

MyHealthGuide

Newsletter for the Self-Funded Community

MyHealthGuide Newsletter
News for the Self-Funded Community
7/15/2019

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General & Company News

The Phia Group Announces PACE Certification

MyHealthGuide Source: [The Phia Group](#), 7/12/2019

We are proud to announce that our [Plan Appointed Claim Evaluator \(PACE\) Certification](#) program will be launching on August 1, 2019.

Details: The PACE Certification program will educate you using 3 distinct chapters of information:

- **Chapter One** - Explore the ins and outs of self-funding while learning about its risks and rewards. This chapter will transform any individual into a self-funding pro.
- **Chapter Two** - Take a deeper dive into the laws that apply to self-funded plans. We cover it all, from federal preemption to adverse benefit determinations and appeals.
- **Chapter Three** - Explain what PACE is, what PACE does, and how it's obtained, implemented, and utilized.

The PACE Certification program is free of charge and will create immense value for your organization. By going through the Certification program, you, or a select person, or team, within your organization, can become PACE Certified. Once PACE Certified, the Program participant(s) will become highly educated PACE business owners and will serve to assist your organization in growing your PACE business, enhancing your PACE revenue, and assuring your appeals processes are the most compliant and best in the industry. Those who complete the Certification will also receive a PACE Certification Fact Sheet, providing an easy to understand summary of the content and best practices covered, which will allow you to maximize the lessons learned within your business.

Additionally, the PACE Certification program will provide education on self-funding in general, claims and appeals regulatory education, and overall best practices surrounding fiduciary duties, claims, and appeals.

The PACE Certification program will be released to all those interested starting August 1, 2019.

Please see the [PACE Certification flyer](#) for more information.

Please contact **Tim Callender** (tcallender@phiagroup.com) or **Garrick Hunt** (ghunt@phiagroup.com) for more information.

About The Phia Group

The Phia Group, LLC is an experienced provider of health care cost containment techniques offering comprehensive consulting services, legal expertise, plan document drafting, subrogation and overpayment recovery, claim negotiation, and plan defense designed to control costs and protect plan assets. Visit www.PhiaGroup.com.

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Tatum Re Launched by Dominic Hagger

MyHealthGuide Source: Tatum Reinsurance Intermediary, LLC, (Tatum Re) , 7/9/2019

Tatum Reinsurance Intermediary, LLC, (Tatum Re) - a New Jersey domiciled, fully licensed Insurance and Reinsurance Intermediary, has been launched by its President - **Dominic Hagger**. With over thirty years of industry experience, Dominic's knowledge, relationships and expertise in the Program Business arena, uniquely places him to develop Tatum Re in to a significant Broker in this sector of the market.

Tatum Re specializes in all Accident and Health and Casualty products. Working to the theme of Tatum Re, which is 'Empowering Partnerships', Tatum Re takes a structured approach to challenges, identifying opportunities, anticipating and managing risk throughout the process. Powered by an entrepreneurial spirit and united by a team mentality, Tatum Re will pool its resources and collaborate with clients to fully understand and address their risk position.

Contact **Dominic Hagger** at 732-672-7752, DHagger@TatumReinsurance.com and visit www.tatumreinsurance.com.

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Health Decisions Sells Eligibility Verification Business

MyHealthGuide Source: [Health Decisions, Inc.](#), 7/10/2019

PLYMOUTH, MI -- Health Decisions, Inc., a company with more than 30 years helping employers and trusts discover, recover, and remove waste, abuse, and fraud in their health plans, announced the sale of select assets to Part D Advisors, Inc. (PDA) in Livonia, Michigan. The assets are related to Health Decisions' Dependent Eligibility Verification and Ongoing Eligibility Maintenance services. Health Decisions pioneered dependent eligibility verification services, and have been conducting dependent audits since 1993.

Health Decisions' experienced Dependent Eligibility Audit team, in-house Call Center, and proprietary software will now be under the PDA umbrella. PDA customers will benefit from Health Decisions' proven approach for verifying all dependents listed on the health plan, and discovering any ineligible dependents, which drive up health care costs for employers. Health Decisions' "high-tech, high touch" method has resulted in an average response rate of 97%, without a single employee appeal. PDA stores and backs-up all data in a Michigan-based data center with compliance ratings of SOC 1, SOC 2, and SOC 3.

"Health Decisions has an excellent reputation," said **David Alexander**, Part D Advisors' Executive Vice President. "Both organizations excel at handling enrollment data for employers, trusts, and governmental employers and combining our experience will bring synergies to the benefits marketplace that include exceptional response rates and high ROI."

Judy Mardigian, Health Decisions CEO, said, "We are excited to entrust our Dependent Eligibility Verification services to Part D Advisors. They are a top-quality organization, and this sale will enable an even better level of service for our clients and the benefits eligibility marketplace."

About Health Decision

Health Decisions, Inc. has more than thirty years of experience helping employers, trusts, plan fiduciaries, and health payers discover, recover and remove the waste, abuse, and fraud in their specific plan. Visit healthdecisions.com.

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DataPath Recognized by EBN as a 2019 Digital Innovator

MyHealthGuide Source: [DataPath](#), 5/1/2019, [Employee Benefit News \(EBN\)](#)

LITTLE ROCK, AR -- DataPath, Inc., a leading technology provider of benefits administration solutions, was recognized by Employee Benefit News (EBN) for its multi-award winning employee education and engagement program, The Adventures of Captain Contributor™. In EBN's 2019 Digital Innovators article, the program and the voice of Captain Contributor, **Thomas O'Banion**, were honored for their involvement in "transforming the industry by helping employers and employees better engage in healthcare, benefits and the workplace in general."

According to EBN, DataPath's unique program matters because "Gamification like Captain Contributor can be an effective way to increase employee engagement with their benefits." O'Banion expanded further by commenting, "superheroes can transform dry, hard-to-understand information about benefits into a more educational, exciting and accessible experience."

"Receiving recognition from a leading industry publication like EBN is a tribute to the hard work and dedication that Thomas and our marketing team has put in to making the Captain Contributor program successful," says **Bo Armstrong**, chief marketing officer at DataPath. "It shows how important it is to reach out to workers and present benefits in a meaningful way that is easy to understand."

Launched in 2017, DataPath's Captain Contributor program was developed with employees in mind, serving to educate participants about Flexible Spending Accounts (FSAs), Health Savings Accounts (HSAs), COBRA and other employer-sponsored benefits. The program features a website, social media accounts, blogs, videos, comic books, podcasts, and more. Since its inception, the program has reached approximately half a million people through its various media channels.

Captain Contributor has won five national awards, including two from the National Health Information Awards (NHIA) in 2018.

About DataPath

Founded in 1984, DataPath, Inc., is a leading provider of technology solutions for employer-sponsored benefits administration. Summit, the company's cloud-based software solution, was designed specifically for seamless CDH account, COBRA, and billing administration. Visit dpath.com.

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The Phia Group Announces Webinar, *Trump's Executive Order on Transparency* and Podcast: *Tales From the Plan: Episode 2 – Mrs Peck, It's Cancer...*

MyHealthGuide Source: [The Phia Group](#), 7/12/2019

Our next webinar will be held on Thursday, July 23, 2019 at 1pm EST.

Webinar Title: *Trump's Executive Order on Transparency: How it Will Effect Each Segment of Our Industry*

Description: On June 24, 2019, **President Trump** issued his "Executive Order on Improving Price and Quality Transparency in American Healthcare to Put Patients First." This Order requires hospitals to publicly post their prices, and is designed to give healthcare consumers more choice and better decision-making capabilities.

Join The Phia Group's legal team for an hour on July 23, 2019 at 1pm (Eastern) as they discuss the executive order point by point; they'll touch on what they like and don't like about it, and – more importantly – what this all means for you.

Registration Link: <https://register.gotowebinar.com/register/6001972692157724675>

Podcast Title: *Tales From the Plan: Episode 2 – Mrs Peck, It's Cancer...*

Description: In this meaningful episode, **Ron Peck** tells us about his family's battle against cancer, and lessons we can all learn from their experience. Health benefits play a role in our health and survival. You can't afford to miss this one.

Link: <https://www.phiagroup.com/Media/Posts/PostId/868/tales-from-the-plan-episode-2-mrs-peck-its-cancer>

About The Phia Group

The Phia Group, LLC is an experienced provider of health care cost containment techniques offering comprehensive consulting services, legal expertise, plan document drafting, subrogation and overpayment recovery, claim negotiation, and plan defense designed to control costs and protect plan assets. Visit www.PhiaGroup.com.

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Sun Life U.S. Appoints Jennifer Collier to Lead Stop-Loss & Health Business

MyHealthGuide Source: [Sun Life U.S. via PRNewswire](#), 7/8/2019

WELLESLEY, Mass. -- Sun Life U.S. has named **Jennifer Collier** senior vice president of Stop-Loss & Health, the largest independent stop-loss insurance provider in the country, with 2,300 employer clients covering more than 4.7 million people, and \$1.7 billion in premium.

