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CALIFORNIA BROKER

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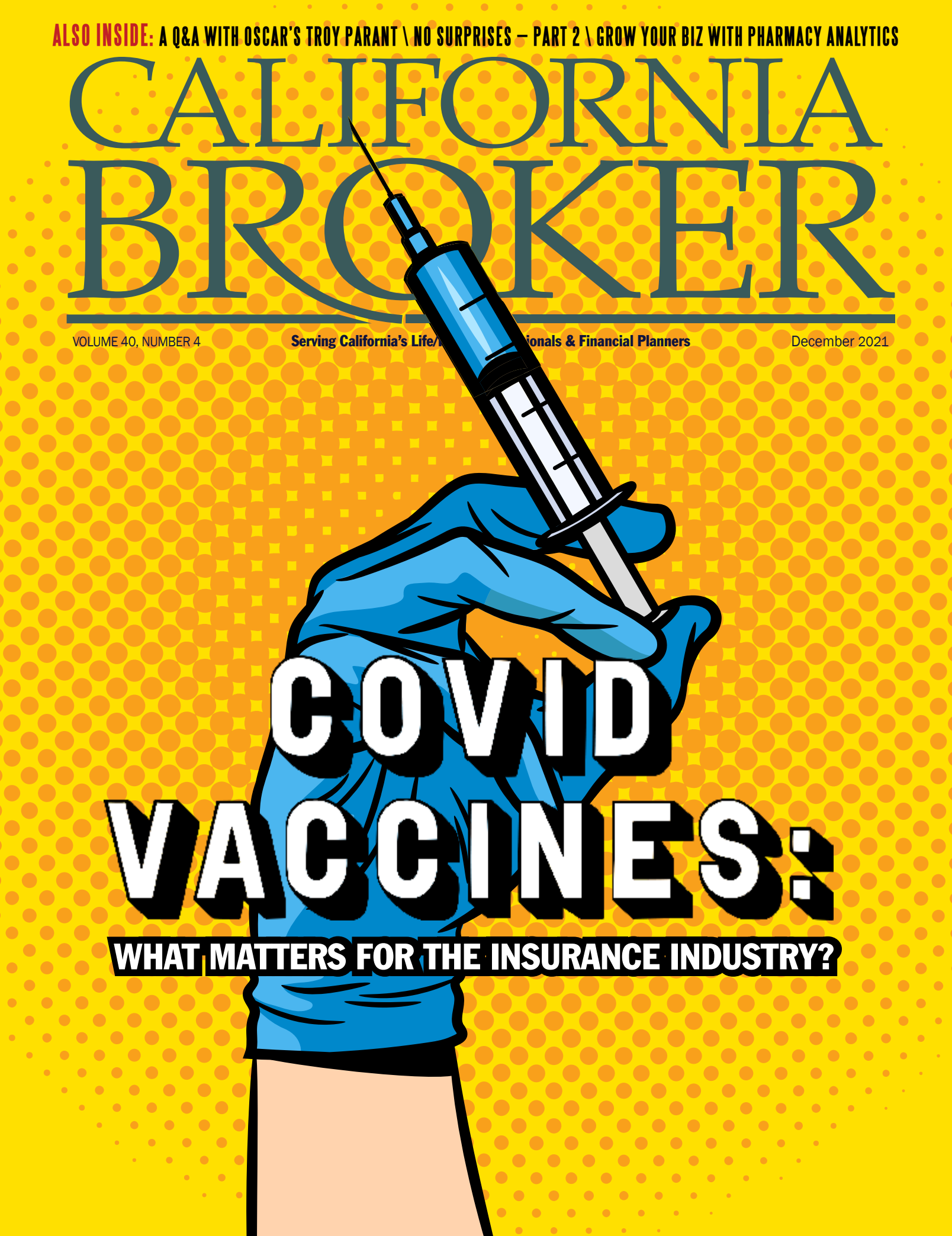

COVID VACCINES:

WHAT MATTERS FOR THE INSURANCE INDUSTRY?

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Data is a prize worth stealing and working from home has only made the theft more prevalent.

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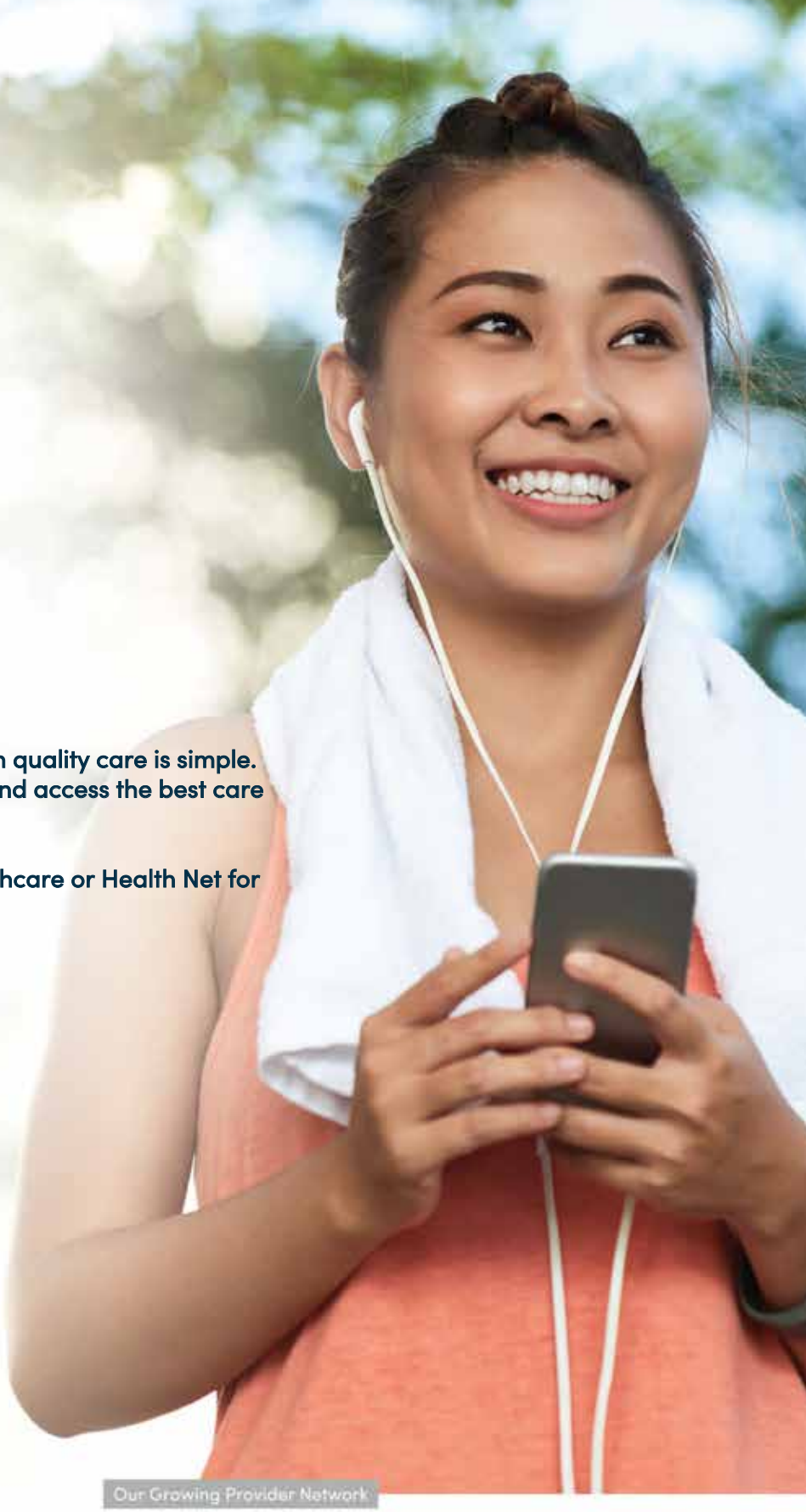

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INDUSTRY/NEWS

UnitedHealth Survey Identifies Consumer Trends

The latest research from UnitedHealthCare helps us identify consumer trends and preferences related to health benefits, here are some key findings from the sixth-annual UnitedHealthcare Consumer Sentiment Survey:

- 44% of respondents said COVID-19 influenced, or will influence, their preferred health plan, with 16% interested in an option with lower out-of-pocket costs; 13% looking for more well-being programs or resources; 8% seeking more comprehensive or richer benefits; and 8% wanting a national health plan instead of a regional one.
- 53% of Americans said they are interested in using digital devices, such as smartphones or laptops, to access care, reflecting the surging interest in telehealth amid the persistent spread of COVID-19.
- Since the emergence of COVID-19, 40% of survey respondents said their exercise habits have changed, including 24% who say they exercise less now and 16% indicating they work out more.
- 30% of respondents said they use a digital fitness app as part of their exercise routine, half of whom added this resource for the first time after the emergence of COVID-19. Among people who previously exercised at public gyms, 12% said they have no intention of ever returning

2 California Hospitals Help Set Bar

Two California hospitals ranked as the most cost-efficient in the country, according to a new analysis by Lown Institute. The researchers concluded that if all hospitals performed like the hospitals that they deemed as the top 10 most cost efficient, Medicare could save $8 billion a year. The researchers analyzed data from more than 3,000 hospitals. The study examined how much Medicare was billed and compared that figure to 30- and 90-day mortality rates. Now for the list of top 10 most cost-efficient hospitals in the country:

1. Pinnacle Hospital, Crown Point, Indiana

2. Saint Mary's Regional Medical Center, Reno, Nevada

3. Mercy Medical Center Dubuque, Dubuque, Iowa

4. Encino Hospital Medical Center, Encino, California

5. Park Ridge Health, Hendersonville, North Carolina

6. Oroville Hospital, Oroville, California

7. Saint Michael's Medical Center, Newark, New Jersey

8. UnityPoint Health-Meriter, Madison, Wisconsin

9. East Liverpool City Hospital, East Liverpool, Ohio

10. Maple Grove Hospital, Maple Grove, Minnesota

KNOW SOMEONE WHO COULD BE BROKER OF THE YEAR?

BenefitsPRO magazine is now accepting nominations for its **2022 Broker of the Year award**. Are you someone who helps shape the industry and provides extraordinary client service? Or do you know a colleague who stands out from the crowd? Those are some of the qualities they are looking for! Nominate yourself or a colleague today.

BenefitsPro will introduce Broker of the Year finalists in the June issue of the magazine and the winner will be featured on the cover of the July/August issue — as well as online at BenefitsPRO.com. The winner will also be honored with an award at BenefitsPRO Broker Expo 2022 in Austin, Texas.

The deadline to submit nominations is February 4, 2022! Go to benefitspro.com. Questions? Contact Paul Wilson, Editor-in-Chief, BenefitsPRO, at pwilson@benefitspro.com.

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- Groups must satisfy standard CCSB binder payment requirements for enrolled employees to count towards incentive program payments.
- Business written through partnering General Agencies qualifies.
- CCSB intends to issue incentive payments 90 days following group qualification. CCSB may modify its payment schedule at any time.

For a complete list of the program rules go to:
http://www.coveredca.com/agents/PDFs/Agent-commission-schedule.pdf

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Insurance companies vary by region and are subject to change. Oscar will no longer be available for new enrollments after January 1, 2022.

HELLO 2022!

If you'd like to share your expert knowledge and wisdom by penning an article in 2022, now's the time to speak up. Email editor@calbrokermag.com. If you'd like to discuss advertising opportunities, email Devon Nuszer devon@nustepinsurance.com.

Make Time for AHU Holiday Parties!

LAAHU sent us a note saying their annual holiday party is Dec. 9, 5pm, at **Ceremony Bar** in Studio City. Don't forget to check with your AHU chapter for other holiday events!

SELF-INSURANCE DIRECTORY NOW AVAILABLE

The Self-Insurers' Publishing Corp.in partnership with the Self-Insurance Institute of America, Inc. (SIIA), recently released The Self-Insurance Directory 2022. The directory connects self-funded employers and industry service providers. Go to SIIA.org for a link to the directory.

NEW SOFTWARE MAKES ANNUITY SHOPPING EASIER

Annuities Genius, a developer of annuity point-of-sale software that helps financial pros find suitable products and meet compliance requirements, announced a partnership with CANNEX to use its data for their new SPIA and DIA comparison tools.

With the addition of SPIA and DIA data, financial professionals can use Annuities Genius to review with clients the full range of annuity options from major carriers, compare product benefits, pricing and performance illustrations, and select the appropriate annuities.

GEN Z WANTS HYBRID WORK AND FREE HEALTH COVERAGE

New research from PromoLeaf aims to help businesses better understand workplace preferences amongst Gen Z, the newest generation. Check out some of the key findings:

- Almost one in four Gen Zers believe that free healthcare increases job retention.
- The median time Gen Z wants to spend in one job is 3.72 years. However, just over 25% of Gen Z would stay in a job only 1-2 years before looking for another one.
- Just under 15% of respondents would want to work in an office full time, and under 11% would like to work remotely full time. While another 15% had no preference, the remainder of respondents would prefer some kind of hybrid mix of time in the office and time spent working remotely.
- Nearly 50% of respondents aged 18-23 years said they would take less pay for a more desirable working environment.
- Transparency also matters to Gen Z when it comes to both perks and salary. Just over 43% believe companies should be clear about which perks they offer employees, and 30% would not even pursue a job if the perks offered were not clear ahead of time.

IRS Doesn't Increase LTC Tax Deduction Levels

The **INTERNAL REVENUE SERVICE** recently announced that the tax deductible limites for LTC insurance will NOT increase for 2022. Jesse Slome, director of the American Association for Long-Term Care Insurance (AALTCI), says the deductions are still significant but no increase is unprecedented. According to IRS Revenue Procedure 2021-45, a couple age 70 or older who both have the right kind of long-term care insurance policy can deduct as much as $11,280 in 2022. This is the same as the maximum for 2021 and an increase from the $10,860 limit for 2020. The 2019 limit was $10,540. Get lots more info on LTC insurance by reading Slome's blog at AALTCI.org.

New Survey Highlights Broker Pain Points

According to the inaugural Workplace Benefits Broker Survey, conducted by Wellfleet and EIS, brokers' top six carrier pain points are all IT-related. They include commission structure (52%), billing errors (48%), lack of real-time data insights for the broker and client (44%), time to underwrite the group (43%), and limited plan customization and slow data processing time (42%), respectively. The survey, conducted to gauge broker sentiment on partner technologies, also examined factors that impact broker satisfaction and their ability to be successful partners with carriers in the current workplace benefits market. The top three factors that influence brokers' carrier recommendation are technology (59%), financial rating (57%) and the claims submission process (36%).

Cigna+Nationwide Promote Senior Pet Ownership

Recognizing the value pet parenting adds to human health, Nationwide's pet insurance business and Cigna announced they've teamed up to educate older adults about how to reap the health benefits of owning a pet and how pet health insurance can help them protect the companions that are so vital to their wellbeing. With the collaboration, older adults will be encouraged to learn more about protecting their health with Cigna and protecting their pet's health with Nationwide.

EVENTS

SIIA Crowdsource Forum, in person,
December 6 - 8, Charleston, SC, SIIA.org.

