
**MyHealthGuide Newsletter**
News for the Self-Funded Community
11/4/2019

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## General & Company News

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### GPA COSTPLUS® Receives Federal Trademark Registration for Metric-Based Pricing Product

MyHealthGuide Source: Group and Pension Administrators, Inc. (GPA), 10/29/2019

Dallas, TX -- Group and Pension Administrators, Inc. (GPA) is pleased to announce that COSTPLUS®, the company's Metric-Based Pricing product, has received federal registered trademark approval by the United States Patent and Trademark Office after more than a decade of serving health plans across the U.S.

GPA was founded by **Jerry McPeters** in 1968. Four decades later, **Jeff McPeters**, President, and **Kathy Enochs**, CEO, envisioned a new payment solution that would revolutionize the healthcare space. McPeters and Enochs presented the concept for metric-based pricing to ELAP co-founders **Steve Kelly** and **Woody Waters**. Together, they developed the first iteration of metric-based pricing backed by legal support.

"Our goal has always been to champion employers and deliver a better option," said GPA President Jeff McPeters. "Employers faced relentless costs, but had no options outside of the PPO networks which were contributing to problem. COSTPLUS® was developed to answer that problem, benefit the employer and protect the member."

In 2008, GPA and ELAP implemented COSTPLUS® for a client in Texas as the first formal, organized TPA-metric based pricing (MBP) platform to combat the problem of skyrocketing healthcare costs. Since then, the model has created over $2 billion in savings for GPA clients to date. COSTPLUS® is now the leading metric-based provider in the U.S.

"We are immensely proud of the success COSTPLUS® has seen in the industry, and the success it has created for our clients and partners," said GPA CEO Kathy Enochs. "Having our trademark registered after more than a decade of creating savings will help ensure that our brand, product and mission will continue to serve our clients with superior strength and market recognition for years to come."

**About Group & Pension Administrators, Inc.**

Group & Pension Administrators, Inc. (GPA) is the largest independently owned third-party administrator (TPA) in the US, providing high-quality, custom healthcare benefit management solutions to self-insured employers. For over 50 years, GPA has combined excellence in service with commitment to clients. They combine industry-leading technology and tools with "high-touch" care to deliver the healthiest employees and the healthiest bottom line. Contact **Kathy Enochs** at 972.744.2445, kathye@gpatpa.com and visit gpatpa.com.

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**AccuRisk Solutions Expands Underwriting Capacity with Acquisition of M-D Underwriting**

MyHealthGuide Source: Business Wire, 10/31/2019

CHICAGO -- AccuRisk Solutions LLC is proud to announce its recently completed acquisition of M-D Underwriting Services, Inc. ("MDU"), a Franklin, TN, based Medical Stop Loss MGU.

AccuRisk CEO **Dan Boisvert** stated: "We are pleased to welcome Cathy Guenther and her team into the AccuRisk family. Our objective is to realize profitable and sustainable growth. MDU has a long history of producing profitable underwriting results and will provide additional underwriting and claim handling talent and capacity to our fast-growing organization."

MDU President **Cathy Guenther** stated: "We are very excited to be joining AccuRisk Solutions. By integrating our experience team with AccuRisk and utilizing their additional resources, I view it as a win-win-win for MDU, AccuRisk and, most importantly, our customers."

**About AccuRisk Solutions LLC**

AccuRisk Solutions LLC is a nationally recognized Managing General Underwriter focused on providing its producers with innovative insurance products and outstanding customer service. The AccuRisk executive management team is composed of proven leaders within the industry who are driven to provide better results for clients. AccuRisk partners with leading insurance carriers and healthcare visionaries to provide a comprehensive array of healthcare and employee benefit solutions. Their objective is to assist producers in providing their employer clients with unique and cost-effective solutions. Contact Dan Boisvert at dboisvert@accurisksolutions.com, 312-888-4786 and visit www.accurisksolutions.com.

**About M-D Underwriting Services, Inc.**

M-D Underwriting Services, Inc., is a full service Managing General Underwriter founded in April 2000 in Franklin, TN. Visit mdusi.com.

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**Inventavis Sells to Advanced Medical Pricing Solutions**

MyHealthGuide Source: Inventavis, 10/28/2019

Fresno, CA -- Inventavis, LLC announced its sale to Advanced Medical Pricing Solutions (AMPS) in Atlanta GA. AMPS is a large healthcare cost management company focused on decreasing the cost of care and driving value.

Inventavis was formed by **Lawrence Thompson** and **Stephen Manzelli** in 2017 to provide consulting

and innovation services to Health Systems, TPAs, Insurance Carriers, AHPs, PBMs, member technology firms, reinsurers and other key industry innovators both domestically and internationally.

Mr. Thompson has joined AMPS as their Chief Strategy Officer and is responsible for strategic development and revenue growth. He noted, “We are truly excited to bring Inventavis into the AMPS family, as this will allow the Inventavis business model of exceptional client execution and expertise to be merged with the broad service-array that AMPS offers in the healthcare vertical.” building, engagement, technology, customer ice, implementation and vendor selection.