Collier joins Sun Life from Cigna where most recently she was chief operating officer of its middle market operations. As a registered nurse and MBA, Collier brings both clinical and business management expertise to risk and cost management strategies for Sun Life's self-funded employer clients. Many employers self-fund their health plans, which can leave them vulnerable to high-cost claims. Stop-loss coverage protects self-funded employers from these claims, which impact 85% of self-funded employers in any given policy year.

"Jen's experience brings a unique perspective in leading our stop-loss business and continuing to develop expanded solutions for our self-funded clients," said **Dan Fishbein, M.D.**, president of Sun Life U.S. "Our Stop-Loss & Health business is focused on recognizing trends that can help self-funded employers reduce and manage costs while improving medical care for members. Jen's background is an ideal fit for Sun Life's approach to guiding clients through complex, high-cost claims, and I look forward to bringing her expertise to our dedicated clinical and claims teams."

Collier spent 17 years at Cigna, where she held senior leadership roles in U.S. commercial business, spanning national accounts to small business lines, including clinical operations, strategic implementation, underwriting, and stop-loss.

"I am thrilled to be working with the Stop-Loss & Health team at Sun Life, and seeing first hand all of the innovative approaches they have fostered in managing high-dollar claims," said Collier. "The right balance of clinical and cost management is how we achieve better outcomes for patients while providing effective solutions for our clients."

Sun Life has been in the stop-loss business for over 35 years, and offers extensive risk management expertise and tools that help self-funded employers effectively manage the cost of their employee medical benefits. As head of Stop-Loss & Health, Collier will oversee all aspects of the Stop-Loss business, including the development of new health initiatives and solutions, such as the Clinical 360 program which combines data analytics and clinical expertise to identify cost containment and improved treatment options for self-funded employers and their employees. In 2018 Sun Life's Clinical 360 program achieved over \$6.2 million in savings for employers.

Before joining Cigna Collier was a cardiac nurse at a Connecticut hospital, and earlier in her career she focused on increasing states' capacities to serve children with disabilities through grants from the U.S. Department of Health and Human Services. She received her Bachelor of Science in nursing from Saint Joseph College, and her MBA in finance and marketing from the University of Connecticut School of Business.

About Sun Life

Sun Life is a leading international financial services organization providing insurance, wealth and asset management solutions to individual and corporate Clients. Sun Life has operations in a number of markets worldwide, including Canada, the United States, the United Kingdom, Ireland, Hong Kong, the Philippines, Japan, Indonesia, India, China, Australia, Singapore, Vietnam, Malaysia and Bermuda. As of March 31, 2019, Sun Life had total assets under management of C\$1,011 billion. Visit www.sunlife.com.

In the United States, Sun Life is one of the largest group benefits providers, serving more than 60,000 employers in small, medium and large workplaces across the country. Sun Life's broad portfolio of insurance products and services in the U.S. includes disability, absence management, life, dental, vision, voluntary and medical stop-loss. Sun Life employs approximately 6,000 people in its U.S insurance and asset management businesses. Group insurance policies are issued by Sun Life Assurance Company of Canada (Wellesley Hills, Mass.), except in New York, where policies are issued by Sun Life and Health Insurance Company (U.S.) (Lansing, Mich.). Visit www.sunlife.com/us.

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H.H.C. Group Welcomes Ada Petties as a Regional Vice President of Sales

MyHealthGuide Source: [H.H.C. Group](#), 7/12/2019

H.H.C. Group is proud to announce the addition of **Ada Petties** as a Regional Vice President of Sales with responsibility for the Midwestern United States. Ada brings experience in the health care field, sales client service.

Immediately prior to joining H.H.C. Group Ada served as a Utilization Review Coordinator at Holy Cross Hospital in Silver Spring, MD. There she gained an in-depth understanding of the provider, payer and patient components of the healthcare system. Ada also brings extensive sales and client service experience, gained in her 10 years as a Home Mortgage Consultant at Well Fargo Bank. A Maryland native, she has a Bachelor of Science Degree in Business Administration.

About H.H.C. Group

H.H.C. Group is a leading national health insurance consulting company providing a wide range of cost containment solutions for Insurers, Third Party Administrators, Self-Insured Employee Health Plans, Health Maintenance Organizations (HMOs), ERISA and Government Health Plans. H.H.C. Group utilizes a combination of highly skilled professionals and advanced information technology tools to consistently deliver targeted solutions, significant savings and exceptional client service.

H.H.C. Group's services include Claim Negotiation, Claim Repricing, Medicare Based Pricing, DRG Validation, Medical Bill Review (Audit), Claims Editing, Medical Peer Reviews/Independent Reviews, Utilization Reviews, Independent Medical Examinations (IME), and Pharmacy Consulting.

For additional information about H.H.C. Group and our services, visit www.hhcggroup.com or contact **Bob Serber** at rserber@hhcggroup.com or 301-963-0762 ext. 163.

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Partners Managing General Underwriters Welcomes Caroline Graham Seid

MyHealthGuide Source: Partners Managing General Underwriters, 7/9/2019, www.partnersmgu.com

Phoenix, AZ -- Partners is excited to announce that **Caroline Graham Seid** has joined our team as an Executive Underwriter.

Carol brings more than 35 years of experience in the insurance industry to Partners. Prior to joining Partners, Carol spent 22 years with Symetra (and its predecessors) selling and underwriting stop loss. Previously she held account management and consulting positions with Independence Blue Cross, Coopers & Lybrand and Johnson & Higgins. Carol and her husband Jay have five children (ranging in ages from 24-29). In her spare time Carol reads, gardens, collects art and travels. Carol is an avid sports fan, but follows football and ice hockey passionately.

Commenting on her new role, Carol said, "It is an incredible opportunity to be a part of the dynamic team at Partners."

Please feel free to contact Carol with questions about her new role, or about becoming a Producer-Partner: caroline.seid@partnersmgu.com, 480.565.8952.

About Partners

Partners Managing General Underwriters is an entrepreneurial organization underwriting medical Stop Loss for the self-insured marketplace. Licensed in all 50 states, our team is comprised of seasoned professionals with a long history in employee benefits. We offer a unique opportunity unlike anything in the marketplace and it's available only to our Producer-Partners. Visit www.partnersmgu.com.

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Mindyra Medical Board of Advisors Adds Michael Genovese, M.D., J.D

MyHealthGuide Source: [Mindyra via PRNewswire](#), 7/10/2019

DARIEN, CT -- Mindyra™ announced that **Michael Genovese, M.D., J.D.**, Chief Medical Officer of Acadia Healthcare, has joined Mindyra's medical board of advisors.

Dr. Genovese has been Acadia Healthcare's Chief Medical Officer since 2017 and has brought years of patient-facing experience to Acadia's leadership team. He is a clinical psychiatrist and addiction specialist. He is also the medical director of the Officer Safety and Wellness Committee of the FBI National Academy Associates (FBINAA), helping to equip first responders with the tools they need to withstand, recover and grow following repeated trauma.

"Michael is a recognized leader in behavioral healthcare and we are excited to welcome him to Mindyra's medical board of advisors," said **Bill Battey**, Mindyra's CEO. "We believe his strong experience, especially in clinical psychiatry, addiction disorders and medical protocols and systems across both physical and mental healthcare, will be extremely valuable as Mindyra continues to grow and innovate with its digital healthcare system."

"We conducted an exhaustive search for someone who would further strengthen our board's breadth of talent and background, and we are delighted to have identified such an outstanding individual," said **Dr. Hank Schwartz**, Mindyra's medical board of advisors chairman. "I'm confident that Michael is going to make an important and positive impact on our company."

"I admire Mindyra for its innovative digital healthcare tools to more precisely diagnose and coordinate care for individuals affected by emotional, behavioral and substance abuse disorders and I'm honored to be joining their medical board," said Dr. Genovese. "I have tremendous respect for Bill, Hank and the other board members, and I look forward to working with them."

Dr. Genovese graduated from the University of Pittsburgh with a B.A. in 1992 and a J.D. in 1995. He did his Residency Training in Psychiatry at the University of Connecticut from 2001 to 2004 and was a Fellow at the Child and Adolescent Psychiatry Residency Program at the New York University School of Medicine from 2004 to 2005. He serves on the CMO Corporate Council of the Joint Commission, seeking to optimize quality and safety in healthcare. He is also a diplomate of the American Board of Psychiatry and Neurology, a member of the American Psychiatric Association, the American Medical Association, the American Academy of Addiction Psychiatry and the American Society of Addiction Medicine.