Future of Health, online,
Dec 8-9, $150 off w/code CALBROKER. CBInsights.com

CAHU Women's Leadership Summit, in person,
March 14-16, 2022, Green Valley Ranch, Las Vegas. CAHU.org.

LAAHU Annual Symposium, in person,
April 26, 2022, Pasadena Convention Center. LAAHU.org.

BenefitsPro Broker Expo, in person,
May 23-25, 2022, Austin, TX. BenefitsPro.com.

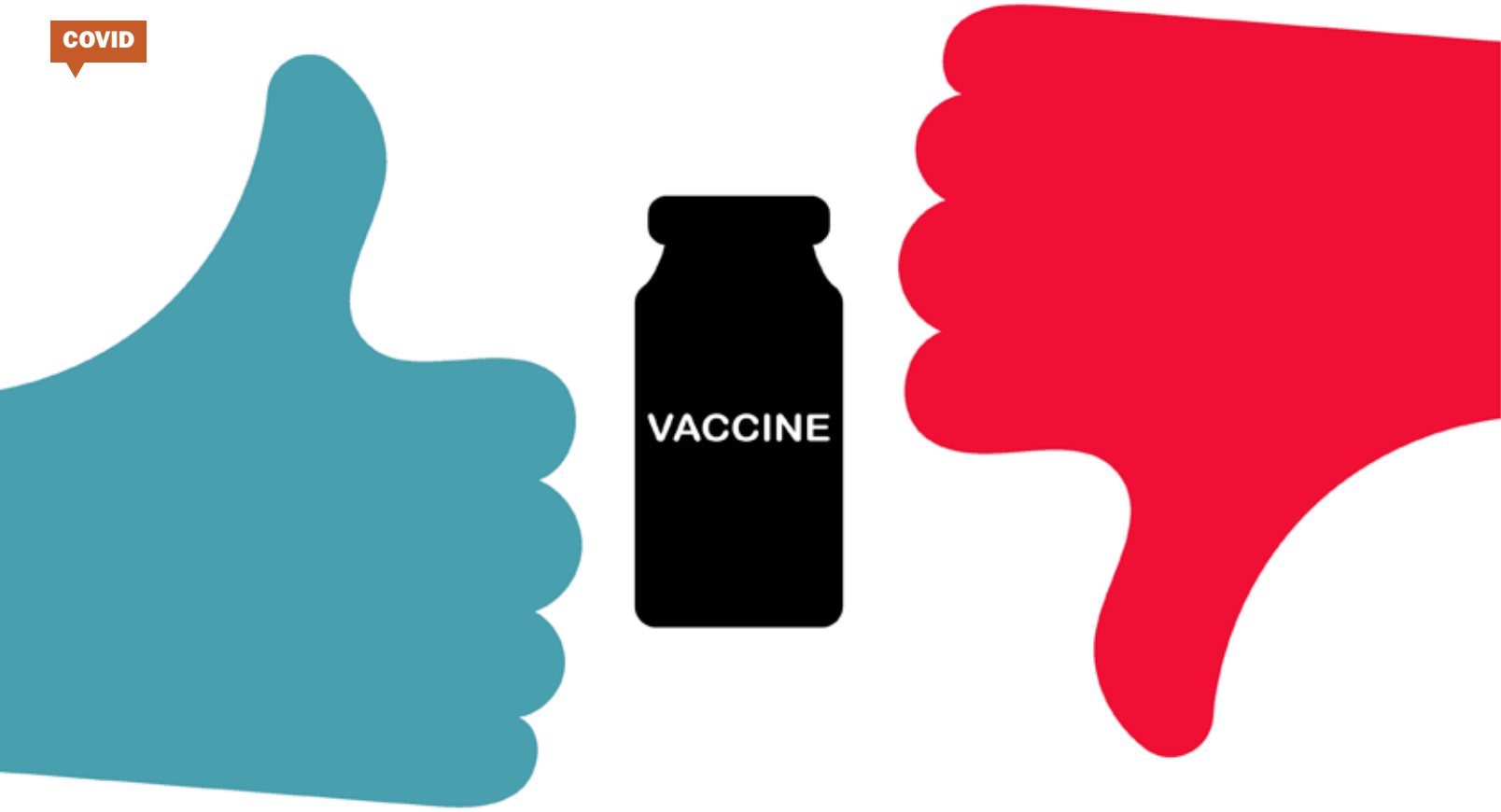
Secure Retirement Institute: Advisors Say Annuities Suitable for Retirees and Pre-Retirees in Middle-and Mass-Affluent Markets

While annuities have features uniquely suited to retirement, they are not necessarily appropriate for all retiree and pre-retiree investors.

New research from LIMRA's Secure Retirement Institute asked advisors which market segment was the best suited for annuities, among their typical retiree and pre-retiree clients. The research also looked at whether advisors have seen any changes in clients' views about annuities.

Most advisors consider wealthier clients (with $1 million or more in household investable assets) to be a less appropriate segment for annuities than clients with lower wealth levels. Among advisors servicing middle- and mass-affluent market segment (under $500,000 in assets) retiree and pre-retiree clients, nearly half (48%) feel that annuities are most appropriate for these clients.

Other SRI research shows households with less than $500,000 in investable assets made up 60% of annuity owners; households with $500,000 to $999,999 in investable assets and households with $1 million or more each represented 20% of owners.



Vaccinations Draw Passionate Response

What matters for the insurance industry?

BY MICHAEL GIUSTI

More than perhaps any other vaccine, the COVID-19 vaccine has drawn passionate responses from nearly every corner of the political arena. But in all the high-volume conversations about the vaccination, few people have been discussing the impact it may have on insurance premiums, both today and down the road.

The most prominent public conversation about the vaccine and insurance came when Delta Airlines announced it was going to impose a COVID-19 surcharge to its unvaccinated employees. That announcement came in the days following the Food and Drug Administration's full approval of the Pfizer vaccine. Delta's surcharge is being billed as a way to offset the immense costs to treat hospitalized coronavirus patients.

Those costs can be astronomical — with a typical COVID-19 hospitalization costing an insurer $20,000, with intensive care units costing many times more than that.

And while a ton of ink has been spilled over Delta Airlines, a higher-level look at those surcharges is in order, as well as potential impacts vaccination status could play on other types of insurance in the short run, but also down the road.

Health Insurance

To start, the Affordable Care Act is clear about one thing — charging similar people different rates based on their health history is forbidden. Tobacco surcharges are allowed, but that is only because they were written into the original legislation.

So, as long as a health insurance plan is regulated by the Affordable Care Act, vaccinated and unvaccinated people must pay the same premiums, deductibles, and other costs for care to stay in compliance with the law.

To get around this prohibition, employers are using a few precisely worded tricks to impose COVID-19 surcharges.

The first way they are maneuvering around the ACA prohibition is by classifying the surcharges as part of their

wellness programs. The idea is that once you get the vaccine, you have taken a step toward wellness and the surcharge that is being charged to everyone can be waived for the vaccinated employees.

Similarly, some employers are leaning on language from the Equal Employment Opportunity Commission, which gave a ruling earlier in the summer specifically allowing "incentives" for vaccinated employees.

And while most employers interpreted incentives to be a $25 gift card, or some similar perk, others have suggested that waiving a COVID-19 surcharge could qualify as an incentive.

The catch with relying on the EEOC ruling is that some readings of the ruling say that it prohibits "coercive" incentives. Arguing that a $2,400 annual fee isn't coercive may be a tough sell.

Another tack to justify the surcharges is defining the surcharges within the confines of the employee assistance program. The departments of Labor, Health and Human Services, and Treasury offered a roadmap of sorts for housing surcharges within the employee assistance program, but those involved several caveats, such as saying that the incentive could not be limited to employees participating in the health insurance program.

Regardless of the legal rationale, given the political temperature surrounding the COVID-19 vaccine, any effort to push employees to get a jab will likely end up in court sooner rather than later.

Speaking of court, however, one vaccine question is clear regarding employment, and that is that employers are more than free to mandate the vaccine as a condition of employment. That is thanks to a federal court ruling earlier this summer that said a Houston hospital was within its rights to fire employees who refused the jab.

Moving forward, the big picture question about the effect COVID-19 will have on health premiums is more likely to involve a return to normal health care patterns, rather than the cost of treating COVID-19 patients.

During the lockdowns of 2020, and to a lesser extent moving into 2021, many people who would have benefitted from medical care for conditions such as diabetes, hypertension, and the like, steered clear of the doctor's office causing a two-fold ripple. First, without those routine care visits, insurance payouts were skewed. And second, without that necessary care, those patients may now be facing higher costs to treat as their conditions worsened.

How those factors will play into premiums will be the bigger story moving into 2022.

Life Insurance

COVID-19 vaccines save lives, but does that mean that vaccinated people will pay less for their life insurance? That is going to be a question for the actuaries and state regulators and will likely not be answered for years to come.

In the short run, life insurers aren't adding vaccination status into their underwriting formulas. The data for how vaccines impact longevity just isn't there on a long enough time horizon.

That said, COVID-19 has left its fingerprint on the life insurance industry, specifically in how insurers approach the in-home paramedical exam.

During the 2020 lockdowns, many insurers decided to forego those in-home visits and many instead looked to some automated processes involving big data, medical records and other no-touch underwriting techniques.

Coming out of the lockdowns, many have continued to offer those options, as well as offering simple no-exam policies.

If a prospective policyholder had recently contracted COVID-19, or if they lived in or traveled to an area with a particularly bad outbreak, insurers tacked on waiting periods before those policies took place. But after those 30-day waiting periods ended, those patients were just as eligible for a policy as anyone else.

Some insurers have stopped writing some policies for some older patients, regardless of vaccination status, though.

If vaccines do end up influencing long-term longevity patterns, it would be perfectly legal, and really the responsible thing to do, for insurers to consider vaccination status as part of the underwriting process. But for that data to shake out from the background statistical noise, it will be years for a clear picture to emerge.

One thing regarding life insurance and the COVID-19 vaccine is absolutely certain, though, and that is that if someone takes the vaccine, they will under no circumstances lose their payout benefit. This emerged as a viral claim on social media where someone claimed their relative was denied a life insurance payout when they died after having received the vaccine.

While that claim is obviously preposterous and has no truth to it, it is important for people in the insurance industry to know about the existence of that misinformation and be prepared to counter it with valid information.

Looking forward

For insurance companies, the biggest issue may not be managing the numbers, data, and analysis regarding COVID-19 vaccines and their impact on pricing, but instead it will be more of a public relations crisis of managing the overheated political rhetoric coming from both sides of the issue.

For some policies in the short run, such as travel insurance, vaccination status may emerge as a pricing factor. But for the longer-term policies, such as health and life, regulators are going to want to see hard numbers and sound rationale before authorizing rate increases based on vaccination status.

As a rule, the more an insurer can rely on data and evidence, the better position they are going to be in when they need to make policy, request pricing changes, and write new contracts. CB

MICHAEL GIUSTI, M.B.A., *is a senior writer at InsuranceQuotes.com.*

BY DOROTHY COCIU

CAA's No Surprises Act– Part 2

A CONTINUATION AND UPDATE

Author's Note: Part 1 of this article was printed in the October 2021 issue of California Broker. This is Part 2 and includes updates from the September 30, 2021 rules on the Independent Dispute Resolution Process of the No Surprises Act.

Independent Dispute Resolution (IDR) Process

Most of us have experienced the unsettling nervousness when an outsider, someone who doesn't know a thing about you, determines your fate. We've seen it in divorce mediation, child custody matters and business matters. All we can do is present our documentation or orally present our argument up front, and then the other side does the same, with vastly differing conclusions and perspectives. But somehow, we must find a way to make it work; to meet in the middle or find a resolution. And sometimes, as we all have experienced, the emotions are overwhelming, and no compromise seems acceptable.

When money is involved, it becomes not only emotional, but financially devastating in many circumstances. Now combine the financial impact to you or your company with the human resources side of wanting to do the best you can for your employees and their dependents covered under your health plan. To employers sponsoring a health plan and wanting to do the right thing for their covered participants, it can become overwhelming.

Your client's employee did the right thing. They followed the health plan's rules and they went to an in-network facility for care, only to receive later an unwanted "surprise medical bill" from a non-network assistant surgeon, as well as one from the anesthesiologist. The total of these bills was over $25,000, which the employee simply does not have the money for. The human resources director (let's call her Judy) sat there fighting to hold back tears as this employee (let's call this employee Pam, who is a wife and mother, and handles all of the insurance and health care related matters of their family) sat across from her desk and showed Judy the stack of medical bills that she was instructed to pay. As Pam explained,with the kids' college expenses and the cost of rent, gas for the car, groceries and everything else going up, there is no way she can pay. Pam, who is a valuable employee, was hysterical, asking why this happened when they took great care to go to the PPO facility that she was told to go to. Pam and her husband planned for this surgery. They saved the money for their co-pays or coinsurance, plus any deductibles and other out-of-pocket costs that might occur. Now Pam is accusing her employer of having a horrible health plan, when in reality it pays 90% of in-network costs, with a low annual deductible of only $250 and affordable co-pays and out-of-pocket maximum for all services.

Surprise billing is something none of us wants to see, yet it happens all too often. The No Surprises Act attempts to stop some of the most egregious balance billing practices of providers in non-network situations by limiting the amount of the bill to the amount that would have been payable under an in-network arrangement. Protections apply primarily to emergency services, non-emergency services delivered by out-of-network providers at an in-network facility, and out-of-network (OON) air ambulance services. I addressed the No Surprises Act in detail in the article entitled: "CAA's No Surprises Act IFRs Spark Administrative Questions and Industry Concerns While

Awaiting Further Guidance," published in the September/October, 2021 issue of The Statement, and the October, 2021 issue (part 1) of California Broker Magazine. If you haven't read that article yet, and are confused on some of the things I state in this article, I suggest you go back and read those articles first... Then this one will make much more sense!

In the last Cal Broker article, I wrote briefly about the Independent Dispute Resolution Process (IDR) that will be required under the No Surprises Act, but we were awaiting rules on how that process would work. Now, we have those rules, as they were released on September 30, 2021, in the No Surprises Act's second interim final rule.

New Federal Portal to Resolve Payment Disputes

The new rules outlined a new resolution process that OON providers, facilities, providers of air ambulance services, plans and issuers in the group and individual markets may use to determine the OON rate for applicable items or services after an unsuccessful open negotiation. The September 30 rules (published in the Federal Register on October 7, 2021) outline the federal independent dispute resolution process, good faith estimate requirements for uninsured (or self-pay) individuals, patient-provider dispute resolution process for uninsured (or self-pay) individuals, and external review provisions of the No Surprises Act. The most prevalent part of the release of new rules on the IDR included the announcement of the newly created federal portal website where providers and plans will submit their payment disputes, which can be found at: https://www.cms.gov/nosurprises/consumer-protections/Payment-disagreements. The full website contents can be found at: https://www.cms.gov/nosurprises. Included in that portal is an application process for entities to become a certified independent dispute resolution entity, or an Arbiter for the process.