Mr. Manzelli will be continuing his consulting efforts via his local NY-based corporation, SSMMC. He added, “Inventavis is the culmination of years of market exposure, successful business execution and relationship building with other healthcare leaders that we deeply enjoy working with. The sale of Inventavis to AMPS will allow us to continue our cycle of innovation on an even broader scale.”

“The acquisition of Inventavis strengthens our ability to form partnerships with health systems, Association Groups, TPAs and other strategic channels to deliver cost containment solutions to the health care market,” explained **Kirk Fallbacher**, AMPS CEO and President.

**About Inventavis**

Inventavis has offices in Albany, New York and Fresno, California to service its national client base. In addition to its operations in the US, Inventavis also performs services internationally, focused initially on the Caribbean and Central America. Visit www.inventavis.com.

**About AMPS**

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

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**Vālenz Embeds Planwatch into Claim Workflow for Actionable Data**

MyHealthGuide Source: Vālenz, 11/1/2019

STOW, OH -- With healthcare spending projected to rise more than 5 percent each year and three-quarters of that spending tied to chronic disease, the need to better manage medical costs has never been greater. To provide self-insured employers, third party administrators, health plans and others with data that drive smarter, more cost-effective decisions, ProServe Health Informatics is pleased to be part of the Vālenz™ ecosystem.

Through Planwatch™, its flagship product, ProServe Health adds deep, integrated financial analytics to fuel Vālenz Claim, a core component of the Valenz ecosystem. By aggregating and mining in-network and out-of-network medical claim data, Planwatch provides intuitive and detailed financial reporting, as well as plan modeling to help direct and systemically lower healthcare spend.

Including Planwatch in the Valenz ecosystem enables more proactive decision-making and a greater opportunity to disrupt the cost curve. “We are leveraging interoperability with partners like ProServe Health to provide actionable business intelligence that helps clients reduce plan costs, not just in the short term but on a more sustained basis,” said **Rob Gelb**, Chief Revenue Officer at Valenz. “For robust visibility into in-network and out-of-network medical claims savings, Planwatch supports our promise to engage early and often for smarter, better, faster healthcare.”

**Georgeann Seuffert**, Vice President of Sales at Planwatch, agrees. “We are pleased to take our existing relationship with Valenz to the next level because we share a common goal to provide solutions

that substantially influence better health outcomes and reduce total cost of care," she said. "It is very refreshing to partner with an organization that wants to invest back into their clients. The Valenz commitment to Planwatch as a value-added service speaks volumes about their dedication to healthcare delivery and savings."

**About ProServe Health Informatics**

Planwatch is a product of ProServe Health Informatics. It was developed in 2005 by company co-founders who recognized both the need and the solution for an economical, user-friendly, high level data analysis, web-based reporting, benchmarking, disclosure and plan modeling tool for the Payor community. Planwatch examines historical, current, and future health plan dimensions, integrates, combines and compares pharmacy and medical costs, identifies cost drivers and performance metrics, and provides tested solutions to minimize plan expenditures. Query and produce ad-hoc reports by cost, coverage areas, procedure codes, POS, geographical locations, network performance, prescriptions, and over 150 query fields by employer, participant or payor block of business. Contact **Georgeann Seuffert**, Vice President of Sales at (888) 275-2242, gseuffert@proservehealth.com and visit www.plan-watch.com.

**About Valenz**

Through a complete health administrative ecosystem, Valenz connects cost and quality data on a single-source, end-to-end analytics platform for smarter, better, faster healthcare. Serving self-insured employers, third-party claim administrators, brokers and benefit consultants, trust and labor organizations, stop-loss carriers, integrated healthcare delivery networks, and health/dental plan payers, Valenz solutions integrate data from comprehensive care management services (Valenz Care), high-value provider networks (Valenz Access), claim flow management (Valenz Claim) and solutions for payment integrity, revenue cycle management and eligibility compliance (Valenz Assurance) into the ecosystem. Valenz is backed by Great Point Partners. Call (877) 601-2200 and visit www.valenzhealth.com.

**About Great Point Partners**

Great Point Partners ("GPP"), founded in 2003 and based in Greenwich, CT, is a leading health care investment firm, currently with approximately $1.8 billion of equity capital currently under management and 28 professionals, investing in the United States, Canada, and Western Europe. GPP is currently making new private equity investments from GPP III. Great Point manages capital in private (GPP I, $156 million and GPP II, $215 million of committed capital, and GPP III which has $306 million in committed capital) and public (BioMedical Value Fund family, approximately $1.1 billion) equity funds. Great Point Partners has provided growth equity, growth recapitalization, and management buyout financing to more than 100 growing health care companies. The private equity funds invest across all sectors of the health care industry with particular emphasis on biopharmaceutical services and supplies, outsourcing and alternate site care, pharmaceutical infrastructure and information technology enabled businesses. The firm pursues a proactive and proprietary approach to sourcing investments and tuck-in acquisitions for its portfolio companies. Call (203) 971-3300 and visit www.gppfunds.com.