Mindyra is a digital behavioral healthcare company that helps care providers efficiently and more precisely diagnose and treat their patients. The Mindyra platform includes proprietary, patient-administered diagnostic (assessing 67 clinical syndromes) and treatment progress measurement tools, providing critical data to help ensure patients are receiving the best intervention.

About Mindyra

Mindyra's system simplifies and streamlines evaluation, treatment planning, and outcome tracking, and provides an ideal solution for populations experiencing comorbid problems that often wax and wane in conjunction with mental health difficulties - such as individuals with substance abuse disorders. Visit www.mindyra.com.

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Benefitfocus Appoints Stephen M. Swad as Chief Financial Officer (CFO)

MyHealthGuide Source: [Benefitfocus](#), (NASDAQ: BNFT), 6/17/2019

Charleston, SC -- Benefitfocus, Inc., a leading cloud-based benefits management platform and services provider, announced the appointment of **Stephen M. Swad** as Chief Financial Officer (CFO).

Swad, who will be joining the Company on July 22nd, brings with him an extensive background with more than 35 years of executive and finance leadership. He is a current member of the Benefitfocus Board of Directors and since 2013 has served on the Audit, Compensation, and Nominating and Governance Committees, as well as Chair of the Compensation Committee.

While already deeply familiar with Benefitfocus, in his new role, Swad will be responsible for managing all aspects of Benefitfocus' finances and corporate development. He joins the company from Vox Media, a leading, modern media company, where he has served as CFO since January 2016. During his time at Vox Media, he helped the company raise debt and equity capital, acquire companies, improve its capital allocation processes, launch a number of new successful businesses, including a SaaS-based technology business and enhance the accounting, finance, and treasury functions through investments in people, processes, and systems.

"As Benefitfocus continues to advance our platform and industry leadership, it was imperative that we selected an established finance chief with a deep understanding of our transformative platform strategy," said **Ray August**, President and CEO of Benefitfocus. "Steve is right for this role in so many ways, from his well-established understanding of our business, serving as a board member since our IPO six years ago, to the depth of his public company financial expertise, serving other leading technology brands and public sector entities, like the SEC."

Prior to Vox Media, from February 2012 until April 2015, Swad was President, Chief Executive Officer (CEO) and a director of Rosetta Stone, a cloud-based software company focused on language learning and reading. He formerly served as Rosetta Stone's CFO beginning in November 2010. Prior to joining Rosetta Stone, Swad was the Executive Vice President and CFO of Comverse Technology, Inc.

Swad has held various senior financial management positions at AOL, Inc. (now part of Oath Inc.), Turner Broadcasting and Time Warner. He was a partner at KPMG LLP and also served as the Deputy Chief Accountant of the Securities and Exchange Commission. Swad previously served on the Board of Eloqua, a SaaS-based marketing and analytics platform, before it was purchased by Oracle. He received his B.A. in business administration from the University of Michigan and is a Certified Public Accountant.

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EHNAC Appoints New Commissioners: Appointees from Change Healthcare and Availity

MyHealthGuide Source: [The Electronic Healthcare Network Accreditation Commission](#) (EHNAC), 7/8/2019

FARMINGTON, CT -- The Electronic Healthcare Network Accreditation Commission (EHNAC), a non-profit standards development organization and accrediting body for organizations that electronically exchange healthcare data, announced **Edward Hafner** of Change Healthcare Operations, LLC and **Jason Wallis** of Availity, LLC have joined the organization's governing body. Hafner and Wallis, whose

terms run through 2022, join a team of 13 EHNAC commissioners from both private and public organizations to assist in the governance of the Commission.

"The EHNAC Board of Commissioners is driven by some of the most prominent and well-respected thought-leadership shaping the healthcare ecosystem, representing the interests of several stakeholders including electronic health networks, health information exchanges, health plans, providers, and health IT vendors," said **Lee Barrett**, CEO and Executive Director, EHNAC. "We look forward to the valuable leadership that Ed and Jason bring to EHNAC as we continue to establish standard criteria/best practices and accredit organizations that electronically exchange healthcare data for security, confidentiality, accountability and efficiency. Their guidance, along with that of their fellow commissioners, is crucial in today's world where protecting patient data from the ever-evolving cybercriminal is paramount and a key to ensuring stakeholder-trust."

Edward Hafner is a Senior Strategist within the Medical Network at Change Healthcare Operations, LLC. Before joining Change Healthcare, he was the General Manager of TIBCO's Multi-Enterprise Connectivity Group that included B2B products, Health Care solutions, and Managed File Transfer products. Prior to TIBCO's acquisition of Foresight, Hafner served as Foresight's Chief Technology Officer and was instrumental in the development of its HIPAA and ICD-10 solutions. He has been involved with EDI since 1983 including a 14-year tenure at Sterling Commerce where he served as Vice President of Development and Operations.

Hafner is active within WEDI as a five-term board member and currently co-chairs its Data Exchange work group. Other health care technology industry involvement includes AFEHCT, co-chair of HCCO Certification, and CAQH's CORE initiative. In addition to his involvement with health care, he has served other industry initiatives including retail, pharmaceutical, grocery, paper, and automotive.

Jason Wallis serves as Vice President of Payer Solutions at Availity, LLC. Before joining Availity in 2018, he served as Senior Vice President, Data and Network Operations with Experian Health overseeing the organization's clearinghouse and data strategy. Through technology and process improvements, he led initiatives to reduce costs and improve data quality, providing richer, value-added content to clients. Wallis also served at a leadership capacity for Experian Health's Patient Access and Content Network business units, where he provided strategic and technical insight to drive product development and sales.

Wallis began his career in software development, which led him to the healthcare IT space and to technology leadership at Passport Health (later acquired by Experian). At Passport he led product and technical teams responsible for several product suites and guided the design and architecture of solutions to meet customer's needs and provide a unique user experience. After the Experian acquisition, he led the merging of clearinghouse teams and expanded his role to include product line ownership and strategy as Vice President, Content Network.

About EHNAC

The Electronic Healthcare Network Accreditation Commission (EHNAC) is a voluntary, self-governing standards development organization (SDO) established to develop standard criteria and accredit organizations that electronically exchange healthcare data. These entities include accountable care organizations, data registries, electronic health networks, EPCS vendors, e-prescribing solution providers, financial services firms, health information exchanges, health information service providers, management service organizations, medical billers, outsourced service providers, payers, practice management system vendors and third-party administrators. The Commission is an authorized HITRUST CSF Assessor, making it the only organization with the ability to provide both EHNAC accreditation and HITRUST CSF certification. Contact info@ehnac.org and visit www.ehnac.org.

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Market Trends Studies, Books & Opinions

How to Comply with the Mental Health Parity and Addiction Equity Act

MyHealthGuide Source: **Marian E. Dodson** and **Nick J. Welle**, 7/8/2019, Foley & Lardner, LLP, [Labor & Employment Law Perspectives Blog](#)

The purpose of this article is to provide a high-level MHPAEA compliance guide for employers who sponsor self-funded health plans.

The Mental Health Parity and Addiction Equity Act (MHPAEA) prohibits health insurance policies and group health plans that cover mental health and substance use disorder (MH/SUD) benefits from imposing limitations on MH/SUD benefits that are less favorable than the limitations imposed on medical/surgical benefits.

The Department of Labor's Employee Benefits Security Administration (EBSA) is actively enforcing MHPAEA, and violations of MHPAEA are a frequent subject of lawsuits.

Overview of Requirements

Classifications. When evaluating parity between MH/SUD and medical/surgical benefits, there are six main classifications of benefits:

1. inpatient, in-network;
2. inpatient, out-of-network;
3. outpatient, in-network;
4. outpatient, out-of-network;
5. emergency care; and
6. prescription drugs

If a plan provides MH/SUD benefits in any classification, MH/SUD benefits must also be provided in every classification in which medical/surgical benefits are provided. The below parity requirements are applied on a classification-by-classification basis (with limited permissible subclassifications).

Financial Requirements and Quantitative Treatment Limitations. The financial requirements (e.g., deductibles, copayments, coinsurance, and out-of-pocket limits) and the quantitative treatment limitations (e.g., day and visit limitations) that apply to MH/SUD benefits in any classification must not be more restrictive than those applied to medical/surgical benefits in the same classification. In addition, requirements/limitations for MH/SUD benefits may not accumulate separately from the requirements/limitations for medical/surgical benefits (e.g., a plan may not impose separate deductibles for MH/SUD and medical/surgical benefits).

Nonquantitative Treatment Limitations. Examples of nonquantitative treatment limitations (NQTLs) are preauthorization requirements, step therapy requirements, and exclusions for failure to complete a course of treatment. Plans are prohibited from imposing NQTLs on MH/SUD benefits unless the NQTLs are comparable to, and are applied no more stringently than, the NQTLs applied to medical/surgical benefits in the same classification.

