vision plan.

The most desired premium lens options include:

- **Anti-reflective or no-glare coatings: 62%**
- **Photochromic lenses, like Transitions lenses: 37%**

These automatically adapt their level of tint to changing ultraviolet (UV) light and offer additional protection from harmful blue light and glare, both indoors and out)

- **Blue light protection: 31%**

Older generations are especially interested in these types of premium lenses, with six in 10 Gen X employees and seven in 10 Boomers wanting no-glare coatings. This is an opportunity to reach and educate younger generations about the benefits these types of lenses bring, in addition to encouraging them to get a yearly eye exam.

VISION AND WELLNESS GO HAND IN HAND

Today's workforce is savvier than ever when it comes to overall health and wellness, and they know protecting their eyes is crucial—especially as screen usage continues to increase. It's essential for today's employers to offer these wellness initiatives, including comprehensive vision benefits. Low in cost, they offer a high return-on-investment for employers. Vision benefits can help to save on medical costs, boost employee productivity, and can even help to attract and retain top talent.

To help elevate the importance of comprehensive eye exams and quality eyewear available through vision benefits, Transitions Optical offers a variety of employee and employer focused tools and education. These can be accessed, free of charge, at **HealthySightWorkingforYou.org.**

JONATHAN ORMSBY *is a key account manager for Transitions Optical, and 14-year veteran of the optical industry.*

How to Fix the Vision Benefits Industry Through AI Technology

A Q&A with XP Health CEO and Co-Founder Antonio Moraes

The user experience was very inconvenient and not transparent.

STARTUP XP HEALTH is touted as the world's only artificial intelligence-powered vision benefits platform covering employees and their families. Curious what that means? So were we.

California Broker magazine caught up with XP Health CEO and co-founder Antonio Moraes. Moraes is an international author, speaker, investor, and serial entrepreneur. He previously co-founded Vox Capital, a healthcare innovation fund that became a Harvard Business School and Harvard Kennedy School case study. As a speaker, he has addressed more than 20,000 people at events such as the World Economic Forum, Harvard Business School, Stanford University, MIT and others. We wanted to find out more about XP Health and how it aims to lower costs with vision benefits and provide a better experience with vision care and maintenance.

California Broker: *What is the problem you have identified in the vision benefits category that led you to found XP Health?*

Antonio Moraes: Before XP Health, my business partner James Wong and I identified a crucial problem in the vision care and benefits space. We saw that the costs for vision care and benefits were going up each year, with people paying more than $300 on average for a pair of glasses, even after using their insurance!

Also, the user experience was very inconvenient and not transparent. That's when we started developing our AI technology to help people find the perfect pair of glasses for them. Suddenly many large tech companies began to see our solution as a way to enhance their existing vision plans and provide a better employee experience and help them save money.

CB: *Could you walk us through how your solution works?*

Moraes: At XP Health, we developed the world's only AI-powered vision benefits platform that is made specifically for companies and their employees and their family members. Through our AI platform, we've made it easier and more affordable for all employees to get frames from the world's leading designers and high-quality lenses from the convenience of their homes or offices.

We created a vertically integrated business model that eliminates intermediaries. This can reduce costs by up to 40% and increase a company's existing vision benefits coverage by an average of 10X.

Further, because of our AI platform, one key benefit is that you don't have to go to a physical store to buy glasses. We provide a 100% digital experience for vision care safely from the employees' home, customized with the company's brand. We're proud of our very user-friendly modern interface that makes accessing vision benefits easier and takes the guesswork out of the equation by transparently communicating to the employee their remaining vision care benefits.

Another critical factor with XP Health is that we provide personal stylists assigned and dedicated to each employer. These stylists help the client try-on up to six pairs of frames from some of the world's leading designers like Tom Ford, Ray-Ban, Armani, Gucci, and Coach, with a prepaid return label included. And because of our proprietary deep learning model that uses facial recognition technology, we can recommend the best frames based on facial dimensions with 98% accuracy.

We also offer onsite care to our clients, bringing a complete vision care experience to their offices. Companies are seeing this service as a tremendous welcome-back-to-the-office gift to their employees.

CB: *Who is your typical customer? What size are the businesses that use your solution?*

Moraes: Our typical clients are companies that want to provide the best employee experience and benefits. Most of them are in the tech, biotech, financial services and service industries.

CB: *How many customers do you have now? How have you been growing thanks to COVID and the move to virtual care?*

Moraes: Between our digital and onsite services, we have over 30 clients, including some very familiar ones in Silicon Valley like Zoom, Chegg and Sequoia Consulting Group. Each of the companies we are honored to work with has noted the benefits of using the XP Health platform.

CB: *How have you seen the health tech space evolve in recent years? Where do you see it going, and how will XP Health help it get there?*

Moraes: Some of the main trends in the health tech space that I see are:
1) a growing adoption of telemedicine across many different areas
2) consumerization of services and products, with user-centric design becoming more and more a central piece in this process
3) innovations that improve outcomes without leading to higher costs (and ideally reducing costs).

XP Health is working on all these fronts in the vision space, intending to make high-quality vision care accessible to everyone and providing the best experiences in the category. CB

ANTONIO MORAES is *also the co-author of the movie "A New Capitalism," a documentary about entrepreneurs who advocate for profitable businesses that tackle social inequality. Check it out on Netflix, Amazon Prime and iTunes.*

The Origins of LAAHU's Diversity, Equity and Inclusion Committee

Industry Leaders Step Up to Tackle Something Necessary

Los Angeles Association of Health Writers (LAAHU) has launched a new committee called **Diversity, Equity and Inclusion** (DEI). The committee has been doing great work with hosting lunch Zoom discussions, a new book club and more.

LAAHU's vision with DEI is succinct: “LAAHU is a diverse community of health insurance and benefits professionals committed to equity and inclusiveness for all its members and those whom they serve.”