The new federal portal is not yet completed, but is a work in process, and all indications to date are that the portal, once fully operational, should ease the independent dispute resolution process. Because it is a complicated process, I will attempt to walk you through how it will work.

I recently interviewed Ryan Work, Vice President, Government Affairs and Chris Condeluci, Washington Legal Counsel for the Self Insurance Institute of America (SIIA) for my podcast, Benefits Executive Roundtable. This podcast aired on November 2, 2021. In that interview, I asked Ryan and Chris some important questions and gained some valuable opinions on how the IDR process will work. I'll refer to some of their comments throughout this article, as I think they will help you to better understand the process.

When asked about the creation of the federal portal and if they thought it would be helpful in the IDR process, Ryan commented: "The fact that the federal agencies have moved quickly to implement this is pretty amazing to me... I think everyone should bookmark that page..."

Chris also seemed to be happy with the new CMS portal for the IDR process. "I do think that it will be very helpful, and I do think that the plans, service providers and everybody in this process should indeed bookmark that page, because it will be a living, breathing entity or tool... There will be important information relating to CIDREs, all information on time periods, etc. So, it's advisable to keep looking back at that federal portal for informational purposes."

The No Surprises Act requires the Departments to establish a process for receiving complaints regarding potential violations of the law by providers and insurers.

I also discussed these new rules with Colleen Dempewolf, Director, Strategic Product Development, MultiPlan, who we will hear from later in this article. MultiPlan is a national PPO network which also owns HS Technologies, a Referenced-Based Pricing vendor. I previously interviewed her and Ryan Day, President of HS Technologies, for an earlier No Surprises Act podcast from both the Benefits Executive Roundtable and CAHU.

Before initiating the federal independent dispute resolution process, disputing parties, according to CMS, must initiate a 30-day "open negotiation" period to determine a payment rate. In the case of a failed open negotiation period, either party may initiate the federal independent dispute resolution process. The parties may then jointly select a certified independent dispute entity (or CIDRE – a new industry acronym coined first by Ryan and Chris from SIIA to the best of my knowledge) to resolve the dispute. The CIDRE and personnel of the entity assigned to the case must attest that they have no conflicts of interest with either party. If the parties cannot jointly select a CIDRE or if the CIDRE has a conflict of interest, the Federal Departments will select a CIDRE for them.

After a CIDRE is selected, the parties will submit their offers for payment, along with supporting documentation, into the federal portal. The CIDRE will then issue a binding determination selecting one of the parties' offers as the OON payment amount. Both parties must pay an administrative fee ($50 each for 2022), and the non-prevailing party is responsible for the CIDRE entity fee for the use in this process. The CIDRE total compensation is discussed later in this article.

Before I get too deep into the IDR process, I want to first make mention that not all parties seem to be happy with the IDR rules in the No Surprises Act IFR, Part 2. I asked Ryan Work about how the response from the provider community has been on the IDR process.

"The best word I can use to describe it was 'enraged,' by the arbitration rules. I think one of the best quotes from one of the hospital associations

was that this was a 'gift to the insurers on a silver platter,' which I disagree with, but I think that everything else that was done with Surprise Billing and the politics of it, and honestly the tens of millions of dollars spent by the hospitals against this in the first place, that the policy that came out of the IFR was well deserved."

If this process sounds simple so far, let me tell you... It's not. Let me get into more of the details.

Step One: Initial Payment or Denial of payment.

Once a plan receives a claim for an OON service, the plan has 30 days to either choose to send the provider and initial payment or a denial of the payment. The provider and payer may negotiate with each other on a final payment amount over a 30-business day period. If they agree on an amount within this 30-day period, the process ends. The claim is finalized, and all is well. If, however, they cannot agree on a payment amount within the 30-business day period, either party can enter into the federally-developed arbitration system (IDR process) within four business days after the end of the Open Negotiation Period. If this occurs, the "certified arbiter" will make a final determination within 30 business days after being selected to consider the dispute.

The No Surprises Act attempts to stop some of the most egregious balance billing practices of providers in non-network situations by limiting the amount of the bill to the amount that would have been payable under an in-network arrangement.

The Open Negotiation Period: The 30-business day Open Negotiation Period does not begin until the provider receives the initial payment, or the denial of payment, and the provider sends an "Open Negotiation Notice" to the plan indicating that the provider wants to negotiate. If this happens, it must be sent within the 30-business day period. This notice, which may be sent electronically to the plan, marks the date that the 30-business day period begins for the Open Negotiation Period. The initial payment or denial of payment that is sent to the provider must include a written statement that informs the other party that the Open Negotiation Period has begun and must include the appropriate contact information to send the Notice.

It is possible, and somewhat probable, that the majority of the claims will be settled within the first 30-business days, during the Open Negotiation Period. "I think the federal agencies have written these rules to give as many options in the open negotiation period as possible and avoid arbitration. I also think that reaching a settlement in open negotiation will probably depend on the amount of the service [cost]...," stated Ryan. "I think price strategy by the plans and providers will play into that as well.... It depends on where the savings are."

Colleen Dempewolf had similar thoughts: "The departments have written the No Surprises Act to incent providers and payors to come to agreement rather than employ an arbitrator, so we expect the arbitration volume to be well below the volume of claims negotiated. However, the new reimbursement process will have a significant impact on both provider revenues and payor medical cost, so we fully expect that there will be claims where the arguments for arbitrating are compelling for either party."

For the most part, it seems as though many providers may want to try to settle in the Open Negotiation Period, rather than to risk a lower payment in the arbitration process, but we shall see.

The Arbitration Process: It begins with either party initiating the IDR process within four business days after the Open Negotiation Process ends. Keep in mind, the 30-business day Open Negotiation Period must be exhausted before the arbitration or IDR process can begin. It starts by the initiating party sending a "Notice of IDR Initiation" to the non-initiating party. This notice MUST be sent electronically to the plan and the federal Departments. The date of receipt in the Federal IDR portal will begin the arbitration/IDR process. Once the arbitration/IDR process begins, the parties must agree on a CIDRE within three days. If the parties cannot agree, the Federal Departments will assign a CIDRE within six days.

I want to comment on this part of the process before we go any further. The Federal Departments have reported that they only expect to have approved 50 to 75 arbiters to be certified by the effective date of January 1, 2022. CMS is actively looking for parties to apply to become a dispute resolution organization. It's now November... The effective date is January 1, 2022... That is not a lot of arbiters to act as the deciding party, particularly in the first six months or so of this process. I can't imagine that the providers are happy with the No Surprises Act, as I mentioned above, so I am guessing that they will not want to accept the initial payment offered for the higher cost claims, such as hospital stays and high cost air ambulance services, and will likely try to negotiate those in the first 30 days, in the hopes of receiving more revenue per claim. I will discuss this further later in this article, but I wanted to point out that we will likely begin with very few approved arbiters to do a lot of claim settlements.

When I asked Colleen Dempewolf about the number of arbiters that will be available for the IDR process, she shared her thoughts. "The time available for CMS to make a reasonable pool of certified IDR entities available is very short and it is difficult to tell how many would be in place, trained and operational at the start of the year. Of course, there is a considerable lag between the date services are rendered and the time it would be in the IDR process. In addition, we don't know how

many arbitrators would be available from the 50-75 entities that SIIA is expecting. If the supply can't support the demand, we expect CMS will have to accommodate the resulting inability of payors and providers to comply with the process requirements."

Choosing An Arbiter: If the initiating party and the non-initiating party should come to an agreement on the CIDRE, a notice must be sent to the Federal Departments though the Federal Portal that includes the following:

- The CIDRE Name and Registration Number
- An attestation by both parties that the CIDRE does not have a conflict of interest (or by the initiating party if the other party has not responded)
- The attestation must be submitted based on conducting a conflicts of interest verification by using information available, or by using information accessible by using reasonable means
- Providers and payers can petition the Federal Departments and argue that a particular entity that is seeking to become a "certified arbiter" should be denied a certification
- Parties can request to the Federal Departments that an existing certified arbiter's certification should be revoked

In summary of the latter, the rule provides a process by which members of the public, including providers, facilities, providers of air ambulance services, and plans or issuers, can petition for the denial or revocation of a certification of an independent dispute resolution entity.

Arbiter Certification: When choosing an arbiter, there can be no conflicts of interest on either side. The arbiter cannot be an employee or former employee of a disputing party within the past year or a former employee of the Federal Government within a year of the time which the employee left the employment of the government. They cannot have a financial, professional, or family relationship with either party. In addition, the arbiter cannot be owned, either directly or indirectly, by an insurance carrier or medical provider. The arbiter also cannot be an affiliate/subsidiary of a professional trade association for the group health plan, carrier, or providers.

The arbiter needs to have sufficient expertise in the arbitration and claims administration of health care services, managed care, billing, coding, medical and the law. They must also have expertise which is considered sufficient in the field of medicine, especially where the payment determination depends on the patient acuity or the complexity of the medical procedure, or the level of training, expertise, experience and quality and outcome measurements of the provider or facility that furnished the medical service or services. Arbiters are required to maintain current accreditation from a nationally recognized and relevant accreditation organization, such as URAC, or employees must have requisite arbitration and topical training. So, the bottom line is, not everyone can apply and be accepted as a CIDRE.

The Submission of Offers: When submitting "offers" of payment, both parties must submit an "offer" for the OON payment in dollars and a percentage of the QPA represented by that dollar amount, within 10 business days of the CIDRE selection. Providers must provide the size of their practice by the number of employees that they employ, and whether the provider is a specialty provider. Health plans must provide their coverage area, QPA geographic area, and must state whether the plan is fully insured or self-insured. Health plans must also state the QPA for the applicable year of the claim dispute.

Before initiating the federal independent dispute resolution process, disputing parties, according to CMS, must initiate a 30-day "open negotiation" period to determine a payment rate.

Arbitration/IDR Payment Factors/QPA: It's important to state that the QPA, or the median in-network rate, is the primary factor in a final payment determination. The CIDRE must assume the QPA represents a reasonable market-based payment. The CIDRE must begin with the presumption that the QPA is the appropriate OON amount. The CIDRE must also consider the QPA, or the offer closest to it, as the final payment amount. Keep in mind that it is NOT the role of the CIDRE to determine whether the QPA was calculated correctly. Their job is to simply consider the information that is submitted by both parties and consider whether any "additional criteria" is already reflected in the underlying QPA, to assure there will be no "double-dipping." The CIDRE can also consider whether information that shows efforts to alter the service codes have occurred, which might result in "up-coding" or "down-coding" billed amounts. Down-coding may show that the QPA is artificially low, for example. However, the CIDRE is permitted to consider "additional criteria" that may lead to a higher payment amount than the QPA. Such additional criteria includes the level of training, experience and quality of care, as well as the outcome measurements; the acuity of the patient and complexity of services, a good faith effort to enter the network by the health plan and provider, market share held by the provider or facility in the region; teaching status, case mix, scope of service of facility; or contracted rates over the prior four years. This additional criteria could cause the payment rates to increase for providers, so it's likely that providers will include as much of this as possible in their submissions. Part 2 rules made it clear that the IDR entities will not give equal weight to both the QPA and additional factors, and that the IDR entities will be instructed to "select the offer closest to the QPA" unless the certified IDR entity determines that credible information submitted by either party is materially different from the appropriate out-of-network rate.

If the "credible information" demonstrates that the QPA is "materially different" than what an appropriate payment for the OON service should be, the CIDRE may choose a higher amount.

I asked Colleen Dempewolf of MultiPlan about the IDR entities being instructed to select the offer closest to the QPA unless the CIDRE can determine that credible information submitted by either party clearly demonstrates that the QPA is materially different from the appropriate OON rate.

Once a plan receives a claim for an OON service, the plan has 30 days to either choose to send the provider and initial payment or a denial of the payment.

"Most observers, including MultiPlan, see this rule as favoring the payor. Providers most certainly would prefer that more weight be given to training, acuity, etc. in selecting between the final offers. That said, the rule doesn't prohibit them from arguing these points – it just makes it harder to do so because they must show evidence, not just that these considerations are applicable to the claim, but also that the QPA doesn't sufficiently take them into account. Effectively, with QPA holding so much weight at arbitration, it's possible providers will be less inclined to take claims to arbitration and more inclined to negotiate a settlement. Of course, this depends on how reasonable the provider views the payor to be."

I also asked Ryan Work about those additional factors that may warrant higher payment amounts, and how these will impact self-funded health plans. "For this final amount that potentially a self-insured plan is submitting as part of the arbitration process, it behooves the plan to consider these other factors… And put those into the payment amounts, so they are close to that, and the arbiter sees that and understands that they are included. That's one of the differences between the QPA and a final payment amount that is submitted in the arbitration process."

There are many factors that the CIDRE may not take into account, including a provider's usual and customary charges, a provider's "billed charges," rates paid by any public payer payment or reimbursement rates such as Medicare, Medicaid, CHIP or TRICARE, or past arbitration decisions as a precedent. That is not to say that a plan using referenced-based pricing, for example, cannot use some form of rating above Medicare rates (such as 150% of Medicare). The interim final rule clarifies that the CIDRE cannot consider which "offer" is closest to 150% of Medicare; however, the Federal Departments noted that in-network contracted rates are frequently based off a percentage of Medicare rates. Because such basis of the Qualified Payment Amount is the in-network contracted rates, if the QPA is calculated using a percentage of Medicare, then the CIDRE can take into account this percentage of Medicare value. In this case, the percentage of Medicare value represents the QPA and not a particular offer from the disputing parties.

To clarify this concept for RBP plans, I asked Chris Caladuci to break it down. "The federal agencies specifically said of payer and provider… your offer can't be 150% of Medicare. But what an arbiter is allowed to do when we're dealing with a value based on the percentage of Medicare, is that if the percentage of Medicare value is the basis for the QPA, this median in-network rate then, by definition, the CIDRE can take into account the percentage of Medicare, because the CIDRE has to look at the QPA, the median network rate, as the primary factor."

Chris continued: *"You can't come in with a 150% of Medicare offer, but if the QPA is based on a percentage of Medicare, then that can be taken into account by a CIDRE."*

Colleen Dempewolf had this to say on the matter: "The Act does not say that the initial payment cannot be based on these amounts, only that at arbitration the IDR entity may not consider these amounts as justifying a final offer. An RBP program using a percentage of Medicare to price claims where there is no network would likely consider the default Medicare-based price to be the QPA for these claims, and can make any reasonable arguments for an offer that speaks to that Medicare-based price. What they can't do is justify it as an appropriate payment because it is over the amount Medicare would pay for the service in that geography."

In our discussion, Ryan Work also had some helpful comments on RBP plans and use of Medicare Rates in the QPA determination. "There was an important footnote in the 2nd IFR. Basically, if you use a multiple of Medicare to determine the QPA for your in-network rates, you can continue to do that, and the arbiter must consider that as the QPA amount. To me, that footnote in and of itself is the Agencies' trying to understand and bring in RBP plans into the QPA when it comes to an OON emergency care event."