Self-Compliance Tool

Happily, the EBSA offers a [self-compliance tool](#) (summarized below) to assist plans in determining whether they comply with MHPAEA.

Two-Step Test for Financial Requirements and Quantitative Treatment Limitations.

First, confirm that the requirement or type of limit at issue applies to “substantially all” (at least two-thirds of) medical/surgical benefits in the classification. If the first test is satisfied, then determine the predominant level of the requirement/limitation (generally, the level that applies to more than half of medical/surgical benefits subject to the requirement/limitation in the classification), and then do not impose a requirement/limitation of that type that exceeds the predominant level.

For example, if 75% of outpatient, in-network visits involving medical/surgical services are subject to a \$30 copayment, then the plan cannot impose a copayment higher than \$30 for outpatient, in-network MH/SUD visits.

Four-Step Test for Nonquantitative Treatment Limitations.

First, identify the NQTL and which classifications it applies to for both MH/SUD benefits and medical/surgical benefits.

Second, identify the factors (e.g., excessive utilization or lack of clinical efficiency) that are considered in designing the NQTL and, if only certain benefits are subject to an NQTL, substantiate how the applicable factors were used to apply the NQTL and determine the reason(s) why certain factors were given more weight than others, if applicable.

Third, identify the sources (e.g., internal claims analysis or medical expert reviews) used in defining the factors, and confirm they were applied comparably to MH/SUD and medical/surgical benefits.

Fourth, evaluate whether the processes, strategies, and evidentiary standards used in applying the NQTL to MH/SUD are comparable to, and applied no more stringently than, they are applied to medical/surgical benefits, both in writing and in operation.

Specific Benefits. The tool clarifies that medication-assisted treatment for opioid use disorder and treatment for eating disorders are both subject to MHPAEA requirements.

Disclosure Requirements. The tool also details MHPAEA disclosure requirements. Specifically, upon request, the plan administrator (or health insurance issuer) must make available the criteria for medical necessity determinations with respect to MH/SUD benefits to current and potential participants, beneficiaries, and contracting providers. The plan administrator must also provide the reasons for any denials of MH/SUD benefits, and the tool highlights that the Affordable Care Act’s claims procedures include a right of claimants to access the documents detailing the processes, strategies, evidentiary standards and other factors used to apply an NQTL.

Takeaway

Although third-party administrators and pharmacy benefit managers will do most of the heavy lifting when it comes to plan design, employers who sponsor self-funded health plans that cover MH/SUD should know that any difference between the handling of a MH/SUD benefit and a comparable medical/surgical benefit is a red flag warranting special attention. For further details, see the final rules, at this [link](#).

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Legislative News

Eighth Circuit finds the SPD was the Plan's Written Instrument for ERISA Purposes When no PD Exists

MyHealthGuide Source: [Thomas Reuters Practical Law Employee Benefits & Executive Compensation](#),

Case: *Jobe v. Med. Life Ins. Co.*, 598 F.3d 478 (8th Cir. 2010) [Court Document](#)

In a health plan reimbursement dispute, the US Court of Appeals for the Eighth Circuit held that a summary plan description (SPD) was the plan's "written instrument" under the Employee Retirement Income Security Act of 1974 (ERISA) because the SPD was the only document that provided benefits.

As a result, a reimbursement provision found solely in the SPD was enforceable against a participant who was paid plan benefits following an accident but who later obtained a settlement from a third party.

Joining other circuit courts, the Eighth Circuit has held that a health plan's summary plan description (SPD) was the plan's written instrument for ERISA purposes because it was the only document providing benefits (*MBI Energy Servs. v. Hoch*, (8th Cir. July 3, 2019)). As a result, a reimbursement provision in the SPD was enforceable against a plan participant who received benefits under the plan after an accident and later secured a settlement from a third party.

Participant's Injury Leads to Reimbursement Dispute

The defendant in this case, a covered participant under his employer's self-funded health plan, was injured in an accident and received more than \$68,000 in medical benefits from the plan. The participant later reached a settlement with the third party responsible for his injury and was compensated by the third party's insurer. Because the participant was compensated twice for the same injury, the employer sued the participant for reimbursement of the benefits paid on his behalf, with an offset for attorney's fees incurred by the participant in obtaining his settlement. In doing so, the employer relied on a reimbursement provision disclosed to the participant in the plan's SPD. No written instrument (as required under ERISA) was clearly identified as the formal plan document.

The participant asserted that the reimbursement provision was not binding because it was not part of the health plan's formal plan document. A district court ruled in the employer's favor, however, and the participant appealed.

Employer Is Entitled to Reimbursement Under SPD

Affirming the district court, the Eighth Circuit concluded that the plan authorized the employer to be reimbursed after the participant's settlement recovery. In considering whether the SPD's reimbursement provision was enforceable, the Eighth Circuit addressed a 2007 decision in which it rejected the argument that an SPD cannot also serve as the plan.

In the 2007 case, which also involved a plan reimbursement dispute, a district court had determined that a reimbursement provision found only in an SPD was not binding. The Eighth Circuit reversed, however, concluding that if no other source of benefits exists, the SPD – regardless of its label – is the formal plan document.

The participant in the current case argued that the Eighth Circuit's 2007 decision was inconsistent with an intervening Supreme Court decision (*Cigna Corp. v. Amara*, 563 U.S. 421 (2011)) holding that the terms of an SPD are not part of the plan itself (see Article, Expert Q&A on the Impact of *CIGNA Corp. v. Amara*). The Eighth Circuit acknowledged that *Amara* undercut aspects of its 2007 decision.

- However, the Eighth Circuit reasoned that *Amara* did not address the specific issue in its 2007 decision – that is, whether an SPD can constitute the plan in the absence of any other plan document providing benefits.
- The Eighth Circuit therefore distinguished *Amara* (where there was both a plan document and an SPD) from the present case (in which the SPD was the only plan document that provided benefits).
- The Eighth Circuit concluded that its 2007 decision remained binding law in the Eighth Circuit.

Applying the 2007 decision, the Eighth Circuit held that the SPD was the plan's written instrument for ERISA purposes because it was the only document that provided benefits.

Practical Impact

It's not uncommon for an ERISA health plan to be established under a single document that functions as the plan's SPD – perhaps, as here, in coordination with an ASA. In the litigation context, that practice gives participants a strong basis to challenge the enforceability of provisions that can be found only in the SPD. And as the Eighth Circuit acknowledges here, conflating the plan and SPD requirements may also undermine an SPD's ability to function as the clear, simple communication envisioned under Amara. Nonetheless, the "equities" in this case (that is, not allowing a participant to claim benefits without also honoring the plan's reimbursement requirements) were sufficient to win the day for this employer.

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Medical News

A Sense of Well-being Extends Life with Less Disability and Illness

MyHealthGuide Source: **Paola Zaninotto, PhD** and **Andrew Steptoe, DSc**, '*Association Between Subjective Well-being and Living Longer Without Disability or Illness*', 7/10/2019, [JAMA Network](#)

People who report high levels of subjective well-being live longer and also healthier lives than those with lower well-being. These findings add weight to endeavors to promote the subjective well-being of older people.

This study followed 9,761 older men and women from the English Longitudinal Study of Ageing who were followed up for a maximum of 10 years, higher affective well-being was associated not only with longer life expectancy at older ages, but also with a greater proportion of additional years in good health without chronic disease or disability. Data were collected between March 2002 and March 2013 and analyzed from December 2018 to April 2019. Analyses were adjusted for wealth and cohabiting status.

Study findings

- High affective well-being was associated with longer life expectancy and with longer disability-free and chronic disease-free life expectancies.
- For example, a woman aged 50 years who reported high affective well-being could
 - expect to live 6 years longer than a woman of similar age with low well-being;
 - 31.4 of her remaining years would be likely to be free of disability, compared with 20.8 years for a woman with low affective well-being.
 - A man aged 50 years with high affective well-being could expect to live 20.8 years without chronic disease, compared with 11.4 years (95% CI, 8.5-14.6 years) for a man reporting low well-being.

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Recurring Resources

Medical Stop-Loss Providers Ranked by 2018 Annual Premium

Source: MyHealthGuide, 5/25/2019, [2016 Premium Ranking](#) and [2017 Premium Ranking](#)

The table below reflects Direct Earned Premium from the "Accident and Health Policy Experience Exhibit" ("Supplemental Pages, Insurance Expense Exhibit" section) of publicly available Statutory Reports filed annually by each insurance carrier.