On the following pages members of the DEI committee share what motivated them to get involved. Thank you to:

Dr. Jezabel Urbina, Latin X, senior at Blue Shield CA

Ross Pendergraft, senior vice president, Leavitt Group

June Taylor, senior sales executive, regional sales & broker relations, Kaiser Permanente

Jezabel Urbina, DrPH, MPH, Latin X, senior at Blue Shield of California

Ross Pendergraft, senior vice president, Leavitt Group

June Taylor, senior sales executive, regional sales & broker relations, Kaiser Permanente

California Broker: What made you interested in getting involved in DEI? Was there a pivotal point?

Dr. Urbina, Blue Shield:
"My interest in getting involved with DEI started four years ago when there was political talk about certain races or immigrants being called rapists and drug dealers and such. So, that's pretty much why I got involved—because of the inequities and the health disparities involved due to stereotypes and racism. Having worked in hospitals, I know firsthand that the immigrant population is the least likely to use medical services, because they're very frightened and scared to be honest."

Pendergraft, Leavitt Group:
"What's my story? Good trouble. Lots of good trouble. [Akin to the late civil rights hero Congressman John Lewis]. The George Floyd incident and the subsequent movement started our conversation. Whether any of us like it or not, we have a problem with racism in the United States. We have to learn how to get rid of racism and learn how to bring unity to all the people living here. Our book club that we just started in March addresses three out of the four of the DEI initiatives: training, communications and mentorship. Essentially this book club is going to bring a bunch of people together who may not believe they are racist, but may become aware of subtle and not-so-subtle biases. It's really a book on how to unify. The author, Miles McPherson, preaches that we have to learn how to deal with things we don't like. We have to learn how to communicate with people who have different ideas from us. We don't realize all the elusive conditioning."

CB: It's time for all people to have a better understanding of what is racism from the inside out—from the perspective of the people being disrespected. We need to be able to have these difficult conversations. "What are my boundaries? What are my beliefs? Am I doing something that is offensive, harmful or abrasive to others in some way?" It seems like this is the first step to reconciliation and healing.

Taylor, Kaiser Permanente:
Exactly. I too was inspired by George Floyd's death. As an African-American mother of three sons there's not a day that goes by that I do not think about their safety. When George Floyd screamed out 'I can't breathe' and called for his mother, every Black mother in America could feel the weight of his words, and our hearts were saddened that day.

Brian Sullivan, the president of LAAHU, was kind enough to open a forum for those members who wanted to express what they were feeling regarding the incident. And I had to speak up. From that meeting the DEI committee was formed, and I was asked to lead the charge.

I'm excited about the work that I will be doing this coming year with Ross, Jezabel and NAHU DEI Chair Wayne Guzman. We're eager to roll out our

"Whether any of us like it or not, we have a problem with racism in the United States. We have to learn how to get rid of racism and learn how to bring unity to all the people living here." — Ross Pendergraft

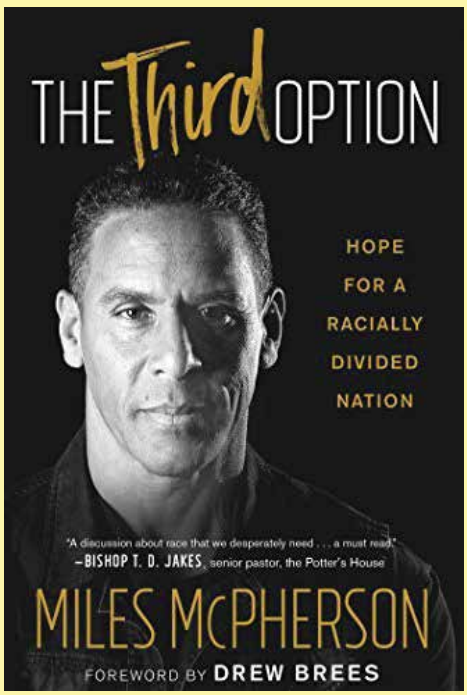
eight initiatives to guide our efforts. We look forward to sharing our progress with California Broker readers throughout the year. And we are hoping to get more people involved with our association!

CB: Would you give us an example of your own experience of racism?

Dr. Urbina, Blue Shield:
There was a research study done that found people of color have a longer wait time to get an appointment to see a doctor than a white person—it was some ridiculously high statistic. That just reminded me of a time in my very early 20s when I was a single mom. I called a doctor's office to make an appointment. They asked me, 'what insurance do you have?' I said, 'Medicaid.' 'Okay, well we don't have anything available until April,' which was about four months away. And then I asked, ' what if I have a PPO?' and they said 'we have an appointment two weeks from now.' So, people don't really understand that it's things like that that make a huge difference. Why should what insurance you have be a determining factor of when you can receive care? And who is more likely to have a PPO, right? So, I'm very involved in research because I spent so many years in college doing research. Data can show us how these subtle and not-so-subtle behaviors translate into effects on minority populations.

CB: Can you give us a peek into what else you're up to?

Taylor, Kaiser:
We also have our mentorship initiative. Along with recruiting from the Cal State Colleges and community colleges, we want to reach out to millennials to give them more insight into our industry and all the great benefits that come with it. There's so much opportunity here! This industry was a life changer for me. I went to UC Irvine and got my degree and I came into this industry after I had my first son. And I said, 'Okay I'm going to do this until I get a real job.' Eventually, though, I realized this industry was the best thing that ever happened to me. I just want to see others have that same opportunity. CB



Join the Book Club!

Sponsored by Dickerson Insurance Services, LAAHU's DEI Book Club will run through September. The group is reading and discussing The Third Option by Miles McPherson. McPherson, a former defensive back for the San Diego Chargers, is the pastor of The Rock Church. The group plans to culminate their discussion by taking a trip down to San Diego to meet the author. All are welcome in the club. Register at **www.laahu.org.**

Enhancing Your Client's Retirement Picture

Safe & Secure: Why Fee-Based Advisors Should Embrace Annuities

BY SHANNON STONE

I'm a financial advisor with DHR investment Counsel, a fee-only advisor, located in Oakland, California. Until recently, we rarely recommended annuities to our clients. Most were too costly and complex and didn't fit our fiduciary model. But with the persistence of low interest rates, COVID-19 and a wave of clients seeking secure income in retirement, we've had to take a look. Both the advent of commission-free insurance products and significant academic research supporting the use of annuities as part of the planning process means we are now more regularly recommending annuities as part of our financial plans.