Final Payment Determination:
The parties may continue to negotiate after the IDR process begins. If an agreement is reached, the initiating party must inform the Federal Departments within three business days after agreement, and the final payment must be made no later than 30 business days after they have reached agreement. If the parties cannot agree on a payment rate, the CIDRE must make a final payment determination 30 business days after its selection. The Federal Departments may extend the 30-business day period on a case-by-case basis if the extension is necessary to address delays due to matters beyond the control of the parties or for "good cause."

The determination of the IDR entity is binding on the parties and is not subject to judicial review, except in narrow circumstances, such as fraud.

As an attorney, I asked Chris Caladuci about the binding arbitration. He responded: "The arbiter's decision

cannot be challenged in court, unless there is fraud or misrepresentation that can be proven. Otherwise, the arbiter's decision, the CIDRE's decision, is binding on both parties and final."

Ryan Work also commented on this, stating, "That arbitration determination for that case does not have precedent for the future. So, the arbiter or a similar case, or a code two months from now can't go back into the files and look at another arbiter's decision on that. It's not a precedent. It's basically almost like blinders from one case to another."

As stated in my last article, the IDR process will use a "Baseball-Style" Arbitration process, meaning that the CIDRE is required to pick one of the two "offers" which is closest to the QPA. The amount of the offers will determine that amount. It could be that the QPA itself is the final amount, or it may be higher or lower than the QPA, depending on the offers submitted.

I asked Chris Caladuci to better explain the "baseball arbitration, for anyone not as familiar with it. "Baseball arbitration is, in short, the plan comes in with an offer, the provider comes in with an offer. The CIDRE must pick either the plan's offer or the provider's offer. The CIDRE does not pick something in-between. That is what baseball arbitration is…. You pick an offer that is submitted by the parties."

For the most part, it seems as though many providers may want to try to settle in the Open Negotiation Period, rather than to risk a lower payment in the arbitration process, but we shall see.

The arbiter cannot split the difference. The amount closest to the QPA should be the final amount of payment, unless the additional factors come into play. The cost of the arbitration is paid by the losing party.

Keep in mind, as mentioned above, if the provider submitted "credible information" showing a "material difference" between the QPA and the value of the service, the arbiter could choose the provider's offer, even if that offer is further from the QPA than the plan's offer. Once this determination is made, the CIDRE must provide the underlying rationale in a written decision to the portal submitted to both parties and the Federal Departments.

It may take a year or more to make this process understood by everyone. It may not be smooth in the beginning. With this and the claims process itself having to make adjustments due to the No Surprises Act, I am guessing it will be at least a year before it's running well. I think the first six months will be rocky for everyone, particularly if they don't have enough CIDREs. They could rush the decision-making to move onto the next case, or there could be a backlog. We'll have to see what happens as this rolls out in January.

Cost of the Arbitration/IDR Process: To begin the process, each party must pay a non-refundable $50 fee when the CIDRE is selected. The CIDRE is required to post their charged fees in the Federal Portal. The IDR fee range at this time, according to guidance, is expected to be in the $200 to $500 range for single determinations and $268-$670 for batched determinations. Both parties must then pay the CIDRE fee when they submit their respective offers. Within 30 business days of making the final determination, the CIDRE must refund the prevailing party's fee payment. The losing party does not get a refund. So if the fee is $500, both parties submit $500… The losing party pays the $500 fee, and the winning party gets their $500 refunded. The loser pays fees; winner does not in baseball-style arbitration.

Cooling Off Period: The initiating party may not submit a subsequent dispute with the same other party for the same or similar item or service with 90-calendar days. In this situation, a plan can't constantly be filing for IDR for the surprise billing process with the same provider.

No one wants to be the HR Director we called Judy. Even more, no one wants to be in the position that our employee, who we called Pam, was in when she sat across from Judy's desk.

The stress of the past 18 months+ was more than enough stress for all of us. The last thing we need is to be hit with Surprise Medical Bills. Hopefully, these new rules will at least reduce considerably the number and amounts of large surprise medical bills; at least for those situations stated in the No Surprises Act.

Facility/Provider Notices

There are required notices for Facilities and Providers. The first is the Patient Consent for Out-of-Network Care, which requires providers and facilities to provide a notice to a patient regarding potential out-of-network care. The patient must consent to such out-of-network care and any additional costs that may be incurred. However, there are exceptions. A patient is not required to sign the form and should not sign it if they didn't have a choice of health care providers when they received care (i.e. a forced provider).

There is also a Public Notice requirement for facilities and providers to post a one-page notice on a public website. The Model Disclosure Notice Regarding Patient Protection Against Surprise Billing is required under Section 2799B-3 of the Public Service Act. A provider must make publicly available such notice by posting it on a public website of the provider or facility, and provide a one-page notice that includes information in a clear and understandable language on 1) the restrictions on providers and facilities regarding balance billing in certain circumstances, 2) any applicable state law protections against balance billing, and 3) information on contacting appropriate state and federal agencies in the case that an individual believes that a provider or facility has violated the restrictions against balance billing.

The Model Notices can be found at cms.gov.

Health insurance and Health Plan Notice:

Health insurers and Health Plans must provide a notice to individuals

about their rights under the No Surprises Act. There is a Model Notice available on the DOL website (although it has been on and off the site a few times since I started researching for this article, so they could be updating it). The notice must be posted on the plan's website and be included on each EOB for an item or service covered by the No Surprises Act. Although TPAs may assist in preparing this notice for self-funded plans, the plan sponsor has the ultimate responsibility for compliance.Plan participants can expect that their EOBs will become quite thick when they receive them in the mail... Hence, more administrative/ postage costs also.

I asked Marilyn Monahan if a plan is self-insured and uses a TPA, is there coordination that is needed between the plan sponsors and the TPA about the notices that are included in the EOB? Does (or should) the Plan Sponsor notices be the same, consistent notices? I expressed to her my fear that the plan notice may differ from the TPA's notice, causing some confusion and possible liability. Marilyn clarified: "The IFR contains new notice and posting requirements. For example, health care providers must provide certain notices to the plan or issuer, and additional notices to patients. Another notice and posting requirement applies to plans and issuers; plans/issuers must post and provide certain notices to participants, including a notice that should accompany explanations of benefits (EOB). Regulations have not yet been issued on the mandate applicable to plans/issuers. In the meantime, the Departments expect plans/issuers to comply using a 'good faith, reasonable interpretation' of the CAA. Also in the meantime, a model notice has been issued which may be used by plans/ issuers. Ultimately, in the case of a self-funded plan, the responsibility for issuing compliant notices rests with the plan, and not the TPA. The employer should therefore work with its TPA to ensure that compliant notices are prepared and distributed, and that all legal requirements are satisfied."

The CIDRE can also consider whether information that shows efforts to alter the service codes have occurred, which might result in "up-coding" or "down-coding" billed amounts.

No Surprises Act Impact on Self-Funded Health Plans Using Reference-Based Pricing

The No Surprises Act's limitation on balance billing for services provided in an "in-network" facility by an out-of-network provider is likely to be quite problematic for self-funded plans that use Reference-Based Pricing as their financing method, in place of a PPO network. Because there is no network, and all claims are generally paid at a reference-based rate (most commonly a percentage above known Medicare Rates, such as 150% or 200% of Medicare), such self-funded health plans and their RBP vendors will need to discuss how they intend to deal with the No Surprises legislation, sooner rather than later.

Financing plans with reference-based pricing have grown in popularity over the last decade. However, as RBP has become more prevalent in the industry, hospital systems have become more knowledgeable about it, and at times, have refused payment entirely from RBP plans, and instead, have opted for immediate balance billing to all plan participants. In response to these provider actions, certain RBP vendors are struggling to produce solutions that will limit disruption to employer and employees while attempting to retain as much of the savings that RBP Plans have been known for. RBP plans generally pay claims at a stated percentage above Medicare (such as 140%, 150%, 200%, etc.), while PPO contracts, although a great savings over non-contracted provider rates, generally result in (if compared to Medicare, which of course their rates are not based on) costs ranging from 300% to 800% of Medicare rates. Sadly, I've seen many initial bills from hospitals coming in at over 1,000% of Medicare rates when no network is in place.

"Work-arounds" or "Alternatives" for RBP vendors have included (so far) one-off facility agreements, creating a networked facility, or single case agreements, which is negotiated oftentimes prior to the participant entering the facility for service. An example is a known procedure or surgery, such as an ACL reconstruction, hip replacement or other procedure. In these cases, some RBP vendors have opted to offer pre-payment to the facility, to encourage them to accept the patient at the RBP rate. There is concern, however, that such pre-negotiated rates could be perceived as a contracted rate, and may set precedents. One of the administrative concerns of this type of solution is the burden that would likely result from pre-negotiations, as well as a possible delay in service while negotiations are in the works.

Another work-around may be direct provider contracts, but those may likely be limited to certain services only, and if providers result in providing additional services, they could opt to balance-bill for those additional services, which may or may not be prohibited under the No Surprises Act, depending on the type of service.

It is assumed by most in the self-insured industry that work with RBP plans that the level of payment for RBP plans may end up increasing to a higher percentage, to still provide savings over PPO plans, but not at the wide difference we are seeing currently. Many of us are expecting payment levels to raise from the 140%-200% rate to perhaps raise to something more like perhaps 200% to 250% for normal facility payments, to cut back on the provider pushback and possible

refusal to accept patients under RBP plans.

Before the new September 30, 2021 IDR rules Part 2 were released, I asked two RBP vendors I work with about how they intend to deal with the No Surprises Act. When asked how HS Technologies, an RBP vendor based in Orange County, California, will adjust, President Ryan Day responded as follows: "The No Surprises Act impacts reference-based pricing programs with no facility network. The Interim Final Rule published in July specifically mentions these types of plans in the context of indemnity plans, acknowledging that the scope is limited to emergency facility and professional claims. If there is no facility network associated with a plan, there can't be a scenario where a member is surprised by receiving services at an in-network facility from an out-of-network provider. This limited scope doesn't apply when there are one-off agreements with a facility. Our reading of the rule made clear that these agreements would now make it a surprise bill if a member receives out-of-network care at a facility that has such an agreement."

Ryan Day continued with additional solutions. "HST will be able to identify these surprise bill scenarios and, when the plan includes access to a MultiPlan network, ensure the plan administrator has the network QPA needed to determine the member's cost share." HST is now part of Multiplan, with contracted national networks such as PHCS and MultiPlan.

I asked the same question of Larry Thompson, Chief Revenue & Strategy Officer for AMPS, another RBP vendor. Larry stated: "There are many pieces to this. Our Chief Legal Counsel is working on a White Paper to address all of this, and I will provide it once it is complete. In the interim, here are few things to consider. The Act does not specifically target RBP or repricing. While it does address OON, we are prepared to assist our clients who use us for this service. More to follow from our CLO."

I also asked Ryan Day how they propose to bridge the gap if/when facilities refuse to accept payment entirely from RBP plans? Ryan replied: "HST has routinely experienced a 98% acceptance rate from providers, recognizing not only the fair reimbursement we generate, but also the benefits we can bring to high-accepting facilities. Our HST Connect application helps to steer plan members to those providers, delivering the steerage benefits they typically only expect from network participation. We also engage the provider at key points before service is rendered, to ensure they understand the plan benefits. Should the facility disagree with the reimbursement, our PAC program and settlement portal make it efficient for the provider to engage in the negotiation now required by the No Surprises Act. Any subsequent arbitration resulting from an inability to reach agreement will leverage the analytic and arbitration support services of MultiPlan to help our employers present the best case."

Larry Thompson, when asked the same question, responded as follows: "Rarely does this happen – less than 1% of our members ever face this problem. When they do, our advocates work with the facility to explain how our program works, and in the majority of the cases, access is allowed. Failing that, we offer single case agreements so that the facility will allow service. Barring that, we can revert to safe harbor contracts we have in AMPS America, or redirect the service to another facility."

As stated in my last article, the IDR process will use a "Baseball-Style" Arbitration process, meaning that the CIDRE is required to pick one of the two "offers" which is closest to the QPA.

I also asked Larry how the RBP vendor will coordinate these efforts with the TPA? "Our TPA's are the first line of contact for most members and providers," responded Larry. "Through our integration the TPA will know when to transfer members to our Advocacy or Care Navigation teams to resolve any issues with providers."

Lastly, I asked Ryan Day what types of plan changes/provisions they are recommending plans that are using reference-based pricing add to their plan documents specifically related to the No Surprises Act? "We are considering adjusting the negotiation corridor to allow for settlement above the typical level for surprise bills specifically ER claims. We are also looking at changing the default reimbursement for ER claims that are impacted by the No Surprises Act."

Federal vs. State Balance Billing Laws

It is important to note that the No Surprises Act is not intended to displace any state balance billing laws. The issue of state vs. federal law is quite complex and I suggest you seek the advice of legal counsel on this. I will attempt to summarize just the basics of the interaction, but again, this is only a brief summary. The Interim Final Rules defer to existing state requirements with respect to state laws and states that have an established process in place to resolve payment disputes and allow for arbitration. Self-funded plans have the option to opt into a state law where payment standards of the state are expanded, with full protection against balance billing.

Existing federal law says that the out-of-network provider must have a patient sign a consent to receive non-emergency services, but the sate law might prohibit an individual from providing consent to be balance-billed. If a state develops model language that is consistent with the No Surprises Act, HHS will consider a provider or facility that makes appropriate use of the state-developed model language to be compliant with the federal requirement. Again, this is quite complex. I asked Marilyn Monahan if she could comment on the state of California's balance

Important Timeline Chart

I've created a summary chart with the timelines to assist in the understanding of the IDR Process.

Departments select CIDRE in the case of no conflict-free selection by parties	6 business days after the IDR initiation date	Selection posted in Federal Portal
Submit payment offers and additional information to CIDRE	10 business days after the date of CIDRE selection	Initiated by both parties. Submit into the Federal Portal with required data elements.
Selection of Offer and written decision. Payment determination made	30 business days after the date of the CIDRE selection	Initiated by CIDRE. Entered into Federal IDR Portal with data elements.
Payment submitted to applicable party upon final determination	30 business days after payment determination	Party that owes payment under the determination initiates.
"Cooling off" period during which no further IDR claims may be raised.	90 calendar days after initial determination	Party initiating IDR initiates.
Departments select CIDRE in the case of no conflict-free selection by parties	6 business days after the IDR initiation date	Selection posted in Federal Portal
Submit payment offers and additional information to CIDRE	10 business days after the date of CIDRE selection	Initiated by both parties. Submit into the Federal Portal with required data elements.
Selection of Offer and written decision. Payment determination made	30 business days after the date of the CIDRE selection	Initiated by CIDRE. Entered into Federal IDR Portal with data elements.
Payment submitted to applicable party upon final determination	30 business days after payment determination	Party that owes payment under the determination initiates.
"Cooling off" period during which no further IDR claims may be raised.	90 calendar days after initial determination	Party initiating IDR initiates.

billing laws and how they will interrelate with the No Surprises Act... "Existing state limits on balance billing – and California has some – will remain in effect for fully insured plans, to the extent that they provide participants with greater rights than they are entitled to under the CAA."