Stop-loss Premium Ranking Based on Carrier's 2018 Statutory Report			
New Rank (2018)	Entity Name	Prior Rank (2017)	Stop Loss Premium Earned (2017) Thousands
1	Cigna	1	\$3,311,558
2	CVS Health Corp. (Acquired Aetna)	8	\$1,615,122
3	UnitedHealth Group	2	\$1,555,316
4	Sun Life Financial Inc.	3	\$1,452,870
5	Tokio Marine	4	\$1,302,685
6	Anthem	5	\$1,245,359
7	Voya Financial Inc.	6	\$933,523
8	HCSC	10	\$809,508
9	Highmark (HM Insurance Group)	7	\$751,768
10	Symetra	9	\$702,116
11	Companion - Blue Cross Blue Shield of SC	11	\$486,632
12	W. R. Berkley Corp.	13	\$369,193
13	Swiss Re	14	\$366,447
14	Blue Cross Blue Shield MI Inc	12	\$345,455
15	QBE	*	\$288,959
16	Humana	20	\$268,800
17	Fairfax Financial	16	\$238,344
18	Blue Cross and Blue Shield of Minnesota	15	\$210,728
19	Wellmark	17	\$200,754
20	Nationwide	21	\$194,593
21	National General Holdings Corp	22	\$193,368
22	Munich Re	18	\$184,892
23	Medical Mutual of Ohio	19	\$171,164
24	Fidelity Security Life	32	\$146,332
25	Blue Cross Blue Shield of MA	24	\$140,190

26	Liberty Mutual	77	\$126,819
27	Union Labor Life Ins Co	28	\$123,177
28	Blue Cross NC	29	\$122,627
29	Premera Blue Cross	27	\$120,585
30	Noridian Mutual Insurance Co.	23	\$117,407
31	Berkshire Hathaway Inc.	46	\$117,362
32	Trustmark Cos.	26	\$116,633
33	American Fidelity	30	\$98,441
34	HealthPartners	33	\$98,080
35	Capital Blue Cross	37	\$90,797
36	Regence	39	\$83,890
37	Houston International Insurance	38	\$82,494
38	Pan American Life	35	\$79,544
39	BCS	34	\$76,833
40	GuideWell Mutual Holding Corp.	42	\$73,135
41	BC&BS AZ Inc	40	\$72,604
42	Guardian	36	\$69,597
43	BlueCross BlueShield of TN	43	\$67,886
44	Blue Cross & Blue Shield of KS	41	\$67,770
45	Zurich	31	\$67,227
46	EMI Health	47	\$59,728
47	Excellus/MedAmerica	48	\$56,016
48	AXA	56	\$55,975
49	PartnerRe	53	\$54,550
50	CareFirst	45	\$46,796
51	American National	50	\$45,647
52	Blue Shield of California	44	\$44,372
53	PreferredOne	41	\$43,779
54	Blue Cross & Blue Shield of Kansas City	55	\$35,997
55	Time Insurance Co. II	52	\$34,606
56	Blue Cross of Idaho	54	\$33,413
57	Amalgamated Life Insurance Co.	61	\$30,326
58	GoodLife Partners Inc.	49	\$29,244

59	Priority Health	57	\$28,917
60	Blue Cross & Blue Shield of LA	58	\$27,337
61	Horizon Blue Cross Blue Shield of NJ	62	\$27,308
62	Aultcare	60	\$26,559
63	BIC Holdings LLC	59	\$22,450
64	HealthNow New York Inc.	64	\$20,991
65	Transamerica	25	\$18,927
66	The Health Plan	71	\$12,777
67	RGA (Reinsurance Group America)	66	\$12,498
68	Liberty Union Life Assr Co.	*	\$10,262
69	Hawaii Medical Service Assn.	69	\$10,093
70	PacificSource	65	\$8,981
71	BC&BS RI Inc	67	\$8,953
72	US Health & Life Insurance Co.	*	\$8,908
73	Health Alliance	68	\$8,649
74	SelectHealth	73	\$6,734
75	Harvard Pilgrim Health Care	70	\$6,449
76	Network Health	79	\$5,454
77	BlueCross BlueShield of VT	72	\$5,368
78	Oregon Dental Service	74	\$5,362
79	Solstice Health Insurance Co.	75	\$4,741
80	Arch Capital	63	\$2,903
81	WEA Insurance Corp.	78	\$1,346
82	Independent Health	84	\$1,173
83	Kaiser Permanente	80	\$1,123
84	Nippon Life Insurance Co of Am	83	\$1,113
85	Centene Corp.	81	\$1,082
86	ProMedica	76	\$652
87	Blue Cross Blue Shield WY	82	\$621
88	Physicians Health Plan of Northern Indiana	88	\$610
89	New Era Enterprises Inc.	87	\$140
90	Gulf Guaranty Life Ins Co.	89	\$91

91	Scott&White Health Plan	86	\$83
92	Talcott Resolution	90	\$46
93	The Hartford	91	\$19
	Total		\$20,227,756

* Stop Loss premium not reported in prior period.

Stop-loss Premium Volume is not the Whole Story

Industry executives question the purpose of a chart reporting only stop-loss premium without additional information such as:

- Ratings from Best, S&P, Moodys and others
- Capital size of the insurance company
- Reinsurance purchased and from whom
- Length in the business
- Number of open litigation claims
- Is stop-loss a core business or ancillary business?
- % age of risk retained vs. ceded
- Average stop-loss claim processing turn-around time
- % age of claims denied

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ICD-10 stop-loss Trigger Diagnosis Tools

MyHealthGuide Source: Industry Study Group (ISG)

In the early 2000s a group of industry professionals collectively known as the Industry Study Group ("ISG") created a Standard Disclosure Notification form and a standardized list of ICD-9 diagnosis codes, known as the Trigger list. On October 1, 2015, our industry transitions to the new ICD-10 coding system. The ISG has once again undertaken the development of a new Trigger list based on the ICD-10 diagnosis codes. *The new ICD-10-CM Trigger list is endorsed by SIIA and HCAA and supported by SPBA.*

Below are useful links for members of the self-funded community including TPAs, stop-loss carriers, MGUs, and others.

- [A YouTube video regarding ICD-10 Coding Basics](#) (26-minute interview with AHIMA official)
- [A basic Introduction to ICD-10](#) (eHealthUniversity produced by CMS)
- [ICD-10 stop-loss "Trigger Diagnosis" Code Ranges](#) (Word docx format from Industry Study Group)

- [ICD-10 Codes All codes with Descriptors](#) (Excel xlsx format from Industry Study Group)
 - Tab 1 - All ICD-10 Codes (91,757) codes. The trigger list codes are highlighted in yellow.
 - Tab 2 - Trigger List Codes (11,803) with Descriptors. (Revised 9/17/2015)

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The Value of Self-Funding

MyHealthGuide Source: The Self-Insurance Educational Foundation, Inc. (SIEF) www.SIEFOnline.org and [The Self-Insurance Educational Foundation, Inc. \(SIEF has published The Value of Self-Funding.](#)

Self-funding is an important contributor to the financial and physical health of America's wellness future. Self-funding is more than processing claims and receiving premiums, it provides quality coverage and proactive healthcare management for employers of all sizes and industries.

About the SIEF

The Self-Insurance Educational Foundation, Inc. (SIEF) is a 501(c)(3) non-profit organization affiliated with the Self-Insurance Institute of America, Inc. (SIIA). The foundation's mission is to raise the awareness and understanding of self-insurance among the business community, policy-makers, consumers, the media and other interested parties. Visit www.SIEFOnline.org.

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An Introduction to Self-Funding: What, Who & How

MyHealthGuide Source: [SELF Funding Success](#)

What is Self-Funding?

In terms of employee benefits, self-funding (also referred to as self-insurance) is a funding mechanism in which an employer funds health care claims independently rather than engaging an insurance company to purchase health coverage for its eligible employees.

There are several different names out there used to describe plan types and structures these days, but a health care plan either fits the category of fully insured or self-funded.

With steady growth in the last four decades, self-funded plans are now the most common type of health plan that workers are enrolled in across the United States. Various sources put this number at nearly 70% and climbing. Nearly all self-funded employee benefit plans are managed through a third party administrator (TPA) firm, an independent organization that assists with overall plan operations, benefit coordination and claims processing.

Who Uses Self-Funding?

From the 1970s to the 1990s, a common belief was that self-funded plans were only viable for large-size companies with hundreds to thousands of employees who needed health insurance coverage.

The idea that a company's size should be a determining factor in choosing whether or not to self-fund continues to be challenged. The reality is that a combination of factors should be evaluated on a case-by-case basis – including an employer's financial condition, cash flow, risk tolerance, and the need (or desire) for flexibility in designing a group health plan for its wide-ranging workforce.

Today, the majority of employee benefit plans in the U.S. are self-funded, with a growing number offered

by small-sized businesses and public employers. This overall market growth is the result of, in large part, the expansion of stop loss (somewhat like re-insurance) offerings. New stop loss options better fit small- to mid-sized employers' needs to manage risk, and work to foster closer relationships between carriers and their TPAs.