Today, annuities are part of our overall planning toolkit and we often recommend them as part of a client's asset allocation. We recommend commission free annuities which are different from the legacy commissioned base annuities so many of us avoided in the past.

THE ANNUITY STIGMA

In the past we occasionally used investment-only variable annuities in our clients' portfolios, but rarely used them to generate guaranteed income.

Like many other advisors, we felt annuities carried a stigma due to high commissions. We also felt they were difficult products to understand and were not user-friendly or advisor friendly. We were also concerned about liquidity and the lack of access due to high surrender charges. We weren't alone in not fully understanding them—we've had clients come to us who owned a $50,000 or $100,000 annuity, yet they don't recall why they purchased it.

RETIREES WANT INCOME

In our experience, people want income in retirement. They want to feel secure and safe. With interest rates as low as they are, we've looked more closely at annuities to see how they can enhance a client's retirement picture and build future retirement income. We are now modelling annuities in our financial planning software and the results have been dramatic. Introducing another source of fixed income into a client's portfolio can dramatically change the total retirement picture.

Research from academics like Wade Pfau, Michael Finke, Robert Merton and others have helped us better understand strategies around funding efficient retirement income with annuities. That research supports annuities as a partial bond replacement in a traditional asset allocation to cover an individual's non-discretionary spending. It makes a lot of sense and can give a client comfort to know that their basic expenses are taken care of.

Today, annuities are part of our overall planning toolkit and we often recommend them as part of a client's asset allocation. We recommend commission free annuities which are different from the legacy commission-based annuities so many of us avoided in the past. When you can strip away the commission, it can have a significant effect on the end benefit to the client.

CONVINCING CLIENTS

The challenge comes in overcoming client objections to annuities, because of their historical reputation. Many of our clients have heard of annuities, and all they know is to stay away from them.

It often takes a couple of conversations to lay the groundwork and show them how they could benefit them. Clients really come around when we are able to show them, using financial planning software, the results of multiple scenarios with and without an annuity. It becomes visibly clear what an annuity could do for their overall outcome.

In one specific case, I worked with someone in a local school district who, prior to hiring our firm, had suffered investment losses. An annuity was a great way for him to secure another source of income in addition to his pension. Even after realizing the investment losses, our plan, including an annuity, gave him new hope that he'd be able to retire when he hopes to.

In multiple cases, my clients need to see the results modelled in our software compared to their alternatives. This grabs their attention.

CONSIDER A PARTNER

I know other fee-only advisors who remain skeptical about using annuities. Annuities can be complex, and based on past experience and training, many advisors are simply dismissive. But they'd be surprised at the solutions available to meet clients' needs.

What is true is that it can be hard to explore all the possibilities for your clients if you aren't a specialist. To address this challenge, we work with a partner to help us do our due diligence and research. When considering an annuity for our clients, we engage with DPL Financial Partners, a platform offering commission-fee insurance products, to support us and help us find the right solutions.

I think one of the most valuable pieces of our partnership with DPL is the educational piece. The illustrations and education on various solutions have raised our awareness of all aspects of the products and their uses.

As fiduciary advisors, we have to consider what is best for our clients. We found we can't ignore annuities. Now that we are regularly including them in our clients' financial plans, we find they are giving our clients peace of mind and helping meet their retirement income needs. CB

SHANNON STONE, CFP®, *is a financial planner, advisor and operations manager at DHR Investment Counsel, Oakland, Calif. In that work, Shannon manages investment portfolios and places annuities as part of "longevity portfolio" planning. Previously certified as a Performance and Family Coach, Shannon's passion is working with people, whether it's through advising and financial planning or creating high touch and memorable client experiences. Her value draws on many years of experience in investment advisory work including wire houses, a municipal bond firm and RIAs.*
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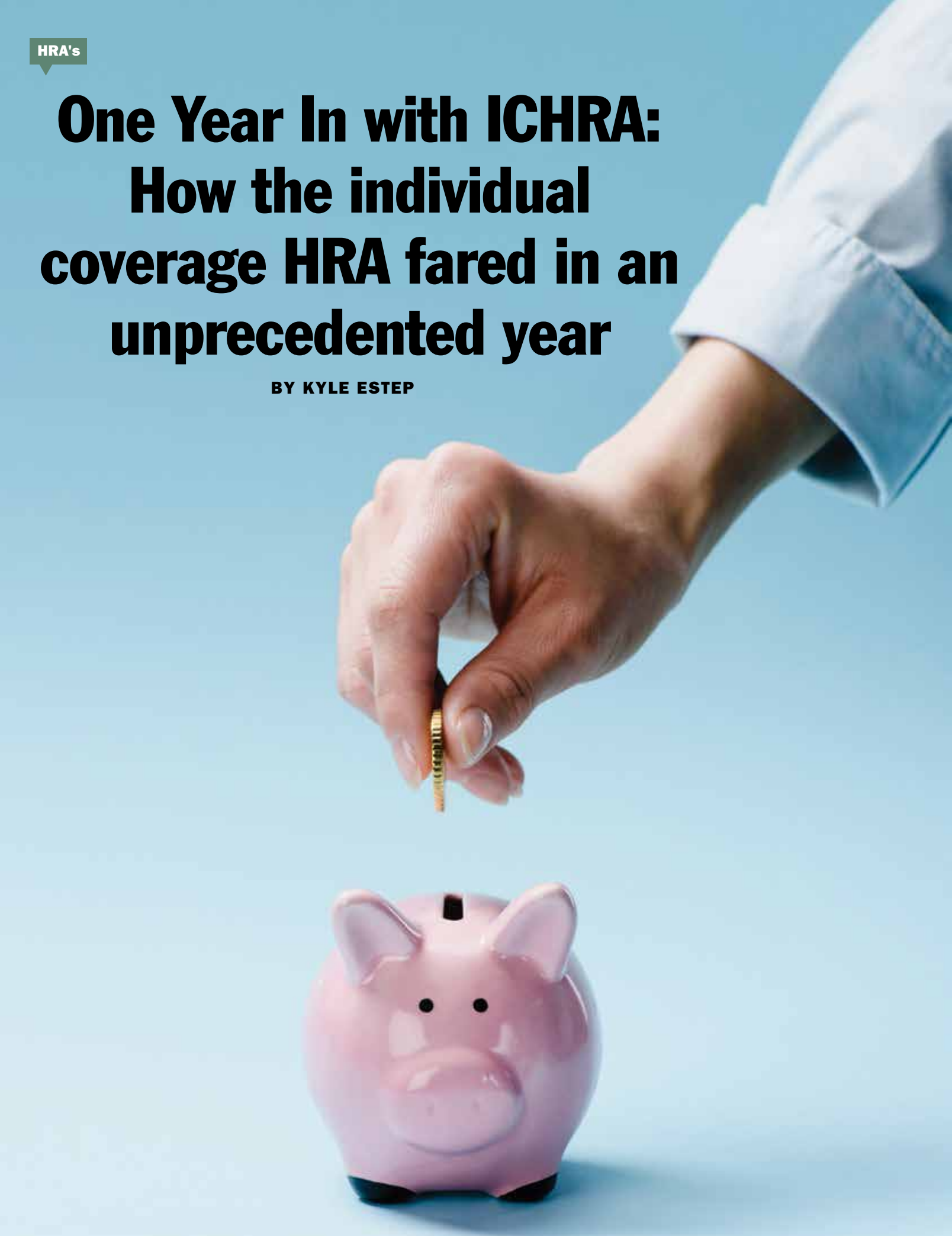
One Year In with ICHRA: How the individual coverage HRA fared in an unprecedented year