Enforcement

Enforcement of the No Surprises Act is similar to that of the Affordable Care Act. If a fully insured plan sponsor contracts with a third party, then the third party will be responsible for compliance. In a self-funded health plan, the employer plan sponsor will be responsible for compliance, even if they contract with a third party, such as a TPA, to assist them with providing all of the necessary requirements. The Department of Labor will regulate self-funded plans, and fully insured plans will be regulated by the states.

As of now, it is stated that up to 25 health plan audits per year will be performed to ensure compliance with the Act, starting in 2022. If, however, the Departments should receive a consumer complaint, they can audit that consumer's health plan.

Complaints

The No Surprises Act requires the Departments to establish a process for receiving complaints regarding potential violations of the law by providers and insurers. They announced their intention to create one system to intake all complaints related to the various components of the law and direct them to the various departments. The IFR clarifies that there will be no time-limit on complaint filing, but the relevant departments must respond in writing no later than 60 business days after a complaint is received. The regulations contained within the IFR are set to be effective on September 13, 2021, which is 60 days after its publication in the Federal Register.

The No Surprises Act's limitation on balance billing for services provided in an "in-network" facility by an out-of-network provider is likely to be quite problematic for self-funded plans that use Reference-Based Pricing as their financing method, in place of a PPO network.

Next Steps & Conclusion

If you're feeling stressed over these rules, or if just reading them is making you have that tunnel vision I mentioned in the beginning of Part 1, or if you're employer dealing with HR issues like the one I described in my example with Judy and Pam, remember to breathe, and remember, the goal of this legislation is to help people and prevent surprise billing practices. Anything new is often confusing and frustrating. Just take one step at a time and keep an eye out for the anticipated end game. Won't it be nice to one day soon not have to listen to the anxiety in your family member or your clients' voices and angst in their eyes when they tell you they've received an unexpected, surprise medical bill? The No Surprises Act won't help in every case, but it should help the majority of cases in which surprise medical bills show up in our mailboxes. Personally, I'm hoping they expand the No Surprises Act (or offer something similar) to cover other provider bills not covered under this legislation.

Helpful Links

If you need/want additional information, you can visit the following links to assist you...

Interim Final Rule and Comment Period: https://www.cms.gov/files/document/cms-9909-ifc-surprise-billing-disclaimer-50.pdf

Federal Register: https://www.federalregister.gov/documents/2021/07/13/2021-14379/requirements-related-to-surprise-billing-part-i

CMS Fact Sheets: https://www.cms.gov/newsroom/fact-sheets/requirements-related-surprise-billing-part-i-interim-final-rule-comment-period

https://www.cms.gov/newsroom/fact-sheets/what-you-need-know-about-biden-harris-administrations-actions-prevent-surprise-billing CB

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How to Use Pharmacy Benefits Data Analytics to Play Offense

Good strategy to grow your book of business

BY RICK SUTHERAND

Rising prescription drug costs are a significant concern for employers, many of whom are struggling to reign in dramatically increasing pharmacy benefit spend while protecting the health of their members. Over 60% of employers say their prescription drug and medical spend is costly and unsustainable, and specialty drug spending is forecast to continue increasing 15% year over year. Many HR leaders are seeking creative ways to reduce costs while continuing to provide a rich benefit as part of their talent acquisition and retention strategy.

In an increasingly competitive hiring environment like we are currently seeing, helping your clients develop a pharmacy benefits program that is attractive to both current and future employees and reduces overall prescription drug costs can not only help employers attract and retain talent – it can solidify your relationship as a trusted advisor with clients and prospects.

As you help your clients evaluate how to optimize their pharmacy benefits, taking a data-driven approach can set you apart – and set them up for success.

Pharmacy benefits is a black box

The pharmacy benefits industry is very opaque. The reality is most employers overpay an average of 14% per year for pharmacy benefits – while receiving suboptimal clinical management and customer service – simply due to misaligned pharmacy contract terms or a lack of a pharmacy contract altogether. In addition, clinical misalignment results in many employers overpaying by an incremental 5-10% per year.

Without data, pharmacy benefits is a black box. It's essential for employers to have transparent contract terms as well as full visibility into the performance of their plans to improve the health of their employee population at the lowest net cost. Data analytics is critical to gaining this visibility.

Data analytics enables you to optimize pharmacy benefits

Data analytics brings much-needed transparency to the pharmacy benefits landscape.

Applying data analytics enables you to help your clients evaluate and compare pharmacy benefits options as well as gain insights into their plan's performance and utilization so they are equipped to make better decisions. Advanced data analytics can uncover potential financial and clinical risks that would not otherwise be easily identifiable, and which can contribute to wasteful spending. Leveraging business Intelligence and data analytics can also help identify risk areas and trend drivers in a company's claims data - such as chronic health conditions or other disease prevalence and high medication utilization - and forecast cost trajectory and program impact. The insights provided can uncover opportunities to introduce hyper-targeted clinical strategies to help the employer address any potential issues, such as by promoting medication appropriateness, dose optimization, and member safety and quality of life.

Data analytics can also be used to forecast the cost and potential employee impact of any decisions before they're made, so employers are empowered to make the best decisions for their plan and their members and communicate them effectively.

By using data-driven pharmacy decision making, you can help your clients construct a pharmacy benefits plan that is attractive to both current and future employees, optimize their wellbeing, and reduce overall prescription drug costs. In fact, employers are often able to reduce their pharmacy spend by more than 25% on average the first year, as well as protect themselves against future drivers of increased spend, like the rising cost and utilization of specialty medications.

Getting started with data analytics

When applying data analytics to optimize a pharmacy benefits plan, an effective strategy begins with analyzing the employer's prescription claims data. Gaining access to actionable pharmacy plan-specific data is the best way to understand your client's employee population, predict future spending and healthcare needs, and

The reality is most employers overpay an average of 14% per year for pharmacy benefits – while receiving suboptimal clinical management and customer service – simply due to misaligned pharmacy contract terms or a lack of a pharmacy contract altogether.

make better decisions to improve the quality and affordability of the benefits plan without sacrificing service experience. Through the analysis of the claims data, you can help your client determine which drugs and drug classes are driving costs for their plan. One or two high-cost drugs can have a significant impact on the overall budget – and in many cases, specialty drug spend for a small number of members is a primary cause of rising pharmacy benefits costs. Understanding which medications members rely on is essential to customize a formulary that will minimize employee impact.

It's also important to combine analysis of pharmacy claims data with specialized clinical expertise – in other words, pharmacists who can address clinical risk areas and cost-savings opportunities. Employers do need to support their employees with chronic and rare conditions and ensure they have access to the treatment they need - but taking care of employees doesn't necessitate the wasteful spending that is often seen when data analytics and clinical expertise is applied to pharmacy claims files. In order to effectively optimize a formulary, a pharmacy or clinical expert is needed. For example, independent clinical reviews can help prevent the off-label use of prescription medications or intercept prescriptions for high-cost, low-clinical value drugs. By combining data-driven insights with applied clinical expertise, you can help your clients strike the right balance between drug access and cost.

As a broker, you will be best positioned to serve your clients if you have an established relationship with a team of clinical experts you can trust to evaluate the medical necessity, appropriateness, and effectiveness of prescription medications. It's important that your clinical partner is independently aligned with your clients' goals and evaluates everything according to what is in the medical best interest of members and the best financial interest of the employer.

Additionally, it's important to note that employers in self-funded, carved-out arrangements have the most opportunity to optimize their pharmacy benefits. Carved-in pharmacy arrangements rarely, if ever, provide the transparency needed to understand how a plan's members utilize the benefit so you and your client can make informed plan decisions. Carved-out agreements, however, empower your client with data and provide more options to control both the formulary and pharmacy benefit costs.

Finally, at RxBenefits, we have found that the ideal way to highlight the impact of leveraging data analytics is by analyzing the employer's pharmacy claims data at no cost and then forecasting the cost-savings and member impact of each pharmacy benefits strategy we recommend. We then provide that data to the broker, who is then more empowered to help the employer make the best, data-driven decision about their pharmacy benefits plan for them and their members. Often, when the employer sees how much more visibility, control, cost savings, and member benefit they can achieve by leveraging a data-driven approach, they are excited to move forward.

The future of data analytics for pharmacy benefits

When data analytics is applied to pharmacy benefits, you and your client gain visibility and control rather than accepting a black box of benefits. You can help your client better evaluate their options, obtain insights into their plan's performance and utilization, uncover potential risks, and make better decisions about their benefits programs – including analyzing the cost and employee impact of any decisions before they're made. Ultimately, optimizing pharmacy benefits with data analytics drives cost savings for your client and helps improve health outcomes for their members.

Moving forward, AI/machine learning and predictive analytics will also become more mainstream, enabling the analysis of a broader array of employer trends, patient demographics, prescription patterns, and more, so employers can make better decisions in real time.

With prescription drugs continuing to be the most expensive component of healthcare benefits, brokers have an opportunity to use data analytics to proactively help their clients identify and address pharmacy-related factors that are driving up their plan costs. By understanding the driving forces behind high-cost pharmacy claims and identifying strategies to optimize utilization, you can help your clients reduce costs while continuing to provide a comprehensive benefit – in turn, building strong client relationships and a book of business as a result. CB

RICK SUTHERLAND *is Business Development Executive of RxBenefits, the nation's first Pharmacy Benefits Optimizer. He supports brokers in the California and Hawaii regions, guiding them through the pharmacy benefit contracting process to help them evaluate their clients' prescription drug plans for optimal savings, clinical management, and service. Rick is also the current Board President for the Employee Benefit Planning Association of Southern California (EBPA). He can be reached at* **rsutherland@rxbenefits.com.**

How Artificial Intelligence is Transforming Insurance

BY RAJEEV SHRIVASTAVA

While the term artificial intelligence might conjure up images of sci-fi movies for many, it's quietly responsible for many practical functions in the insurance industry. Artificial Intelligence—otherwise known as AI—is defined as intelligence that utilizes machines, computers, and datasets to problem solve, as opposed to utilizing the natural intelligence displayed in humans or animals.

Companies are deploying AI to make precise decisions based on large volumes of data--often petabytes--at speeds that most humans can't match. When optimized, AI can automate functions that help organizations make informed business decisions for competitive advantage which best serves their businesses and customers.

For example, popular apps like Google Maps or Waze are examples of AI, since they rely on machine learning to identify changes in traffic flow so they can recommend a route that avoids congestion. Similarly, the future of the insurance industry will utilize machine learning and advanced technologies to enhance productivity, adapt to customers' needs, and ultimately optimize the customer experience.

How AI is Implemented in the Insurance Industry

As AI technology evolves, the insurance industry is looking to leverage its capabilities in order to provide better and more relevant services to its customers. According to McKinsey & Company, insurers accelerated the adoption of AI significantly during the pandemic. Since social distancing made it more difficult to conduct face-to-face business interactions, a number of insurance carriers noted that moving to a digital interface was crucial to not only maintain business but to deliver an exceptional customer experience. On the other hand, the businesses that relied on traditional practices of sales and business were left behind.

But, how exactly is AI being implemented in the insurance industry?

Delivers Individualized Sales Processes

Since AI requires no in-person involvement, AI can streamline and expedite the insurance policy purchasing process. Just as the machine learning behind Google Maps understands where you want to go and creates a customized route to get you there, machine learning in the insurance industry means that a customer's profile will be used to create an individualized sales experience. Computers use algorithms to gather information and data about a user in order to offer auto, commercial, travel or life insurance policies that best meet a customer's specific needs.

Offers a Wide Breadth of Policies

Whereas humans are limited by the amount of information a human brain can retain, machines don't have those same limitations. Considering how insurance companies have a vast array of options and plans in the marketplace, this puts AI at a huge advantage. Insurers can feed any number of plans and terms into an AI algorithm, and trust that it will synthesize any changes related to COVID-19, new guidelines, government regulations, etc.

Limits Subjectivity During the Claims Process

If humans are responsible for deciding the fate of insurance claims, then there is always an element of subjectivity. On the contrary, creating environments where computers are responsible for sifting through data and making predictions helps decrease fraud and limit subjectivity during the claims process.

The more that AI learns about

customers' needs, the more it's able to automate tasks such as answering common questions, providing quotes, and sending customers' insurance policies and cards. These time-saving advantages free up resources so companies can focus on business development.

Provides 24/7 Customer Service

Throughout the pandemic, AI smartbots have become critically important to providing around-the-clock customer service in the insurance industry, especially for health insurance and travel insurance. The machine learning aspect of these bots means that they can "get smarter" with every customer interaction. As their knowledge base grows, AI smartbots use their data to guide desired outcomes without the need for live customer representatives. Customers can benefit from being able to access important information, anywhere, at any time.

How will AI Impact Your Business?

Truth be told, it's not a matter of "if" AI will impact your business; it's a matter of when. Humans are becoming more dependent on their devices to simplify everyday tasks, and the advancement of algorithms and machine learning means that companies can use data to better understand their customers and to provide an overall better customer experience.

For the insurance industry, AI is being used to tailor policy options and present users with a customized purchase process. As AI becomes more advanced, insurance companies will be able to synthesize data at scale and provide customers with human-like interactions, while freeing up company resources.