As businesses face the challenge of finding affordable health insurance year after year, many – of all industries and formats, including public employers – are finding that self-funding can be a smarter and more cost-effective alternative to buying traditional health insurance coverage.

How Are Self-Funded Plans Regulated?

The majority of self-funded health insurance plans are regulated by a variety of federal agencies (government and church plans may be subject to similar state rules, depending on the state's discretion). The Employee Retirement Income Security Act (ERISA) is the main law that applies to private employer self-funded plans. It is administered by the Employee Benefits Security Administration (EBSA), a division of the Department of Labor (DOL). The drafters of ERISA called it the "ultimate consumer protection" law because of the strong fiduciary duty obligations and transparency reporting requirements. Other federal agencies that regulate self-funded plans include:

- Department of Treasury
- Department of Health and Human Services (HHS)
- Equal Employment Opportunity Commission (EEOC)

Many self-funded plans are not regulated by state-specific mandates. The good news about that? If you have employees working in multiple states throughout the U.S., they can all be covered by the same group health plan without having to adjust your administrative or compliance efforts by location. Self-funding allows greater customization of employee benefits, making it easy to tailor each plan to meet the specific needs of each workforce.

Self-funding has become the most popular type of health plan in the United States as care costs keep rising and affordable health insurance becomes harder to find. Determining if the self-funded plan model and a TPA partnership will be a good fit for your workforce is something that should be considered by many of the organizations that offer health care as a benefit to their employees.

About SELF Funding Success

SELF Funding Success showcases success stories from the self-funded employers and their TPAs and provides information on how self-funding works, TPA definitions, stop loss basics, considerations for employers and choosing a TPA. Contact **Brenda Timm** at brenda@willemsmarketing.com and visit www.selffundingsuccess.com.

About the Society of Professional Benefit Administrators (SPBA)

Established in 1975, SPBA helps TPAs navigate a complex and ever-changing employee benefits landscape by keeping them educated and informed with the latest information. SPBA TPAs, along with their Stop-Loss and Technology Service Partners, serve the largest segment of non-federal employee benefit participants today. SPBA is unique in that its members represent every size and type of employment, industry and area of the United States. This all-encompassing perspective, plus a thorough grasp of the compliance picture and a strong relationship with government regulators, makes the SPBA and its hundreds of members an invaluable resource. Visit SPBA.org.

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Upcoming Conferences

July 15-17, 2019

HCAA TPA Summit 2019 presented by [Health Care Administrators Association](#). Remarkable lineup of industry leaders to engage in a series of high-level discussions focused on confronting challenges, implementing best practices and navigating towards the future of the self-funded industry. Featuring: *Effectively Managing Your Stop Loss Relationship*, **Rodney Gagne**, Director of Operations and Claims Management, National Underwriting Services. *PPO, RBP and What's Next?* **Erich Blumburg**, Sr Vice President, Lockton Dunning Benefits, **Jordan Hersh**, Vice President of Product Strategy and Development, NX Health Network, **Mac Meadows**, General Council, Entrust. [See the full schedule and register.](#)

July 16-18, 2019

Montana Captive Annual Conference. Whitefish, MT. Information www.mtcaptives.org.

August 19-20, 2019

Mentor Connection Forum presented by [The Self-Insurance Institute of America, Inc.](#) (SIIA) in support of the increasingly popular SIIA Future Leaders initiative. Speakers: **Craig Clemente**, Chairman, SIIA Future Leaders Committee and **Adam Russo**, Chairman, SIIA Board of Directors. This first-of-its-kind event has been designed to connect younger SIIA members (under age 40) with several of the most successful senior self-insurance/captive insurance industry executives in a "speed-mentoring" format. Attendees will have unique access to those who can provide practical career advancement advice, including tips on how they can be more valuable to their employers. Dallas, TX. [Registration..](#)

August 27-28, 2019

Texas Association of Benefit Administrators (TABA) Fall Conference and Account Manager Seminar. Historic Downtown Hilton, Ft. Worth, Texas. Contact Phyllis Campbell at pcampbell@tabatpa.org and visit www.tabatpa.org.

August 29, 2019 -Webinar 2:00pm Eastern

An Anthropologist and a Rocket Scientist Talk Stop Loss: Using Data to Empower Smart Decisions Overview. Deriving data from group dynamics and market insights helps to create informed, knowledge-backed solutions. This is essential in a market facing a rising high-dollar claims trend. Self-funded employers need your help implementing Stop Loss coverage that truly works to protect their bottom line. And to help ensure proper protection is available, Stop Loss carriers must make smart decisions fueled by data. Just ask an anthropologist and rocket scientist who walk the talk and bring analytical focus at a leading Stop Loss company. Speakers: **Mark Lawrence**, Senior Vice President, Underwriting, HM Insurance Group, BA, Anthropology and **Tom Doran**, President, HM Insurance Group, BS, Mechanical and Aerospace Engineering – aka Rocket Science. . [BenefitsPro Registration](#).

August 30, 2019 1:00pm – 3:00pm

Worksite X presents Jack London - London Medical Management, Inc...For the last couple of years, Amazon, Berkshire Hathaway and J.P. Morgan Chase have made news headlines by voicing their frustration with employee health insurance options and have begun building a model outside of the traditional health insurance carrier. Although this concept is new for the industry, pioneers like **Jack G. London**, have trailblazed these creative practices for years. Location: Undivided Experience Center, Suite 102, 657 Spirit Airpark West Drive, Chesterfield MO 63005. Register Here: <https://wxjacklondon.eventbrite.com>

September 18-20, 2019

SPBA Fall Meeting (*members only*). Phoenix, AZ. Society of Professional Benefit Administrators (SPBA). www.SPBATPA.org

September 19-20, 2019

7th Annual NAWHC Forum presented by [National Association of Worksite Health Centers](#). Provides actionable information to develop and expand your onsite or near-site facilities. In response to member interest, the event is being expanded to a day and a half, with the format designed not only for speaker and panel sessions, but for dedicated small-group networking sessions. Contact **Larry Boress**, NAWHC Executive Director at lboress@nawhc.org.

September 30 - October 2, 2019

39th Annual National Educational Conference & Expo presented by [Self-Insurance Institute of America](#). World's largest event focused exclusively on the self-insurance/captive insurance marketplace and typically attracts more than 1,700 attendees from around the United States and from a growing number of countries around the world. Registrants will enjoy a cutting-edge educational program combined with unique networking opportunities, and a world-class tradeshow of industry product and service providers guaranteed to provide exceptional value in four fast-paced, activity-packed days. Marriott Marquis. San Francisco, CA. [Information and Registration](#).

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January 20-22, 2020

29th Health Benefits Conference + Expo. For 29 years, the Health Benefits Conference & Expo (HBCE) has been a premier source of information and learning for professionals who want to improve their employee engagement and wellness programs. In this session, you will hear about new validated and evidence-based wellness and prevention strategies, yielding compelling clinical and financial results at companies across the globe. Learn why "good employee health continues to be good business" and how integrating features from other successful programs can result in lower health care costs, absenteeism and presenteeism with a measurable positive impact on your employer's bottom line. Speaker: **Ron Loeppke, M.D., M.P.H., FACOEM, FACPM**. [Registration](#).

February 24-25, 2020

HCAA Executive Forum 2020 presented by [Healthcare Administrators of American](#) (HCAA). Wynn Las Vegas. [Information](#)

March 16-18, 2020

Self-Insured Health Plans Executive Forum presented by [Self-Insurance Institute of America](#). Charleston, SC

April 15-17, 2020

SPBA Spring Meeting (members only). Washington, DC. Society of Professional Benefit Administrators (SPBA). www.SPBATPA.org

July 13-15, 2020

HCAA TPA Summit 2020 presented by [Healthcare Administrators of American](#) (HCAA). St. Louis. [Information](#)

September 16-18, 2020

SPBA Fall Meeting (members only). San Antonio, TX. Society of Professional Benefit Administrators (SPBA). www.SPBATPA.org

October 11-13, 2020

National Conference & Expo presented by [Self-Insurance Institute of America](#). Phoenix, AZ

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Job News (Listings are generally published for 1 month)

Tokio Marine HCC – Stop Loss Group Seeks Client Representatives

MyHealthGuide Source: [Tokio Marine HCC](#) – Stop Loss Group, 7/15/2019

Tokio Marine HCC – Stop Loss Group heightens operational excellence by introducing Claims Client Representative positions

The Claims Client Representative (CCR) will be the personal point of contact for our top producers and administrators for issues that may impact a stop loss claim. The CCR will be available to provide prompt

status requests, answer questions related to stop loss coverage and complex claims, and provide claim reporting to assist in client management. The CCR will assist in claim related issues from the initial submission to final reimbursement. They will collaborate with other Tokio Marine HCC - Stop Loss Group departments as necessary to facilitate:

- Implementation calls for new groups, producers and administrators
- Claim submission and documentation
- Claim reimbursement issue resolution
- Escalated communications with the producer and administrator regarding anything claims related

Interested candidates should [click here](#).