BY KYLE ESTEP



In the midst of great uncertainty, and arguably because of it, the individual coverage health reimbursement arrangement (ICHRA) is catching on. HRA signups at Take Command Health have grown drastically since ICHRA's inception, with only a small dip shortly after the pandemic began and an open enrollment season surpassing expectations. Possibly more telling, however, is a renewal rate of 96% for the 2020 "freshman class" as they entered 2021. Employers that make the switch don't seem to be looking back.

With the dust beginning to settle from 2020, it's time to unpack a year's worth of data. I'd like to share three key insights from our research, three success stories, and the bipartisan support we believe we'll continue to see.

WHAT THE DATA TELLS US

Based on our own client research from our 2020 ICHRA report, companies of all sizes are signing up. Small business interest doesn't come as a surprise, but the number of larger employers with 50 to 500 employees is a critical insight. These clients must offer health insurance coverage per the Affordable Care Act (ACA) employer mandate, but often lack the sophisticated resources to administer a group plan, manage the risk, or negotiate favorable rates.

According to our study, the average reimbursement rate for ICHRAs is $750 for singles and $932 for families. Around 60% of employers chose to reimburse for medical expenses and premiums—a more generous choice, and 40% reimbursed premiums only—a more predictable one.

Correlating with a strong individual market, California continues to be a leader in ICHRA adoption. We see similar adoption trends in other states with strong individual markets—notably Minnesota, Massachusetts and Colorado. On the small business side, common industries include professional services, non-profits, religious institutions and tech companies. The momentum in the mid-market space appears more widespread, with service sector industries including hospitality and logistics leading the way.

While President Biden has swiftly reversed many of the executive orders of his predecessor, ICHRA is fulfilling a campaign goal of stabilizing the ACA by infusing new lives into the marketplace.

ICHRA IN ACTION

While our clients represent a broad sweep of industry and location, they are tied together by their common pain points: budget concerns, participation rate worries, the predicament of covering hourly, remote or gig workers, or how to prepare for premium hikes. ICHRA, with its design flexibility and tax advantages, is the right solution for many companies to combat these challenges. Here are three examples.

- A mid-sized company with 90 employees was facing large renewals for their fully insured group plan before they opted for an ICHRA. When designing their HRA, they varied reimbursements by age, benchmarked allowances off of previous group plan offerings, and employee participation remained strong (66%). Once the ICHRA was implemented, the company ended up saving close to $120,000 on benefits over the previous year.

- A fast-growing company with 4,000 employees in 20 states was unhappy with their self-funded plan's performance. They implemented an ICHRA in some states while keeping the group plan in others. Allowances were adjusted by region to optimize budget and maintain buying power. They saved about $1.5 million in their first year.

- A large hospitality company wasn't ready to switch to ICHRA from a group plan before the pandemic, citing the tight labor market. With the hospitality industry hit particularly hard with furloughs and layoffs, the company changed course, opting to rebuild their benefits structure around ICHRA once it could bring its employees back to work. With the number of hourly workers and part-time workers who couldn't participate in the group health plan previously, the defined contribution model just makes more sense.

WHAT COMES NEXT FOR ICHRA

The pandemic and the recession certainly have played a hand in ICHRA adoption, but it's important to consider the political implications for ICHRA with the agenda of the new administration. Remember, the framework for these new models of HRAs was created during the Obama administration and expanded during the Trump administration via executive order. While President Biden has swiftly reversed many of the executive orders of his predecessor, ICHRA is fulfilling a campaign goal of stabilizing the ACA by infusing new lives into the marketplace. Seventy percent of our small business clients are new to benefits, meaning healthy individuals are joining the risk pool without subsidies and are covered by quality, ACA-compliant plans.