Although the potential for advancement is limitless, you shouldn't feel threatened or scared about technology taking over. Instead, be part of the change. Stay informed and stay prepared. Welcome these changes with open arms. The brokerages and agents that will fare the best are the ones who seek to understand AI so that they can take advantage of the technology. Those that choose to work with AI instead of against it will stay relevant, competitive, and ready to tackle the ever-evolving digital economy. CB

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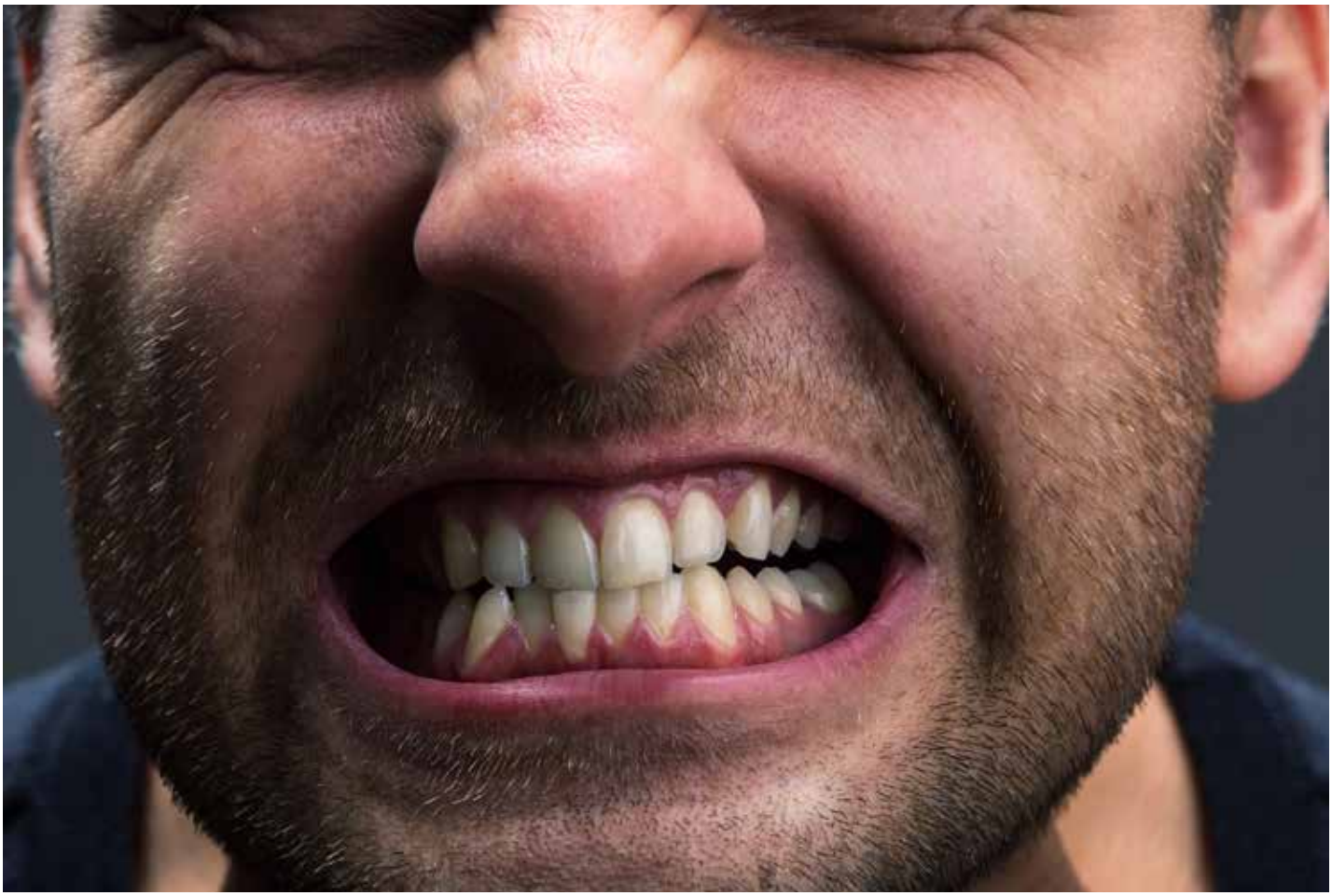

Pandemic Demonstrates Value of Dental Benefits

BY RANDI TILLMAN, DMD

COVID-19 was a challenging period for dentists and patients alike. At the start of the pandemic, dental offices were forced to close for a period of time leaving many patients without access to dental care, and many dentists and staff with few patients. Slowly, dental offices re-opened, safety measures were put in place, and adults resumed visiting their dentist. According to Guardian's Workplace Benefits Study, seven in 10 adults say they have been to the dentist during COVID-19 and 76% brought their child.

Despite overall lower dental utilization during the pandemic, only a fraction of U.S. adults reported that the pandemic made them value their dental benefits less, and those with insurance were far likelier to visit the dentist during COVID than those without. In fact, our research confirmed that 75% of adults with dental insurance visited the dentist at least twice during the pandemic versus only 58% of those without dental coverage. These findings continue to reinforce the value of dental benefits, and the impact they have on oral health.

For example, let's take a look at a survey conducted earlier this year by the American Dental Association. As patients began to return to dental offices, general practice dentists reported the following changes in patients' oral health conditions: 76% reported an increase in grinding/clenched teeth; 67.7% saw an increase in chipped teeth; and 68.5% saw an increase in cracked teeth, as compared to before the pandemic. The findings also showed an increase in tooth decay (30%) and periodontal disease. We know that these conditions can result in tooth loss, and it has been widely documented that poor oral health can have a negative impact on overall health.

With a renewed focus on physical and emotional well-being as a result of the pandemic, this is an opportunity for brokers and benefits consultants to remind employers of how important it is to consider including dental benefits as part of an employee benefits package. The upside is that our research revealed that COVID-19 influenced employer's attitudes toward dental benefits. Though only 11% say they've made changes to dental coverage during COVID, nearly a quarter report they are planning future changes to dental benefits with 44% saying they plan to add coverage.

The latest findings also underscore

As patients began to return to dental offices, general practice dentists reported the following changes in patients' oral health conditions: 76% reported an increase in grinding/clenched teeth; 67.7% saw an increase in chipped teeth; and 68.5% saw an increase in cracked teeth, as compared to before the pandemic.

the value of understanding consumer attitudes and behaviors toward oral health. As we all know, The Great Resignation is impacting the labor market, and employers should think about the overall make-up of their benefits package to help attract and retain talent. What's encouraging is that dental benefits continue to evolve with the times, and as we see time and time again, employees who have dental benefits, use them and are more likely to have better oral health. One key example is the importance of a strong dental network - 88% of those surveyed said their dentist is in-network – which also reinforces that if consumers have dental insurance and it has a strong network, they will visit a dentist for annual check-ups.

Additional key takeaways that brokers should keep in mind from our research include:

- **Infection Control Measures Better Than Ever:** COVID-19 was a turning point in more advanced dental safety with more than eight in 10 dentists adopting new infection control processes and procedures during the pandemic. While dental offices have always been held to a high standard when it applies to safety, the pandemic raised it to another level. The increased usage of PPE for staff, equipment that minimizes aerosols, and limiting the number of patients coming in and out of the office - all of these have played a positive role in increasing patient confidence and reducing risk. Our research also showed that 58% of patients noted that personally being vaccinated against COVID-19 made them feel more comfortable about returning to the dentist.
- **Teledentistry on the Rise:** Dental office closures prompted more practices to implement teledentistry than in the past. Teledentistry is the use of technology and tactics to provide virtual dental, medical and education services to patients who otherwise may need a consultation before visiting the dentist. This was incredibly useful for patients during the pandemic who may have been hesitant to see their dentist in person. Our research validated consumers believe teledentistry is a good option in certain situations with 72% saying it's helpful for consultations related to future dental work; 66% cited emergencies and 58% said it's good if they are traveling. Long-term, we believe that teledentistry will continue to be appealing to consumers, particularly for millennials and GenZ employees.

Many consumers reported using digital methods to communicate with dental practices and insurance companies during the pandemic and want to continue to have this as an option.

- **Preference for Digital Communications:** Whether it's providing information around dental benefits or oral health, our findings validated that clear communications and the manner of delivery is important to today's consumers. Many consumers reported using digital methods to communicate with dental practices and insurance companies during the pandemic and want to continue to have this as an option. For example, 69% said they want to use tech to get explanation of benefits, and 62% said they want to use tech to get information on oral health. This makes it equally important for employers to think about providing digital tools and frequent communications to their employees since benefits education will only contribute to overall utilization.
- **Innovation in Dental**: When it comes to consumer preferences around dental innovation, alternative filling materials (41%), teeth whitening (39%), smart toothbrushes (36%) and 3D printing techniques (36%) capture the most interest. At the same time, our research confirmed the growing interest in consumers who say they'd be interested in discounts on cosmetic services through their dental insurers, particularly when it comes to invisible aligners and teeth whitening. It would be worthwhile for brokers to find out if the dental carriers they work with have started to form partnerships with innovative companies, like byte®. Including discounts on cosmetic dental services as part of their dental benefits is a plus, especially for the millennials and GenZ consumers, who want to have these options.

The pandemic put a lot of stress on many industries, particularly for dental practices who have slowly started to rebound this year as more Americans return for their annual check-ups. At the same time, employers and employees are demonstrating a greater awareness on the importance of physical and emotional well-being. Dental benefits – whether employer-sponsored or employee-paid – need to be part of every employer's well-being strategy. Our research validated that without access to dental offices during the pandemic, oral health declined. Whether that means adding and/or increasing contributions to dental benefits or improving employee communications to increase awareness around their dental benefits, employers – alongside brokers – can play an important role in helping improve America's oral health. CB

DR. RANDI TILLMAN, DMD
is chief dental officer, Guardian Life.

Protect Your Company's Digital Health

Cyber crimes are on the rise. Time for cyber education.

BY JOEL ZWICKER

Insurance agents handle client's sensitive data on a daily basis and in the new digital world, data is a prize worth stealing. Given the amount of personally identifiable information (PII) agencies collect and retain, they can be a tempting place for cyber criminals to strike.

Becoming a victim of a cyber attack can hurt your clients and put your personal reputation at risk. If your agency is determined to be the source of a breach, customers will know your name in association with negative headlines. This is not the way you want prospective clients to find you when they look up your name online.

Technology alone will not provide protection against most types of attacks. Employees must take an active role in the digital health of their organization. Agencies should provide basic cyber education. Your agency is only as secure as its most exploitable staff member. Compromised emails are the entry point for 60% of cyber attacks and create opportunities for criminals to plant ransomware, steal funds, and misuse sensitive information. All agency employees must be vigilant about phishing emails that steal PII by impersonating other people or organizations.

RANSOM PAYMENTS FROM COMPANIES INCREASED 341%, TO A TOTAL OF $412 MILLION DURING 2020.

Know What Phishing Looks Like

It's important to show employees what these attacks can look like and inform agents to flag suspicious emails to management or the internal IT support. If one agent received an email they suspect of being a phishing attempt, other agents likely have the same email sitting in their inbox. All it takes is one successful phishing attempt for a bad actor to install malware and/or steal sensitive information.

All a hacker needs to do is to make an email account impersonating an executive at the company and send a message with a link or an attachment to employees. If they click on it, then malicious malware can be installed and infect the systems that hold sensitive data. These are the emails we joke about - someone from a faraway land wants your help and if you provide your bank account, they will share their great fortune with you. While it is easy to laugh at these blatant attempts to capture personal information, phishing attacks are not always this obvious and if the hackers cast a wide enough net, they are bound to catch something. The problem is that many times when an employee falls prey to these types of attacks it's not immediately evident. Malware can gather information for months, even years before the hacker strikes - pulling data from servers and holding it for ransom.

Spotting those messages before anyone can open them can keep your network safe. Emails asking for sensitive information or for the recipient to click a link should set off red alerts in every agent's minds. Sometimes, simply double checking the sender's email address can help employees identify phishing attempts.

When Things Get Personal: Spear Phishing

If phishing is a shotgun approach to cyber crime, spear phishing is a sniper rifle. Spear phishing is harder to spot because it takes pieces of information available on social networks and tailors a lure to the target. It is targeted and personalized. If the CEO of an agency posts about being on vacation, a sophisticated hacker will take that bit of data and create an email that looks like it's from the CEO (maybe a few letters off from their actual email address) and send a message asking an assistant for passwords or contacts. This is just one example. Spear phishing is so effective because it uses things that the hacker already knows the target cares about. Again, letting employees know what to look for is the best line of defense against this form of attack.

Phishing Can Lead to Ransomware

Using a phishing email, a cyber criminal will gain access to an insurance agency's network. Then what? They don't always sell the information on the dark web. Sometimes they inform the agency that they are holding the information and will destroy the data unless a ransom is met. Hackers have recognized that no one wants data more than the person that they stole it from.

Ransomware attacks have increased over the past two years. Ransom payments from companies increased 341%, to a total of $412 million during 2020. The insurance industry is not excluded from these attacks, with researchers estimating that the industry has lost more than 100 million Americans' PII.

Most offices have antivirus software but there is still some work to be done when it comes to the human element of agencies' digital networks. When we all went remote during the pandemic, phishing attacks increased by 600% during this time. Hacker's realized that many agents were working from home and something about being at home made people lower their guard. Taking the time to educate employees on the methods that cyber criminals use to attack insurance networks can help keep you safe.

Just like a business would put an alarm system on a brick and mortar storefront, it's time for insurance agencies to become proactive and take the necessary, simple steps to beef up their cyber security. With the risk of having client information stolen or exposed, it's not only dangerous but reckless to not educate your team on the role they play in ensuring the agency's safety. Insurance agents need to protect client data so this must be a critical aspect of all agents' operations.

JOEL ZWICKER *is chief evangelist at Agency Revolution (agencyrevolution.com). He has helped hundreds of independent agencies improve KPIs and achieve growth objectives. He coaches them in their digital transformation by helping them leverage digital marketing, marketing automation and content marketing. In addition to his years at Agency Revolution, Joel has extensive agency experience. For 11 years he was an independent agent and spent the last eight of those years overseeing the marketing efforts for a large insurance agency. Reach out to Zwicker at* **1903pr@1903pr.com**

When we all went remote during the pandemic, phishing attacks increased by

SMALL BUSINESS PREDICTIONS FOR 2022

A Q&A with Oscar's Troy Parant

BY PHIL CALHOUN

I RECENTLY CAUGHT up with Troy Parant, the senior director of Sales (West) for Cigna + Oscar, to talk about Oscar group plans. I learned a great deal worth sharing with you here.

Phil: We're thrilled to have more options for our California small group employers. Would you introduce yourself and tell us a little bit about Oscar and what you see for 2022?

Troy: I've been in the benefits space for over 10 years, helping businesses offer better benefits and spend their health care dollars more efficiently. There are so many different strategies and solutions in health insurance. Unfortunately a lot of them are geared toward large group employers. When someone is accessing health care, it is a very personal thing. That puts employers in a position where they need to choose the entry point to the healthcare ecosystem for their employees by picking an insurance carrier.

Historically, all carriers have been created somewhat equally. Oscar is doing things differently by putting the member at the center of everything that we do. We set out to create a health insurance company that behaves more like a doctor in the family. We give you a personal advocate to help navigate care, get questions answered without getting bounced around or waiting on hold. Having a personal advocate has never been a thing in small group insurance. We're happy to be bringing it to a new market segment and setting that new standard.

Phil: You launched Cigna+Oscar in the Bay Area in California on January 1, 2021, then in Southern California on April 1, 2021. Launching a health plan in such a complex market is no simple feat, let alone during a pandemic. How is Oscar doing in this regard?

Troy: Oscar was a pretty remote (virtual) company prior to everyone needing to work from home, so that adjustment was relatively easy. That said, this is the first time we, like many organizations, have interviewed, hired and managed teams in a fully virtual environment.

Cigna + Oscar, a fully insured small group product, is in nine markets across eight states and we are growing quickly. We've learned a lot in the last year and a half and are using those learnings as we launch new markets. There are certainly some challenges that are unique to California, where each region operates like its own market. Likewise, launching a health plan would typically be complemented by a series of general agent/broker meetings. Now that's all gone virtual. The reduction in social events where you would typically build buzz about your product has its own challenges, with only limited in-person interactions. We are a relationship business and we've had fun finding ways to interact with our distribution channels. While we're all craving the big industry events to interact with each other, our partners and clients are all dealing with the same issues within their own day-to-day businesses. Those small businesses need solutions that will keep their employees focused on their jobs.

2022 PROMISES TO BE IN SOME WAYS, EVEN MORE CHALLENGING.

Phil: You mentioned Cigna + Oscar. Can you tell us more about how your organizations came together? And how they are set up?

Troy: This is a partnership where the companies share risk equally under a reinsurance agreement. As for how we came together, Cigna and Oscar leadership teams were eager to grow within the fully insured small group market, believing it's an important segment of the market. For Cigna, many of the existing solutions in the market tend to center on similar networks and pricing, making it difficult to take share from existing carriers. Meanwhile, the Oscar team was eager to find a network solution that could complement our differentiated member and broker experience. It's a great partnership allowing both companies to leverage our strategic advantages to bring a truly differentiated product to market, and we're extremely encouraged by the early market response to the partnership and product.