About Tokio Marine HCC – Stop Loss Group

A member of the Tokio Marine HCC group of companies. Tokio Marine HCC is the marketing name used to describe the affiliated companies under the common ownership of HCC Insurance Holdings, Inc. Tokio Marine HCC's products are underwritten by American Contractors Indemnity Company, HCC International Insurance Company PLC, HCC Life Insurance Company, HCC Specialty Insurance Company, Houston Casualty Company, Lloyd's Syndicate 4141, United States Surety Company and U.S. Specialty Insurance Company. Visit www.tmhcc.com.

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PartnerRe Seeks a Senior Underwriter, Employer Stop Loss in Kansas City, Minneapolis or San Francisco Office

MyHealthGuide Source: [PartnerRe](#), 7/15/2019

Position:

Senior Underwriter, Employer Stop Loss in our Kansas City, Minneapolis or San Francisco office.

Your responsibilities will include:

- Consistent with corporate objectives, monitor and manage assigned accounts using available report mechanisms to ensure ongoing profitability meets and exceeds established targets.
- As part of a dedicated team the candidate will work holistically with subject matter experts and support strategic initiatives to:
 - Manage daily interactions and pipeline activity for assigned network of broker and producer contacts.
 - Assess risk, quote and bind and provide consultative client-centric service to assigned producers and accounts.
 - Ensure account/producer-related issues and complex problems are addressed and resolved.
 - Collaboratively identify opportunities with in-house clinicians and/or claims to find relevant solutions to high dollar and/or serious claimant issues.

- Ensure work product is compliant with PartnerRe and insurance requirements.
- Report on market landscape, trends and developments.
- In conjunction with Client Partner support efforts to improve and build relationships with assigned producers:
 - Meet existing producers and help build new connections.
 - Contribute key metrics for development of producer action plans.
 - Participate in Implementation, Partnership and Stewardship discussions with customers.
 - Enhance PartnerRe's profile through industry conferences and organizations.
 - Contribute to the professional development of support team members.
 - Carry-out projects as required.
 - Build cross-market relationships to the benefit of PartnerRe Health product lines

Interested candidates should email resume to **Ali Duerr** at ali.duerr@partnerre.com.

About PartnerRe

PartnerRe Ltd. is a leading global reinsurer that helps insurance companies reduce their earnings volatility, strengthen their capital and grow their businesses through reinsurance solutions. Risks are underwritten on a worldwide basis through the Company's three segments: P&C, Specialty, and Life and Health.

PartnerRe Health US is a leading accident and health reinsurance group with over 25 years in the industry and a reputation for performance, creativity and a solution-oriented approach. Visit www.partnerre.com/health.

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PartnerRe Seeks an Underwriting Manager, Employer Stop Loss in Minneapolis, Kansas City or San Francisco Office

MyHealthGuide Source: [PartnerRe](#), 7/15/2019

Position:

Underwriting Manager, Employer Stop Loss in our Minneapolis, Kansas City or San Francisco office. The primary function is to grow the revenue and earnings and to manage a team of Underwriters at PartnerRe US Health's Employer Stop Loss division.

Your responsibilities will include:

- Consistent with corporate objectives:
 - Manage and monitor the Employer business portfolio ensuring profitability and stable expansion.
 - With input from CUO and Product leader, develop and deliver management reports, provide

updates and feedback at regular intervals.

- The candidate will lead and manage a team of Senior and Assistant Underwriters:
 - In conjunction with CUO and Product Leader, establish key goals, feedback and provide thought leadership to team.
 - Contribute to the professional development and know-how of team members and as necessary provide training to attain superior results.
 - Oversee and efficiently manage cycle activity to ensure turnaround metrics are achieved and exceeded.
 - Identify, monitor and report on impact of market changes, product enhancements, competitor developments and industry and legislative trends.
 - Work with Pricing Actuaries to address underwriting model and rating requirements, state filings and similar needs.
 - Work in partnership with Health subject matter experts to address large claims, reimbursement, reporting, cost management and related issues.
 - Ensure forms and documents meet business needs as well as compliance and governance standards.
- Actively support customer partnership and relationship goals:
 - Build customer loyalty and communicate value propositions of business.
 - Meet with producers as required.
 - Contribute to development of annual plans and key metrics for producers.
 - Enhance PartnerRe's profile through industry conferences and organizations.
- Provide if necessary underwriting support during high cycle activity.
- Carry-out projects as required.
- Build cross-market relationships to the benefit of PartnerRe Health product lines

Interested candidates should email resume to **Ali Duerr** at ali.duerr@partnerre.com.

About PartnerRe

PartnerRe Ltd. is a leading global reinsurer that helps insurance companies reduce their earnings volatility, strengthen their capital and grow their businesses through reinsurance solutions. Risks are underwritten on a worldwide basis through the Company's three segments: P&C, Specialty, and Life and Health.

PartnerRe Health US is a leading accident and health reinsurance group with over 25 years in the industry and a reputation for performance, creativity and a solution-oriented approach. Visit www.partnerre.com/health.

Sun Life Seeks a Medical Stop Loss Clinical Risk Consultant

MyHealthGuide Source: [Sun Life](#), 7/8/2019

Sun Life is looking for a Clinical Risk Consultant. The Clinical Risk Consultant is responsible for providing medical risk analysis for stop loss underwriters on potential ongoing risk for new business cases and in-force renewals. The primary function is to evaluate large claimants and predict ongoing future claim costs relative to the stop loss individual specific level. This risk evaluation is presented to the stop loss underwriter who will use the information to determine how best to offset or mitigate the catastrophic risk, which could impact the overall marketability of the case.

To apply or learn more, https://sunlife.wd3.myworkdayjobs.com/Experienced-Jobs/job/Windsor-Connecticut/Clinical-Risk-Consultant--RN-_JR00018078

Preferred skills

- Deep knowledge of stop loss product and comfort with medical terminology to identify catastrophic risk.
- Strong communication, interpersonal and negotiation skills to interact with senior underwriters, nurses and market managers.
- Very strong analytical, problem solving and decision making skills with attention to detail to assess future medical claim risks and costs.
- Intermediate skill in Microsoft Excel, Office and strong Internet research skills with ability to simultaneously use multiple systems when reviewing a large claimant.
- Effective self-management skills to prioritize daily work and meet deadlines based on the changing needs of senior underwriter/sales/Market Managers.

Qualifications

- Bachelor's degree in nursing with 3-5 years clinical experience is preferred.
- BA/BS or equivalent with stop loss insurance, medical underwriting or claim experience considered

Responsibilities

- Provides individual medical risk analysis on large claimants for proposed stop loss new business and renewal business.
- Reviews detailed large claim reports from a variety of sources including trigger reports, detailed individual claim reports, pending and denied reports, case management reports, and utilization reports
- Analyzes medical procedures codes, medication J codes, and prescription drug reports to assist in predicting the future claim costs
- Researches rare/complicated medical conditions/treatment options using resources including the internet, nursing, clinical resource tools by state/network.

- Stays informed of current medical and drug trends and shares information with team members
- Projects future costs of care for those claimants who may exceed the Stop loss individual specific level. Determines current treatment and cost of care based on the information received for review.
- Presents and documents a clear medical review summary with an analysis of the current clinical conditions and a future annual claim projection to the senior underwriter who will then present a potential laser/premium load or other creative option to offset the risk if the stop loss deductible level is too low.
- Utilizes resources provided to evaluate shock claims which include ICD-10 coding tool, prior medical underwriting reviews from past renewals, shock claims reports and internet research sites and websites that provide averages on claim costs.
- Provides training to manual/senior underwriters when applicable.
- Reviews any updated medical information that comes in after the initial review to determine if the future risk has changed. Notifies senior underwriter of any updates to the original risk projection.

About Sun Life

Sun Life is an equal employment and affirmative action employer. All qualified applicants will receive consideration without regard to race, color, sex, religion, age, national origin, disability, veteran status, sexual orientation, gender identity or expression, marital status, ancestry or citizenship status, genetic information, pregnancy status or any other characteristic protected by law. Sun Life is committed to building a diverse and inclusive company culture.

Sun Life is a leading provider of group insurance benefits in the U.S., helping people protect what they love about their lives. More than just a name, Sun Life symbolizes our brand promise of making life brighter – for our customers, partners, and communities. Join our talented, diverse workforce and launch a rewarding career. Visit us at www.sunlife.com/us.

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The Phia Group Seeks Multiple Positions

MyHealthGuide Source: [The Phia Group](#), 7/1/2019

The Phia Group has the following positions open. Summaries are provided below. Please [click here](#) for complete listing with details.