Its bipartisan foundation, its role in bolstering the market, and its track record displayed in a year's worth of data all point to the same thing: ICHRA is a critical piece of the puzzle for fixing a broken system—and it's here to stay. CB

KYLE ESTEP *is director of business development for Take Command Health, a SaaS platform that offers an end-to-end ICHRA solution. Prior to Take Command, Kyle led Oscar Health's growth across the country, starting in Texas. To learn more about Take Command Health's broker partnership program and end-to-end ICHRA solution, please visit* **www.takecommandhealth.com.**

Innovation Insights in 2021

Applying Porter's Five Forces to the insurance industry

BY SUSAN HATTEN

For those unfamiliar with Porter's Five Forces, originally described in a 1979 Harvard Business Review article, it is a model framework that outlines five predictive forces which shape every industry. These have also been known to be used in the modeling of various SWOT (strengths, weaknesses, opportunities and threats) analysis for strategic business planning.

Arguably, each of the Porter's Five Forces listed here have specific application for the insurance industry today.

1. **Competitive Rivalry**
2. **The Threat of New Entrants**
3. **The Power of Buyers**
4. **The Power of Suppliers**
5. **The Threat of Substitute Products**

What happens if you flip this framework on its head, and choose to view the state of our industry and situation as one of abundance—rather than scarcity—through the "Infinite Game" philosophy? This is precisely what we've done in building BrokerTech Ventures (BTV).

We asked the following questions to four of our BTV Partner-leaders, to capture their insights and alternative philosophies. They've offered thoughts on everything from competition, mergers and acquisitions (M&A), COVID-19 response, to addressing cyber threats and unknowns.

We are effectively challenging our legacy insurance industry, through the lens of BTV and a convening platform of agencies and insurance companies.

Susan Hatten (SH): Our insurance industry has long been known as a highly competitive environment. Do you view 2021 as a change-agent for this mentality, and if so, how and why?

Keith Schuler, CEO, InterWest:

Clearly the competitive nature of our industry especially in the broker community will become more intense as continued consolidation occurs. New players in the M&A space have elevated multiples and driven larger players downstream to look at smaller agencies that traditionally have been overlooked, and left to regional brokers. Coupled with the large amounts being paid up front and less on a work out basis, there will be added pressure on returns to substantiate the investment. The insurance market itself continues to be under immense pressure due to the unknown financial effects from the current pandemic, social inflation and catastrophic losses across the country that have become more the norm than in the past. The rapid move to remote work back in March 2020 and the reduction on traditional business travel creates both an opportunity and a challenge. How firms deal with this in 2021 could define them for the next decade. The use of emerging technologies will be the cornerstone to efficiency and survival, and we view BrokerTech Ventures as the convening platform to harness this competitive advantage.

Mike Victorson, CEO, M3 Insurance:

The competitive environment and the power of buyers isn't going to lessen this year—or in years ahead. By banding together with friendly competitors to challenge, elevate thought-leadership and activate movement in the insurtech space, we all win. Effectively, those brokers who choose to function as extensions of our client's risk management department—almost viewed as an outsourced Chief Risk Officer—stand to weather the landscape of threats and unknowns with greater certainty, by keeping an eye on the ultimate customer.

Within our own walls at M3, we've adopted the 3 P's to address predictive forces which frame and shape both our role as a broker, and our industry:

1. **Public health**
2. **Population health**
3. **Pandemic specific response**

COVID-19 has really shone a light on the public health challenges in our communities, and this is not going away. We would never be able to tackle a comprehensive response to these three areas of focus alone, wherein we see exponential collaborative opportunity in the BTV community.

At M3, and through BTV, we ask ourselves: "If not us… who?" We are in an immensely exciting time to be in middle market risk management, and we see ourselves as business-builders for the broader insurance industry.

The threats and unknowns of cyber claims will only increase breach response for Cyber. Bitcoin work could be changing on a dime, due to state sponsored terrorism, which is actively on the rise. We are in the business of identifying perils: Fire, Wind, Water, Earthquake—but Cyber is the most imminent threat of all.

We are at a remarkable stage in our industry—with more laws, and an incredible rate of change, speed of processing information and analytics. Think about how fast things are moving right now. We are living in an amazing time. The reams of information available gives us access to intelligence and insights much more rapidly. This leads to more innovation, better decision-making, swifter action. Innovation and technology will allow us to be greater advocates for our customers.

Mike Heffernan, CEO, Heffernan Insurance:

We are right in the path of change for the insurance industry. Here are a couple of points on that:

Technology is starting to change the way to service and engage with clients. As we use it more, those that use it most effectively are going to be a step ahead from a competitive level. To win more, we must remain ahead of the curve.

Also, I'm seeing a lot of private equity transactions in our space. There's a lot of attention on the purchase in our industry, rather than focusing on the level of talent. I see a slight slowing down in terms of the competitive market, and predict an increased competitive landscape in 2022 and 2023. I view 2021 as perhaps a lull period: the calm before the storm in terms of competition coming together to change our industry for the better.

The use of technology to create efficiencies in the service environment allows us to price more effectively, create better risks for our insurance relationships, and be greater advocates for our customers.

Cyber attacks: our own experience with this illustrated the sophistication, cost, damage to business, and the actual need for insurance to protect your assets. We were quite fortunate, but it was incredibly costly. The insurance companies we partnered with were true partners that assisted us in the response. As we result, we are advising our clients more effectively.

Regarding small and commodity business, we have actually stepped up our game, here. As Jay Fishman, leader of Travelers Insurance shared: [IF] "You forget that you are the trusted adviser, you are going to lose your edge."

Collaboration with our brokers and insurance companies through BTV will allow us to embrace the heightened competitive landscape in the years ahead—rather than to be disrupted by it.

Jennie Weiland, managing director, PayneWest:

I sense that broker competition, and a heightened awareness of the need to collaborate with each other, will only become more pronounced in the years ahead. The items we are trying to change for our industry are systemic and massive in terms of lift. There is a change agent happening—and we need each other to change the industry. BTV is allowing us to do exactly this, in partnership with our worthy rivals.