Phil: So, you're bringing Cigna's large group networks to small group. That's great for such a dynamic market like California. What unique challenges do you see for the small group segment?

Troy: 2022 promises to be in some ways, even more challenging. As businesses look to reopen and navigate a hybrid world, benefits will become even more important. Some businesses may be adding remote flexibility, allowing employees to move out-of-state. With this dynamic, small businesses have a challenge that is different from their larger employer counterparts. For example, California state law requires 51% of enrolling employees to live in the state. There could be some regulatory changes needed to relax this requirement or allow carriers to apply some discretion, even if just temporarily. We're lucky to be able to offer a national network option to small businesses to meet this need.

There's also the need to recruit and maintain great talent, which has become increasingly challenging in today's climate. Employers are reevaluating their benefits offering — looking for ways to manage their budget and take care of their employees. And right now, taking care of their employees also means taking care of their mental health. We'll continue to see increased demand for affordable plans that also offer mental health coverage. Cigna + Oscar offers access to Cigna's behavioral health network as well as to Talkspace for virtual behavioral access. Employees need to have access to coverage in-person or virtual and we'll continue to meet those needs.

Phil: What does this mean for brokers?

Troy: What this means for brokers is offering a traditional local provider-based plan as the only option may no longer work for many employers. The 30-mile radius that an HMO requires had some employees questioning how they were going to take advantage of their new flexible work arrangement. I don't see that changing. More employers require access to plans with multi-state networks and greater flexibility around pairing or slicing with another carrier.

At Oscar, our mission has always been focused on refactoring healthcare to make high-quality care affordable and accessible. We are working with Cigna and their national networks but still have to comply with state rules that require more than half the group to be in California. So, we're watching this closely, and you should too. What's encouraging for us and the broker community, is the rapid acceptance of virtual meetings. This has allowed us all to be more efficient by spending less time commuting — both carriers with brokers and brokers with their clients.

At Oscar, we're a tech company and an insurance carrier rolled into one. So, in some ways putting on a good virtual meeting has always been part of our existence. Fast forward a year and a half and almost everyone in the industry is an expert, with fancy backgrounds and other enhancements, to stage webinars. While I don't think everything can be replaced by virtual meetings and we'll get back to in-person work in due time, the decrease in commuting time has led to an increase in efficiency, effectiveness, covering more ground in any given day. I think that is something that will be fine-tuned as we find the right balance between virtual and in-person. It's also been nice to see people create different connections while working from home — a barking dog or crying baby in the background, while an "oops" in the past, can now create connections now that we wouldn't have had before.

Phil: What support is available for brokers to bring the Cigna + Oscar program to their clients?

Troy: One way we've been supporting brokers through these changes is with our ability to deliver virtual care. This was an effort we were focused on before the pandemic and have doubled down since. For example, we recently launched Virtual Primary Care in Georgia and Tennessee. We also recognize the need for concierge care: I mean true concierge teams who form relationships with our members, guide care and answer the simple to the most complex questions –– all without needing to pick up the phone if you don't want to. And we wouldn't be able to reach employers to offer these solutions without supporting brokers in the ways they prefer to be supported. For that reason, we are happy to support — and are grateful for the support of — our general agent partners and tech integrations, who helped launch our products very early. And are now helping us through our big expansion to Southern California. Our general agent partners have been incredible in supporting Cigna + Oscar, getting resources to our brokers and making sure small group employers know the new standard that's available to them. For that, I want to thank them as well.

OSCAR IS DOING THINGS DIFFERENTLY BY PUTTING THE MEMBER AT THE CENTER OF EVERYTHING THAT WE DO.

Phil: Can you tell us a little bit more about that? What trends brokers should prepare for in 2022?

Troy: More acceptance and demand for virtual care. It's interesting to think how far telemedicine has come over the past two years. The idea of seeing a doctor online used to be a hard sell. But when the pandemic hit, virtual care visits grew exponentially. In a survey by the McKinsey Institute, about 40% of consumers said they will keep using telehealth after the pandemic. As we move forward, offering healthcare plans with a virtual component is a must, especially if you are a small business owner. Prior to the pandemic, large employer groups were happy to get anywhere close to 10% adoption. In small group, utilization of telemedicine was virtually nonexistent.

Telehealth is more than just a convenient way to get answers about health concerns while wearing your pajamas. Virtual care is changing how we provide and invest in healthcare. The Deloitte Center for Health Solutions surveyed healthcare executives and found that "by 2040, a major portion of care, prevention, and well-being services will shift to virtual settings." Additionally, three out of four executives predict 'industry wide investments in virtual health would be more than 25% over the next decade than today.'

Although virtual care won't replace in-person care, we believe it's here to stay. While the convenience and affordability make it an attractive offering for both patients and providers, the benefits are also there for small business owners. Out of 1,594 doctors and qualified health care professionals surveyed in the Telehealth Impact Physician Survey, more than 75% said that virtual care allowed them to give quality care for chronic disease management, emergency room follow-up appointments, mental health and more.

Phil: Does Oscar have personalized assistance for members in need of a higher level of help?

Troy: Yes. Oscar's Concierge makes a difference by being truly personal. While most carriers have something called concierge, it is often just a rebrand of their customer service line. Have you ever had to call an insurance carrier, picked up your card, looked at that 888 number and couldn't wait to dial? You can order a pizza from your phone with a few clicks and track it on a map down to the second it is actually delivered. Why does health insurance have to be so archaic?

When we talk about accessible care, it is not just having access to the best providers in the country. Guided care means getting help finding the right providers and getting answers to everyday questions, without long holds or being directed to a confusing website. At Oscar, we anticipate this need growing as consumers have more complex questions and concerns about their coverage. The standard has been set for the business administrator or broker to be the first line of contact for some of these questions but we feel that we can build that foundation of trust directly with our members by having a truly personal relationship.

At Oscar, we support each one of our members by pairing them with a Care Team. This is a team of care guides and nurses who can help answer questions and guide them towards the most affordable and highest quality care in their area. One of the many benefits of having this relationship is that it's an efficient way to gather health-related information, and empowers the member to make well-informed decisions about their care. Members will always have access to the same team who know them personally, and they can reach out anytime via our convenient app.

If members trust their carrier, it frees up our brokers' time and quite frankly, the business administrators too, allowing them to add value to the business itself and not by servicing employees.

Phil: Outside of the platform Oscar has built, what are some other ways you're helping employers attract and retain talent?

Troy: Employee benefits can get complicated. When you look at the different moving pieces that make up a plan, you can make it pretty simple for an employer. They want to know what their employees are going to pay when they need care (ie: copay/deductible), who they can get care from (network) and what they pay each month to have the plan (premium).

We like to think we're creating a new category with the better member experience I mentioned earlier. With that said, there is typically a balance between those points — that's where the broker community is so important. Offering the best benefits out of the box through a Platinum plan is one way to attract and retain talent — we're seeing a lot of that as the Oscar experience has a more "luxury" feel.

> THERE ARE CERTAINLY SOME CHALLENGES THAT ARE UNIQUE TO CALIFORNIA, WHERE EACH REGION OPERATES LIKE ITS OWN MARKET.

But there is also a growing community of brokers who see the value in consumer driven healthcare: namely, how to use a high deductible plan in conjunction with a health savings account or health reimbursement arrangement. I'm fortunate to know a lot of those brokers from my previous roles in healthcare and they're doing incredible work for their clients. It's not often you can get better than platinum benefits for the cost of a silver plan. But the brokers who understand how the numbers work on those plans and how to complement them with the tools provided by Oscar are doing amazing things for their clients.

Phil: How has Oscar grown over the past year?

Troy: On March 3, 2021, Oscar officially went public after nine years of offering affordable access to healthcare for our members. Additionally, during the upcoming Open Enrollment period, we plan to offer health insurance to individuals and families in three new states and 146 new counties. With this expansion, Oscar will have a footprint in a total of 22 states and 607 counties across our Individual & Family, Medicare Advantage, and Small Group (including Cigna + Oscar) plans. 2022 will mark the fifth consecutive year we expand our footprint. In total, Oscar is serving 560,000+ members as of June 30, 2021.

Phil: What message do you want brokers to take away from this conversation?

Troy: Brokers who take a deep look at their relationships with their carriers can consider how those carriers operate as their partner through the changes we're seeing throughout the state and even the country. Are they ready to adapt to the market changes? Are they ready to support you through your changes? Does their "product" still fit your customers' changing needs? Do they value your time and what it takes to serve small businesses in this evolving climate? The standard for what members, business administrators, brokers and general agents expect from their carriers is changing quickly. I'm proud to say that Cigna + Oscar is uniquely positioned, because of the foundation we've built, to serve brokers through these changes. CB

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Reasons Healthcare Professionals Need Extra Disability Insurance

Many need high limit DI

BY JEFF BRUNKEN

REPLACING one's income when unable to work due to a disability should be a crucial consideration for anyone who collects a paycheck. Disability insurance provides such protection, and most working Americans access short- and long-term disability insurance policies through their employer. There are unique aspects of healthcare professionals' earnings, however, that can require special attention.

Similar to professional athletes, entertainers, lawyers and other highly-paid professionals, many healthcare professionals are among those whose earnings extend beyond the income-protection limits of standard disability insurance policies. Because their income creates coverage gaps within traditional policies, they need a high limit disability insurance policy that provides greater monthly and lump-sum benefit amounts. Whether or not they have above-average salaries, many healthcare professionals have student loans from medical school. A special policy could cover those payments if they become disabled.

In reality, there are many reasons a healthcare professional might need extra disability coverage. This may come in the form of individual or specialized group disability, or even high limit disability insurance. There is even specialized disability insurance for student loan debt. Here are the top five reasons:

1. They have earnings that exceed what is available through individual disability insurance (IDI).

Most healthcare professionals carry the IDI policies they secured during medical school, which offered them an income-replacement level that was suitable at the time. But these professionals generally have more income to protect as they advance in their careers — more than any other class of professionals.

According to the most recent data from the Bureau of Labor Statistics, the top 10 highest-earning occupations in the country are physicians and surgeons. The median annual wage among this group is approximately $208,000 per year — nearly four times more than the $56,310 per year made by the average American.

2. They are high earners and have multiple income sources.

High limit disability insurance is most appropriate for healthcare professionals earning over $400,000 in annual income. According to Doximity's 2020 Physician Compensation Report, the highest earning healthcare professionals are neurosurgeons, with an annual compensation of nearly $750,000. Thoracic surgeons and orthopedic surgeons also receive well over $600,000 per year. Many other specialties command a compensation

of over $500,000 per year and could benefit from high limit coverage, including plastic surgeons, oral and maxillofacial surgeons, vascular surgeons, cardiologists and radiation oncologists. Other candidates for high limit disability insurance may include gastroenterologists, radiologists, urologists, ENTs, dermatologists, anesthesiologists, general surgeons, colorectal surgeons, oncologists and ophthalmologists.

Brokers should look carefully at all income sources when calculating pre-disability income. Like many short- and long-term disability insurance policies, high limit coverage considers all sources of income when considering eligible benefit payment amounts. These include income sources beyond annual salary, such as bonuses, partnership (K-1) income and any other income the high earner might have that also needs protection. Additionally some physicians' annual salaries do not exceed $400,000, but still generate considerable qualifying income through bonuses and other income sources.

3. They often have student loan obligations.

Many healthcare professionals have large student loan balances, and they need coverage for the payments in case of a disability. According to the most recent data from the Association of American Medical Colleges, 73% of all medical school graduates hold student loan debt, and the average amount is $200,000. Many of these healthcare professionals carry debt for years or even decades while they work.

A specialized disability insurance plan helps ensure they receive a sufficient monthly payout to cover their loans. The plan should be written to account for not only the monthly student loan burden, but also for federal taxes on benefit payments that could lead to a default. Many physicians are surprised to find their monthly payments are reduced by thousands more than they expected, simply because taxes on benefits are due at claims time for employer-paid group plans. Sometimes there is not enough left to make the loan payments.

4. They need coverage for their particular specialty.

Healthcare professionals may face a greater risk of disability than some other professionals because their medical specialties and procedures performed depend upon physical health and capabilities to perform their jobs. A surgeon, for example, may develop a hand tremor that prevents him from performing surgery. However, his tremor might not be considered disabling enough for benefits under a standard disability plan because the tremor would not prevent him from working as a family physician.

A specialized disability insurance plan works like IDI by paying out benefits based on specific CPT/CDT-coded procedures (like surgical procedures), and therefore would consider the surgeon fully disabled. Having a specialized policy means the surgeon would receive a monthly benefit for his disability, whereas with a traditional LTD policy he may receive nothing at all.

5. They risk burnout.

Healthcare professionals have a real risk of burnout. According to a September 2019 article in The American Journal of Medicine, 40-50% of physicians were already experiencing burnout pre-COVID-19. The article cited studies that suggested this burnout regularly transitions into major depression, substance abuse and even suicide. The COVID-19 pandemic introduced even higher stress levels. The Kaiser Family Foundation/Washington Post Frontline Healthcare Workers Survey published April 2021, revealed that 62% of healthcare workers said worry or stress related to COVID-19 had produced a negative effect on their mental health.

Specialized disability insurance policies provide healthcare professionals with the adequate mental health and addiction coverage they need for burnout- or stress-induced disabilities through Mental & Nervous and Drug & Alcohol (MNDA) benefits.

What Brokers Should Look For

If a healthcare professional client's overall income seems exceptionally high, check to see if their disability policy will adequately provide a true 60-70% income replacement in the event of a claim (most traditional policies will not pay out more than $20,000 to $25,000 per month). If not, a high limit plan should be suggested to fill that gap.

There are two important definitions that brokers should look for in policies for their clients. The first is the "own procedures" definition of disability, considered the gold standard because it guarantees both the right amount and the right type of coverage. The second is the definition of covered income within the disability policy. Healthcare professionals should have an "all sources" definition to cover partnership income and various incentives outside of their normal W-2 income.

For healthcare professionals concerned about what will happen to their student loan debt if they become disabled, brokers should recommend a high-limit student loan payoff policy.

Burnout is also a risk for healthcare professionals that can affect their ability to earn an income. Brokers should look for disability policies that offer adequate mental health and addiction coverage.

Healthcare professionals have unique income-protection exposures, so they need specialized disability income-protection coverage. Most insurance carriers do not offer appropriately specialized coverage simply because they are focused on the broader market. Brokers with healthcare professional clients should work with insurance carriers who offer disability policies that are built expressly for healthcare professionals and have a track-record of meeting these specialized income-protection needs of healthcare professionals and their brokers who advise them. CB

JEFF BRUNKEN *is president of MGIS, a leading national insurance program manager that builds and manages specialized disability insurance programs for healthcare professionals.*

SURVEY
VOLUNTARY BENEFITS

BY THORA MADDEN

We're closing out 2021 with our annual survey of voluntary benefits providers. We contacted a few of our favorite voluntary folks for some insight into what they offer. Thanks to Aflac, Choice Administrators and Guardian Life for weighing in.