Case Investigator I

Braintree, MA

Please [click here](#) for complete listing with details.

Summary: The Phia Group provides, amongst other things, claim recovery services for health benefit plans. When a health benefit plan pays medical bills, and we later discover someone else should have paid those medical bills, The Phia Group – on behalf of the health plan – will seek to recover the funds. The Case Investigator plays an important role in this effort, by determining whether another proper payer exists, and obtaining the details needed to pursue fund reimbursement.

Tasks Include: Handling files for the Case Investigation Department. Communicating with plan members (insured participants) to determine potential sources of recovery (i.e. auto insurance, workers compensation, first party coverage, third party coverage, etc.). Contacting insurance carriers to collect adjuster and claim information. Communicating with clients (health benefit plan sponsors, employers, and claims administrators) via phone and email. Performing additional tasks (on an as-needed basis) to

assist with the day-to-day activities of the Recovery & Case Investigation Departments.

PACE – Intake Client Coordinator

Boise, ID

Please [click here](#) for complete listing with details.

Summary: The Phia Group allows employers who manage their own health benefit plans to submit complicated appeals regarding denied claims to The Phia Group and we help ensure that payable claims get paid, while proper denials remain in place. To ensure these appeals and claims are handled properly, our Plan Appointed Claim Evaluator (“PACE”) team needs dedicated, organized, and passionate members.

As a PACE Intake Client Coordinator, you will be responsible for the Client and Group document inventory with timely responses to all incoming contracts, plan documents, stop loss policies, enrollment requests and various other documents. The PACE Intake Client Coordinator will keep an accurate tracking of all documents received and follow-up with all Clients to acquire all missing documents and other administrative tasks as assigned

Client Intake Specialist

Braintree, MA

Please [click here](#) for complete listing with details.

Summary: As an intake specialist, you represent the first point of contact when clients have questions with which they need assistance. You will work independently with minimal supervision, and perform administrative duties including proofreading, verifying, and editing all materials for extreme accuracy and clarity, preparing documents, reports and correspondence, arranging conference calls, scheduling meetings, the maintenance and organization of the electronic files as well as other departmental clerical duties.

Senior Claims Specialist II, Provider Relations

Braintree, MA, US

Please [click here](#) for complete listing with details.

Summary: Experienced medical claim negotiator needed to combat rising healthcare costs and empower health plans! Among many other things, The Phia Group assists its clients by negotiating medical claims before they are paid, but after the health plan determines the claims are payable. Through this service, The Phia Group enables its clients to get in front of claims and secure reasonable settlements, promoting cost-containment.

The individual filling this role will be responsible for negotiating settlement with facilities and providers on a national basis to reduce healthcare claims costs, among many other tasks, including general consulting on related matters. This position requires an experienced individual that is proactive, persuasive, persistent, respectful, and assertive. The candidate must be comfortable multi-tasking and possess strong communication skills, both oral and written. The Phia Group is growing quickly and so the candidate must be comfortable in a dynamic fast-paced environment.

Marketing & Accounts Coordinator

Braintree, MA, US

Please [click here](#) for complete listing with details.

Summary: The Marketing & Client Accounts Coordinator directly supports relationship management functions within our business and seeks to enhance new and existing client relationships. As the Marketing & Client Accounts Coordinator, it is your responsibility to communicate with the industry through marketing efforts, meant to promote and grow The Phia Group brand, as well as communicate

directly with existing clients to ensure continued satisfaction, as led by the Marketing & Client Accounts Manager.

The Marketing & Client Accounts Coordinator will work closely with the Sales Team and the Marketing & Client Accounts Manager to understand the target market's needs, advertise our offerings and grow the company brand, as well as meet the customer's demands, while building strong and lasting relationships leading to client retention and business growth.

Health Benefit Plan Drafter

Please [click here](#) for complete listing with details.

Summary: The Phia Group's Plan Drafter is required to draft, edit, analyze and review health plan documents and plan amendments and other healthcare materials for clients, and as required by evolving laws and regulations. Communicate with clients regarding compliance and other specified issues and solutions.

Attorney I

Braintree, MA

Please [click here](#) for complete listing with details.

Summary: We are currently seeking a full time attorney with experience in this or similar industries, to solve issues presented by employers, their health plans, and those that service them; such as responding to audits, ensuring regulatory compliance, explaining plan terms, applicable laws, and resolving disputes between health plans, patients, and healthcare service providers – in an effort to protect plan members and sponsors. Duties will include conducting legal research, responding to questions regarding agency rules, statutory requirements, and legal compliance, communicating with plan administrators, and answering any number of questions regarding administration of compliant health plans in light of applicable rules and laws.

IT Intern

Braintree, MA

Please [click here](#) for complete listing with details.

Summary: The IT Intern is responsible for providing a full range of IT support and technology services to internal users. Services include support of desktops and help desk ticketing system. Includes business interaction analysis technology related issues, prioritization and resolution.

About The Phia Group

The Phia Group, LLC is an experienced provider of health care cost containment techniques offering comprehensive consulting services, legal expertise, plan document drafting, subrogation and overpayment recovery, claim negotiation, and plan defense designed to control costs and protect plan assets. Visit www.PhiaGroup.com.

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Symetra Seeks Clinical Risk Nurse Consultant

MyHealthGuide Source: [Symetra, 6/24/2019](#)

Symetra is looking for a Clinical Risk Nurse Consultant in Bellevue, WA, or Enfield, CT or Miami, FL

The Clinical Risk Nurse Consultant is responsible for assisting Stop Loss Underwriters in evaluating potential medical treatment cost of individuals identified in new and renewal business underwriting process to provide estimated claim risk for current and upcoming policy periods. Responsible for

assisting as a resource Policyholder's Third Party Administrator and Case Management Vendor with care and cost management oversight of potential stop loss claimants.

To apply or learn more, [click here](#).

Responsibilities

- Review policyholder data to identify claimants with catastrophic care needs and assess medical & claims information available to calculate potential risk. Provide written claimant assessments within established deadlines to the Underwriters/RGM's to utilize when establishing rates for new and renewal business.
- Review potential stop loss claim notices to identify case management and cost containment opportunities to reduce potential excess loss claim expenses. Notify appropriate management and underwriters of potential claims involving significant risk. Work with Third Party Administrators (TPAs) and external Case Managers utilizing medical and claims management resources to facilitate clinical and financial outcomes for claimants with complex and catastrophic medical conditions. Maintain current claimant clinical status, cost containment activities and contact information in ESL.
- Act as a resource to internal and external customers by: * Identifying and supporting training opportunities for Claims, Underwriting, Sales, and TPA when knowledge gaps are identified. * Providing clinical opinion from knowledge, experience and/or research to claims examiners and underwriters as requested or deemed appropriate. * Assessing and recommending effective claim cost containment and managed care vendors including preferred provider networks in assigned geographical region for introduction to * Identify geographical healthcare trends in assigned geographic marketplace for potential solution implementation and to warn Underwriting and Sales of any risk impacting trends identified.
- Represent Symetra at Industry Conferences attending educational sessions to gain awareness of new diagnoses, treatments, costs and industry trends. Maintain CE hours to meet State RN Licensure and CCM (or Industry) certification renewal requirements. Author educational articles to share industry news with internal contacts. Project leadership and participation as needed.

Education Required: Bachelors degree in related field

Minimum Years of Related Work Experience Required: Four or more years nurse clinical experience and Two or more years case management experience

Specific Industry and/or Specialty Experience Required: Two or more years experience in health care or health insurance industry; stop loss or reinsurance preferred

Specific Licensing, Designation and/or Training Required: Registered Nurse

Skills and Abilities Required: Ability to use varying resources to research diagnoses, treatments and average costs. *Strong computer proficiency (MS Word, Outlook, Excel and PowerPoint) *Ability to work independently and in team environment *Strong customer service mentality *Ability to develop unified internal and external working relationships *Ability to multi-task and adapt promptly to change *Excellent written and verbal communication skills *Strong prioritizing and organization skills

Education/Experience/Licensing Training/Skills/Abilities PREFERRED: Case Manager Certification(CCM) and Insurance industry education (LOMA, HIAA, ICA, etc.)

To apply or learn more, [click here](#).

About Symetra

Symetra is a dynamic and growing financial services company with 60 years of experience and

customers nationwide. In our daily work delivering retirement, employee benefits, and life insurance products, we're guided by the principles of VALUE, TRANSPARENCY AND SUSTAINABILITY. That means we provide products and services people need at a competitive price, we communicate clearly and honestly so people understand what they're getting, and we build products that stand the test of time. We work hard and do what's right for our customers, communities and employees. Join our team and share in our success as we work toward becoming the next national player in our industry. Visit www.Symetra.com,

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Ernie Clevenger
President & Publisher
MyHealthGuide, LLC
Clevenger@MyHealthGuide.com