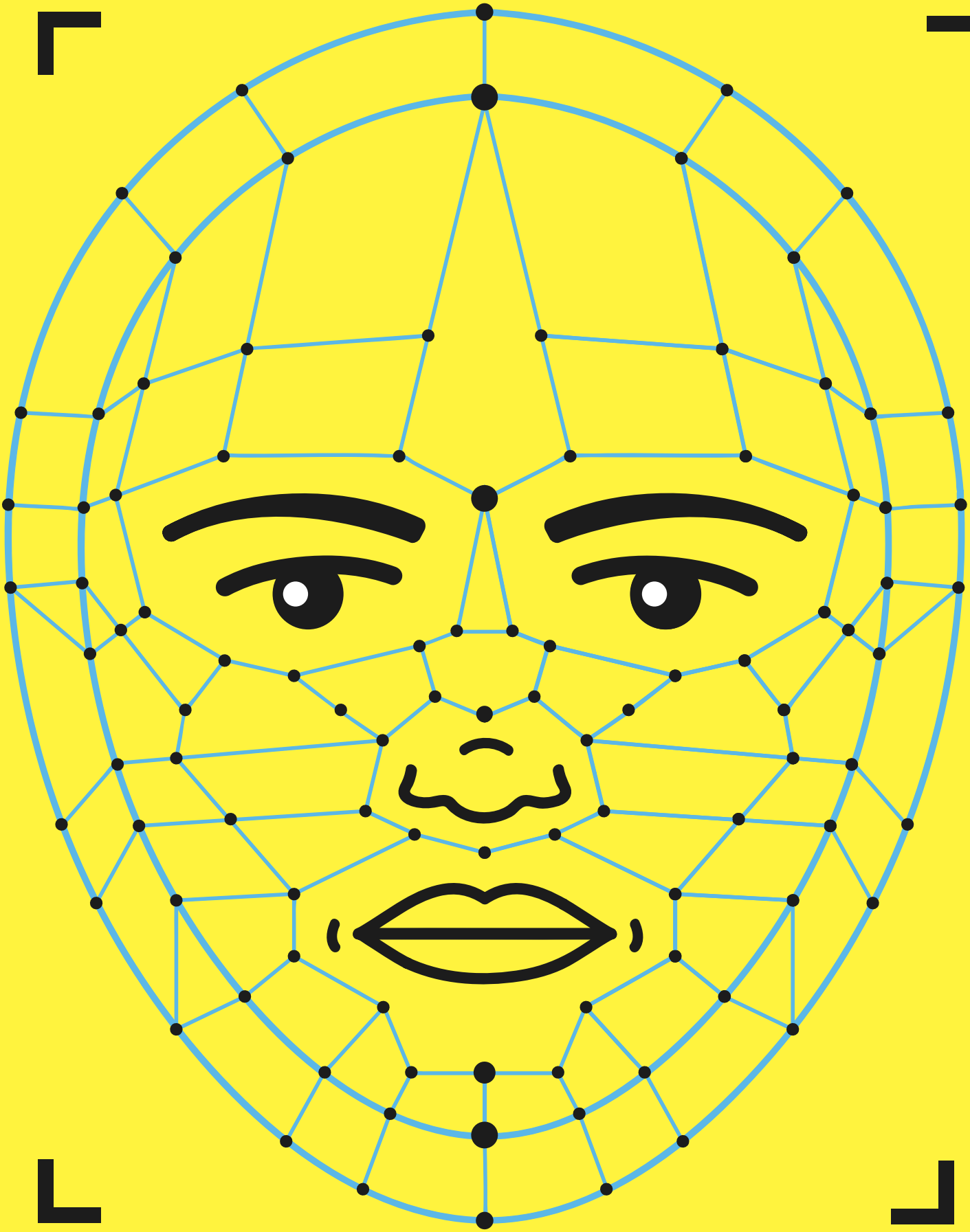
From the consumers perspective, and from the small business purview, at PayneWest we've seen a growing demand to activate greater support and tools for the small business needs. The value of the broker has become apparent this last year more than ever, as our small businesses around the world were adversely impacted by the pandemic. The pendulum has swung back toward the value of the broker, and that's not going away.

In terms of Cyber as a threat and unknown—we have also had our own experience. Thinking back to Target's response from years ago, we thought: "Of course we're talking to all of our customers about Cyber." This experience has completely changed our dialogue. We have adopted the "Cyber For All" mentality at PayneWest, so that this is in our DNA and we walk the talk.

We spent a lot of time pre-COVID-19 basing our thoughts on assumptions. Our customers' reactions turned our assumptions on their head. Consumers' appetite for digital and technology is here, and is here to stay. CB

SUSAN HATTEN *is chief operating officer of BrokerTech Ventures and oversees corporate and community engagement at Holmes Murphy. Hatten was named the 2017 Meredith Corp. Emerging Business Woman of the Year and is a member of the 2011 Forty Under 40 class by the Business Record, among others. Hatten is a graduate of Iowa State University. Contact her at* **shatten@holmesmurphy.com.**

BrokerTech Ventures (BTV) was founded in 2019 to provide a venue for the best minds in insurance and technology to collaborate and bring to market leading-edge ideas and solutions. BTV is the first broker-led investor group and accelerator program focused on delivering innovation to the insurance agent-broker industry. BTV invests in the research and testing for each of the chosen startups, provides access to veteran industry mentors, and helps scale the technology to market through broker distribution channels. Learn more at www.brokertechventures.com, or follow us on Twitter @ **BrokerTechVen.**