California Broker: Please list the voluntary/employee-paid benefits that you offer along with the minimum group size for each offering. Please let us know if you specialize in voluntary benefits.

Bob Ruff, senior vice president of Growth Solutions at Aflac:

Aflac is the No. 1 provider of voluntary/worksite insurance products in the U.S., according to Eastbridge Consulting Group. With our broad portfolio of offerings, Aflac's solutions suit virtually every business size and type. From three employees to more than 300,000, Aflac can fit easily within almost any benefits package.

Aflac offers individual and group plans as well as a portfolio of value-added services. Aflac is a leader in providing policies that pay cash benefits directly to insureds, unless otherwise assigned, to help close the gap for expenses health insurance doesn't cover. Benefits are paid quickly so insureds can focus on recovery instead of their bills.

Aflac offers the following individual coverage:

- Accident.
- Cancer/Specified Disease.
- Specified Health Event.
- Aflac Dental Insurance — Supplemental Plan.
- Hospital Confinement Indemnity.
- Life — Whole, Term and Juvenile.
- Lump Sum Critical Illness.
- Short-Term Disability.
- Aflac Vision Insurance — Supplemental Plan.

Aflac Group offers the following group coverage:

- Accident.
- Short and Long-Term Disability.
- Critical Illness, including cancer.
- Hospital Indemnity.
- Whole and Term Life.
- BenExtend® and BenExtend for Diseases.
- Aflac Dental.
- Aflac Vision.

In order for clients to establish an account, Aflac requests they complete and sign a Payroll Account Acknowledgement form and allow three separate W-2 employees to apply for at least one Aflac policy. To establish group billing, Aflac Group requires a minimum of 25 payers.

Many times in the supplemental insurance business, companies tend to use the same approach to market similar benefits. Aflac is different. We back our plans up with the following:

- Innovative marketing campaigns.
- Design products with consumer and expert input.
- Strong financial stability.
- Brand recognition.
- A solid company reputation and corporate responsibility program.
- Responsive claims and customer service.

Michael Payton, Senior Vice President, Sales and Account Management, CHOICE Administrators:

ChoiceBuilder is a California different approach to ancillary benefits. We offer both employer-sponsored and voluntary benefit options for Dental, Vision, Chiropractic/Acupuncture, and Life. Coverage is available to groups with two to 500 employees. A large percentage of our groups offer coverage on a voluntary basis.

ChoiceBuilder also offers voluntary benefits for groups:

2-9 employees: Vision, Chiropractic, Chiropractic & Acupuncture

10-500 employees: Dental (5 must enroll), Vision, Chiropractic, Chiropractic & Acupuncture

Joe Stefano, Divisional Vice President for Western US, Guardian Life

Guardian offers voluntary Accident, Accidental Death & Dismemberment, Cancer, Critical Illness, Dental, Hospital Indemnity, Term Life, Long Term Disability, Short Term Disability and Vision.

- Voluntary Term Life, Accidental Death & Dismemberment, Short Term Disability and Long Term Disability require a minimum of four enrolled employees.
- All our other voluntary group coverages can be offered to groups with as few as two employees.

CB: Do you have any benefit offerings for employees that work fewer than 40 hours a week?

Bob Ruff, Aflac:

Yes, we do. Aflac individual and group plans are available for full-time employees, as defined by the client, who work fewer than 40 hours a week. Consumers in the U.S. without access to Aflac insurance at the worksite can apply for its supplemental accident, cancer and critical illness insurance through Aflac.com. This enhances the ability of freelancers, gig workers, and contract or part-time employees not offered a traditional benefits package, as well as full-time workers who want Aflac but do not have access to it at their workplace, to enjoy the benefits of Aflac's valuable products.

Please note the following:

- Group plans: Employees must work a minimum of 16 hours a week, with the exception of group disability. In order to be eligible for worksite disability, employees must work a minimum of 19 hours a week, and for group disability, employees must work at least 20 hours a week.

Michael Payton, CHOICE Administrators.

Yes, all of our coverage options are available to employees who work 20 or more hours per week. The employer may define eligibility as 30 or more hours per week or 20 or more hours per week.

Joe Stefano, Guardian Life:

Yes. Guardian offers benefits to employees that work less than 40 hours a week. Our product offerings vary according to whether the employee works 30 hours or 20 hours a week.

CB: Can you explain the tech your company uses especially as it relates to enrollment, billing and claims? We'd like to know about convenience and ease-of-use features.

Bob Ruff, Aflac:

Aflac has the tools and flexibility to meet the unique needs of businesses of all sizes — from benefits marketing and education, to enrollment solutions and multiple billing options.

When it comes to enrollment, we work with employers to design a seamless experience tailored to their business. This means that Aflac products are supported on over 100 different benefit administration/enrollment platforms. Additionally, we work with all major benefit administration and human capital management platforms in the market and treat them as system of record, which gives the employer a consistent experience across all their benefits, including their voluntary benefits.

Regarding billing, Aflac has found that the key to a great billing experience is understanding the client's technical/platform and payroll capabilities. We then assist them with selecting the billing option that best fits their wants and needs. Aflac has the ability to work with employers' systems as well as work with a wide range of third-party billing companies should the need arise. Aflac's goal is to make billing and payment of premiums simple and hassle-free for your client. Aflac's systems are flexible to accommodate a variety of billing methods and can handle almost any type of billing layout.

Aflac is committed to making the claims process easy and paying out benefits quickly. Aflac offers online services for policyholders who have an individual insurance policy. Policyholders can log on to myaflac.com 24/7 to view and manage coverage benefits, set up direct deposit to get paid fast, submit claims quickly and check their claim status. Aflac is also in the process of updating its digital claims experience for group plans in 2021 as part of our digital-first program designed to provide ease of service for our customers.

Michael Payton, CHOICE Administrators.

Brokers working with ChoiceBuilder have a variety of tools available to them to run quotes, review their quote history, view all in-force groups, and more at choicebuilder.com. Fillable forms with flexible underwriting and tools to support employers, members, and brokers are also available.

Consolidated billing is offered for all products in the ChoiceBuilder portfolio.

Joe Stefano, Guardian Life:

We understand through our research that to engage and enroll in voluntary benefits, we have to make it a seamless, digital experience. We have a number of benefits administration partners that allow us to offer API-enabled platforms that not only make it easy to administer the benefits but to enroll. Our APIs with these platforms enable plan setup, member level updates, and real-time evidence of insurability submission for employees.

For employers who don't have their own benefits administration system, we can provide an online enrollment experience. Guardian Enrollment powered by Flock is a benefits enrollment solution for employers who want to provide their employees with a digital experience. It is optimized for both desktop and mobile, and available in Spanish. This offering also enables employees to take advantage of digital decision support tools like Nayya Choose or 1x1 employee education meetings through our VoluntaryWorks team.

CB: Do you honor broker-of-record letters?

Bob Ruff, Aflac:
Yes.

Michael Payton, CHOICE Administrators.
Yes, we honor broker-of-record letters.

Joe Stefano, Guardian Life:
Yes, Guardian honors broker-of-record letters.

CB: Do you require carrier reps to have a comprehensive knowledge of all of the products they deal with? How do you ensure this?

Bob Ruff, Aflac:
Yes. Aflac has rigorous training and certification in place for our entire sales team. Our W-2 group reps and independent agents are trained to learn about products and processes particular to the company. Aflac's brokers also work closely with our W-2 group reps to share knowledge and support their clients.

Michael Payton, CHOICE Administrators.
We pride ourselves on our ability to meet the needs of the marketplace. We have dedicated inside and outside sales representatives throughout the state who have a comprehensive understanding of our products. They are also able to provide strategic input for our broker partners. In addition, our Customer Service team is available through our toll-free number to answer questions.

Joe Stefano, Guardian Life:
Yes. Our Guardian sales representatives achieve a high level of comprehensive knowledge of the Guardian products they present through intensive and ongoing training. Guardian has a dedicated sales training team that helps to on-board new sales reps and provides ongoing regular training via virtual and classroom settings. Additionally, the sales teams have access to Practice Leaders for Absence Management, Life, Disability and Supplemental Health products that they can leverage to gain additional product knowledge.

CB: Do you offer marketing materials that are easy to present and simple for clients to understand?

Bob Ruff, Aflac:
Absolutely. With 65 years of experience in supplemental coverage and a brand name that nearly 9 out of 10 people recognize today, Aflac's worksite marketing materials are designed to create awareness, improve understanding, and increase participation in benefit programs. Whether supporting a small business or large corporation with complex logistics, Aflac can help your clients reach employees through various channels, such as:

- Microsites, web banners and emails.
- Sponsored ads on social media.
- Augmented reality.
- Beacon technology.
- Geotargeting.
- Product videos.
- Brochures and flyers.
- Posters and tent cards.
- Payroll stuffers and direct mail.

Note: All items may not equally apply to both individual and group products.

Michael Payton, CHOICE Administrators.
Yes, we offer a variety of marketing materials designed to help present the value of an ancillary exchange with employers, including our award winning ChoiceBuilder "Fast Facts" brochure.

Joe Stefano, Guardian Life:
In line with our brand, we offer marketing materials that are easy and simple for clients to understand. One notable campaign that exemplifies approachable and simple is our "Simply Put" educational video series we launched last year to help employers and employees understand the value of voluntary benefits. The videos are designed to inform the workforce what products, like hospital indemnity insurance are, so they can make informed benefit decisions (click here to see our videos). The videos are captioned in English and Spanish.

We also understand that timely, effective communication is key in helping create awareness and understanding of our insurance products. As a result, we offer a variety of digital and paper materials that help employees understand their benefit options, then enroll in the coverage that fits their needs. Additionally, our enrollment strategy team works to ensure there is a well-planned employee level communications strategy in place.

CB: How do you track the quality of the customer service you provide to employers? For example, do you set annual service goals and measure and report results?

Bob Ruff, Aflac:
Aflac constantly measures our customer satisfaction level with policyholders and business accounts in a variety of ways, such as surveys and audits, to ensure we are meeting our established customer service goals and standards. We continuously monitor satisfaction with the total Aflac experience as well as satisfaction with enrollment, claims and billing. Aflac's customer service quality program is administered by our Quality Assurance department. Each major business function is sampled monthly. Additionally, for quality scoring, a minimum of five audits per month for each customer service center representative are guaranteed. All scoring and error trending are reported weekly, monthly and quarterly to management. Aflac's Internal Audit department also conducts audits by line of business in addition to their annual assessment of internal claims controls.

Michael Payton, CHOICE Administrators.

Yes, we measure and track both production and call center metrics on a daily, monthly, and quarterly basis. Our goal is to ensure we are delivering quality, timely service to all of our customers.

Joe Stefano, Guardian Life:

We make it a priority to ensure our customers are getting the best service and that we are meeting their needs. We set goals, track and report the results each year. We also do regular Voice of the Customer surveys and monitor our Net Promoter Score and Customer Effort Score to make sure we are hearing what is important to our customers. For our customers with over 100 employees, we have a dedicated Account Services manager who handles all service-related items related to the group.

CB: Do you offer materials in any languages other than English?

Bob Ruff, Aflac:

Yes. Aflac offers access to Spanish-language materials as well as those in English.

Michael Payton, CHOICE Administrators.

Yes, we offer select materials in Spanish and Chinese. Some carrier-supplied materials are available in additional languages.

Joe Stefano, Guardian Life:

We understand how important it is to reach Spanish-dominant employees during open enrollment season and ensure they make informed decisions. Employees who prefer Spanish have access to our voluntary benefit product videos in Spanish, and our "Simply Put" video series offers Spanish captions.

Our Guardian Enrollment Solution powered by Flock is available in Spanish, and our VoluntaryWorks program offers Spanish speaking benefit counselors.

All of our product flyers are available in Spanish, and we offer a bi-lingual employee communications campaign.

CB: Do you have an established local sales and service team that can provide critical service in the same cities that the broker's clients are in?

Bob Ruff, Aflac:

Yes. We have a local account management structure to provide localized support for brokers and their clients. The company also offers a team of dedicated, W-2 group reps in every major metropolitan area to support and service Aflac's brokers and their clients. In addition, Aflac has a team of independent sales agents licensed to sell Aflac products throughout the United States. Aflac's certified enrollers are available to service multi-location accounts, and we have a national sales coordinator team to manage these relationships. Aflac's agent distribution model and broker sales team can help you manage your clients' open enrollment needs no matter the size or location.

Michael Payton, CHOICE Administrators.

Yes. We have Regional Sales Managers throughout the state ready to assist – in-person or virtually – on a client presentation, training, or simply to drop off materials. We also offer inside sales representatives who work in tandem with Regional Sales Managers and specialize in select markets.

Joe Stefano, Guardian Life:

Guardian has more than 40 local sales offices nationwide to support the needs of brokers and their clients. Our team in California is led by Joe Stefano, Divisional Vice President for Western US, with offices in both Northern and Southern California. We have Regional Sales Directors, Regional Service Managers, Sales Reps, Account Managers and Key Account Managers that support the sales and service function at the regional level.

CB: Do you have a sales rep and a service rep? (The sales rep helps the broker market and position products, manage blocks of business, and develop target markets. The service rep helps implement and fulfill account enrollments.)

Bob Ruff, Aflac:

Yes. We have local service teams that provide localized support for brokers and their clients. The service teams lead the broker and client throughout the implementation and ongoing administrative process. In addition, Aflac has W-2 group reps and account executives that focus on new sales, growing the in-force block of business, and assisting the broker in product and market positioning.

Michael Payton, CHOICE Administrators.

In addition to our Regional Sales Managers and inside sales representatives mentioned previously, we also offer our Enrollment Squad. The Enrollment Squad ensures a seamless onboarding experience and offers in-person and virtual meetings. For questions that pop up during the year, our excellent Customer Service team is available to support both the employer and the employee.

Joe Stefano, Guardian Life:

Yes. Guardian has local sales representatives to help brokers market our products. We also have Account Managers and Key Account Managers dedicated to growing the business as well as renewal placement and persistency. Finally, we work with operational staff to ensure cases are implemented smoothly, and we have met the needs of the client. CB

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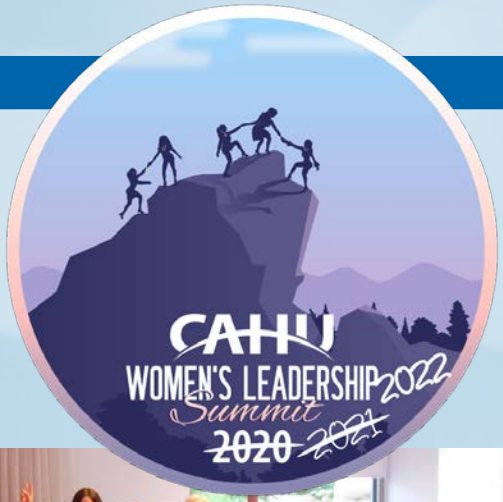
Women's Leadership Summit

March 14-16, 2022 at the Green Valley Ranch Resort, NV



You don't want to miss out on this experience of Speakers, Ladies Night, Golf and More!

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