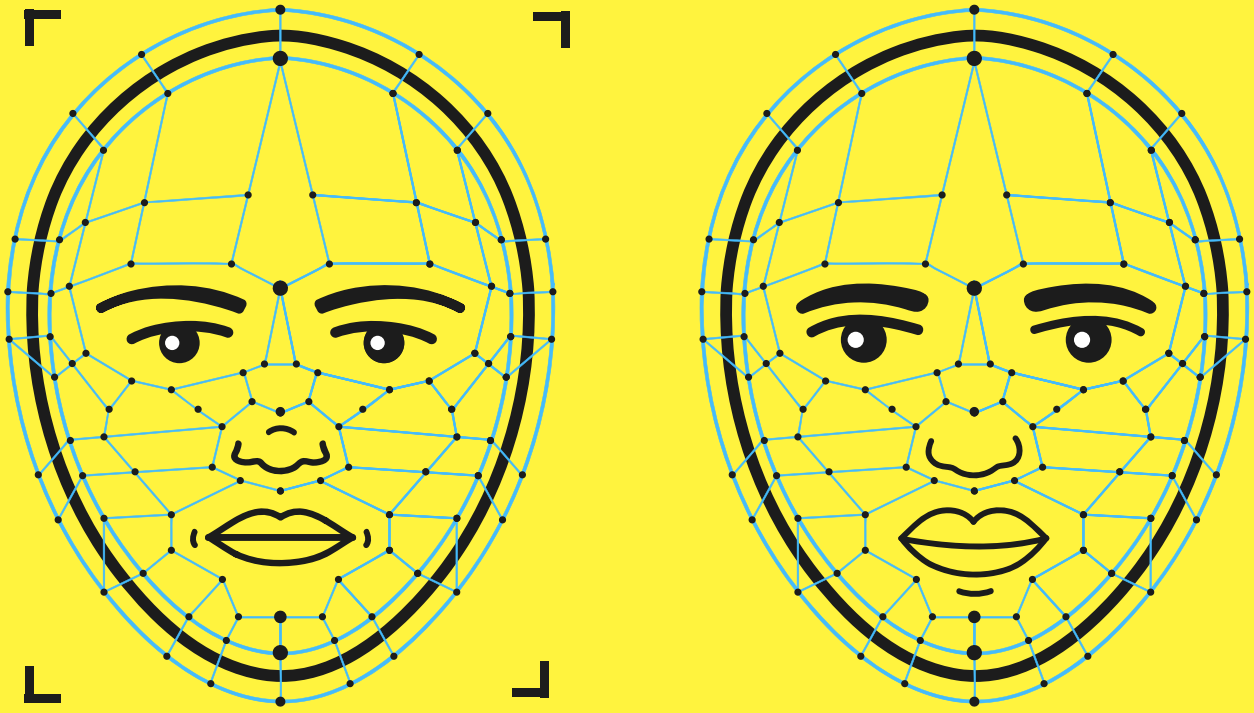


Dealing with Deepfake Scams

It's not just politics anymore

BY KEITH VINCENT

Fans of the "Mandalorian" were pleasantly surprised when a young Luke Skywalker was revealed on the final episode of Season Two. Older fans like myself had to look twice because I knew the representation of Skywalker in his prime was completely manufactured. But it looked so real.



Insurance and finance industries are encountering a sophisticated threat in the cybersecurity landscape that looks and sounds real as well. Like many things originally intended for good, artificial intelligence and deep learning has morphed into the proliferation of deep fake technology—an insidious problem for these industries.

According to the Wall Street Journal, a scam involving an audio call to a CEO of a U.K.-based energy company succeeded in extracting approximately $243,000 from the firm. The voice which was enabled by artificial intelligence sounded so real to the victim he believed he was speaking with his superior at the parent company. The man was directed to make an urgent transfer of funds to a supplier of the firm. Follow up calls made the victim suspicious, so he declined to send more funds but by that time it was too late to recover the initial transfer. According to the story, the CEO reported that he "recognized his boss' slight German accent and the melody of his voice on the phone." Although this type of sophisticated cyberattack was predictable, it stood out as highly unusual at the time for its novelty and success.

Deepfakes are intentionally distorted video, images or audio recordings that portray something that is fictitious or false enabling malicious entities with a novel and sophisticated social engineering tool.

Deepfakes are intentionally distorted video, images or audio recordings that portray something that is fictitious or false enabling malicious entities with a novel and sophisticated social engineering tool. Technology innovations enable deepfakes to look and sound authentic and convincing, leading to abuse and misuse. Social engineering is the idea of leveraging human tendencies to produce the desired result; in this case, commit a cybercrime.

Carnegie researcher Jon Bateman identifies the type of attack highlighted above as deepfake voice phishing or simply vishing.

Vishing leverages synthetic media to reproduce a trusted individual of the victim and highlights how deceptive artificial intelligence can be in the wrong hands. Cybercriminals manipulate their victims, often by enticing them to click on a malicious file or hyperlink or divulge information they would otherwise protect. It is widely understood that social engineering is a favorite of cybercriminals because humans are often too trusting and easily manipulated under the right

Deepfakes are considered low risk to the stability of the global economy... however, the risks of exposure to individuals and businesses are high.

circumstances.

The average consumer of social media will be familiar with deepfakes from an entertainment and social sharing perspective. Online searches are replete with interesting and useful good use cases for artificial intelligence. For example, in May 2019 three Machine Learning Engineers at Dessa showcased a realistic artificial intelligence voice simulation of popular podcast host Joe Rogan.

The demonstration is an outstanding example of how easily the lines between synthetic and real are blurred. A cursory online search returns practical use case examples such as text to speech and video editing. It is both impressive and astounding how a small sampling of a person's voice will create a realistic impersonation that can be manipulated by a keyboard. It only takes about 5 minutes at the current state of artificial intelligence. A website that generated Dr. Jordan Peterson's image and voice had to be taken down after Dr. Peterson threatened legal action. Chinese tech firm Baidu claims it can produce a believable artificial voice with only 3.7 seconds of audio.

Deepfakes are considered a low risk to the stability of the global economy. Nevertheless, the risk of financial and reputation exposure to individuals and businesses are high. A recent study reports that personal banking and payment transfers are considered "most at risk of deepfake fraud, above social media, online dating and online shopping." Financial institutions in general are obvious targets for cybercriminals due to their large amount of assets and customer data. The report outlines deepfake impact on the financial services industry. Areas of concern are onboarding processes, payment/transfer authorization, account hijacking, synthetic identities and impersonation among others.

Cybercriminals target individuals and groups with a variety of techniques. For example, manipulated audio might be used to steal identity information. Synthetic video might be leveraged against an individual putting them in a compromised position in order to extort payments from them. The Wall Street Journal scam outlined earlier is an example of payment fraud.

The same technologies can be leveraged to move businesses and markets as well. Synthetic voice, video, or texts can be used to defame a corporate leader, attack a brand, or spread false information about organizations leading to all kinds of negative outcomes.

Insurance brokers and financial services consultants need to prepare their workforce to meet this credible threat by updating their security program with the following objectives:

- Awareness of the good use cases of artificial intelligence, deep learning and deepfakes as well as their weaponization by malicious actors
- Process and procedure training to address critical functions such as onboarding, payment/transfer authorization, account monitoring, identification procedures, etc.
- Training on technology deployed to detect and eradicate deepfakes
- Cybersecurity awareness training to promote awareness and vigilance.

Workers should be trained to deal with ad-hoc urgent requests with a pre-defined protocol to authorize such requests perhaps requiring an approval chain to ensure authorization has the appropriate checks and balances.

Particular attention needs to be paid to safeguard brand reputation and the customer experience. When a breach occurs, the long-term effects of losing customer confidence and brand reputation can dwarf the short-term financial and systems damages. Insurance and financial services providers understand the trust consumers put in their products and the care taken to protect personal assets. Once that trust is gone it can rarely, if ever, be reclaimed.

Institutions that deploy effective training about deepfakes provide the heightened awareness, procedural discipline and hypervigilance to mitigate the risk of getting compromised by a deepfake scheme. CB

KEITH VINCENT *is a cybersecurity consultant for Technologent focusing on security platforms and programs as well as software-defined and traditional networking. His information technology career started in 1999 as a network administrator working for EMC Corporation. After taking on more senior roles he earned his Cisco Certified Internetwork Expert R&S technical certification and has worked on many Fortune 500 accounts on large networking, security and data center projects. Keith studied at the University of Redlands where he earned a Bachelor of Science in Business, going on to complete an Executive MBA at San Diego State University in 2012. Keith is currently attending SANS Technology Institute in the Graduate Certificate Program for Cybersecurity Engineering. For information, go to* **www.technologent.com**

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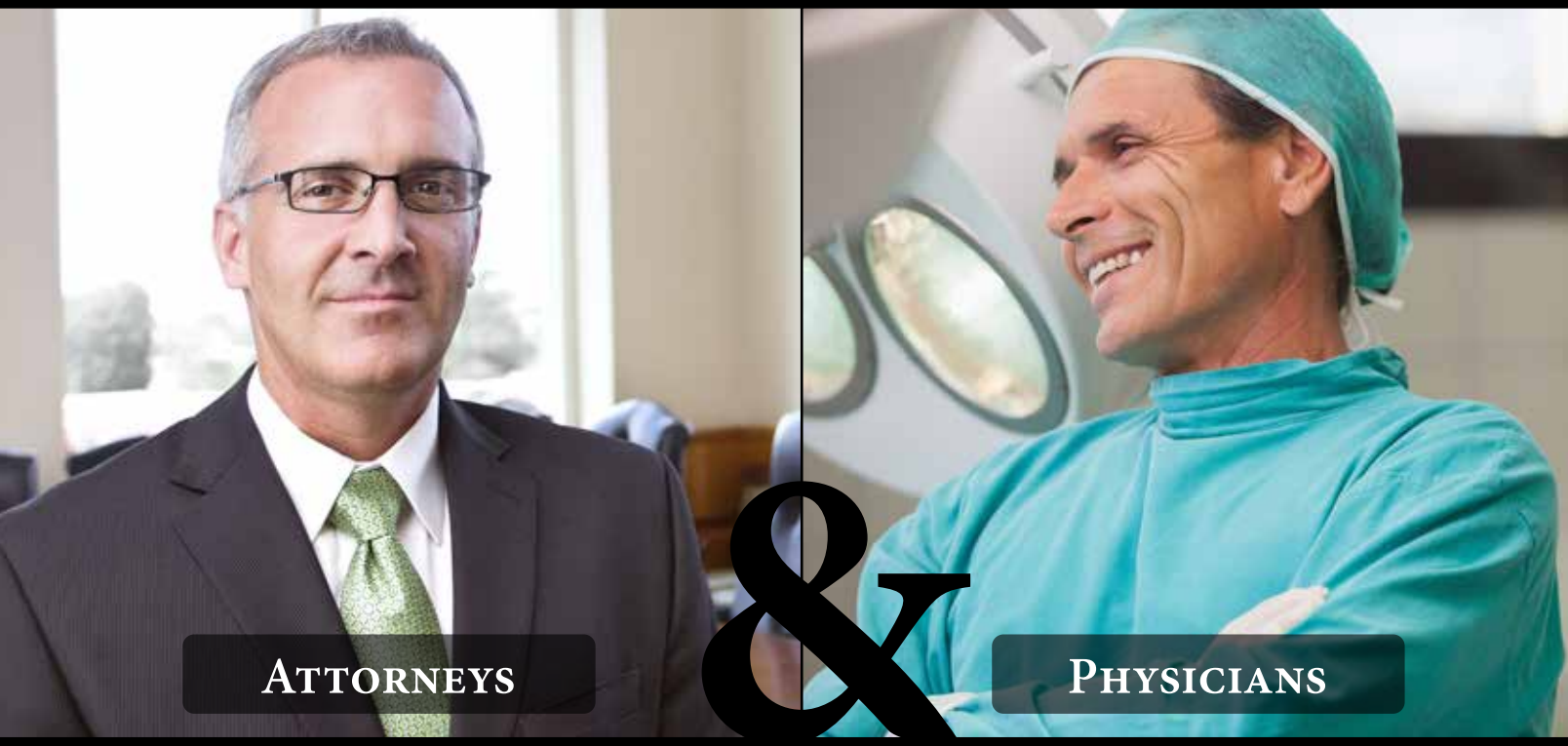

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