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**Sana Benefits Raises $3.6m in Seed Funding to Serve Self-funding Solutions for Small and Medium Businesses**

MyHealthGuide Source: Sana Benefits, 10/29/2019

Sana is excited to announce an additional $3.6M in seed funding led by Gigafund (**Steve Oskoui**) and Trust Ventures (**Sal Churi**), bringing the total funding to date to $6.3M. Changing the healthcare industry is a big lift that requires patient capital and long-term vision. Gigafund and Trust have both, adding Sana to a portfolio of investments that includes startups in space exploration, nuclear energy , AI processor chips and 3D printed homes . Gigafund and Trust join Greenlight Re and Mark VC (**Adam Zeplain**) as the other major institutional investors in Sana.

Sana offers premium health benefits for small and medium businesses at 30% lower cost than traditional options. Through vertical integration, modern care management, and intelligent backend automation, we cut out much of the waste associated with traditional health insurance and pass that benefit on to our customers. Sana members can see the doctors they want and get concierge care.

Sana works to solve a simple problem: healthcare in the US is insanely overpriced. The US is an extreme outlier in healthcare spend per capita. The root causes of accelerating costs are not a mystery - wasteful spending costs the US healthcare system roughly one trillion dollars every year and the waste is easy to identify. Why isn't the market fixing it? We see three main reasons for the market failure: lack of competition, broken distribution and massive cascading technical debt.

Healthcare markets in the US are dominated by giant monopolies across carriers , hospitals and drug companies . Every year, these monopolies pass on arbitrary price hikes to consumers while ignoring myriad innovative care solutions that could deliver better care at lower cost. Those monopolies are enabled by traditional broker distributors who have a direct financial incentive to sell expensive plans. These excessive profits have made incumbent players complacent and they haven't updated their technology in forty years. Now they have so much technical debt that they couldn't innovate even if they wanted to.

Sana has started fresh with a modern, customer-focused approach. We sell our plans directly, cutting out the middleman broker so we can build the product around our customers' needs. We let our members see the doctors they want and we build a network around them. We offer free premium services to our customers through partnerships with Plushcare, Maven, Beam, ClassPass, and Calm . We have built all of our own technology from scratch on a modern HIPAA compliant web stack (AWS, Rails, React, etc.) which enables us to be a leader in back office automation and data-driven approaches to care management. We are obsessed with making a smarter, more human health plan.

**About Sana Benefits**

We launched in Texas last year and now have dozens of customers and thousands of individuals on Sana health plans. Our early customers have had amazing results (see testimonials from Door and Abodewell ). Clients tell us they save tens and hundreds of thousands of dollars each year because of our services and their employees see the doctors they want. Most importantly, our members feel like we have their back when they need it. We are building a more human kind of healthcare that gets us excited. We are hiring in our Austin HQ and across the US (we are a very remote-friendly company). Come join us in our mission to make quality healthcare accessible, understandable and affordable at careers.sanabenefits.com or reach out to our team at hello@sanabenefits.com. Contact **Will Young** at will@sanabenefits.com and visit sanabenefits.com.

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**The Phia Group Announces Webinar *Plan Language, RX, and Lawsuits to Watch (and File): Innovation for a Changing Industry***

MyHealthGuide Source: The Phia Group, 11/1/2019

**Webinar Title:** *Plan Language, RX, and Lawsuits to Watch (and File): Innovation for a Changing Industry*

**Description:** In the face of evolving pricing models, ever-increasing drug costs, difficulties in administering claims, and increased regulatory burdens, the players in the self-funding industry need change. Not just any change, though; creative change that promotes cost-containment and makes life easier for those who support health benefit plans in one way or another.

Join The Phia Group's legal team on November 14th, at 1pm EST as they discuss innovative programs to manage vendor fees, balance-bill litigation, Rx manufacturer assistance, and other ideas being proposed by players in the industry. Join us to assure you are able to manage new regulatory frameworks and keep up with the industry's progress.

**Registration Link:** https://register.gotowebinar.com/register/5011876767671055873

**About The Phia Group**

The Phia Group, LLC, headquartered in Braintree, Massachusetts, is an experienced provider of health care cost containment techniques offering comprehensive claims recovery, plan document and consulting services designed to control health care costs and protect plan assets. By providing industry leading consultation, plan drafting, subrogation and other cost containment solutions, The Phia Group is truly Empowering Plans. Visit www.PhiaGroup.com.

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**EHNAC Releases New 2020 Accreditation Criteria Versions for Privacy and Security Initiatives**

MyHealthGuide Source: Electronic Healthcare Network Accreditation Commission (EHNAC), 11/1/2019

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 that it has posted new versions of program criteria of its 18 accreditation programs for public review. The open process for adopting criteria will commence on Nov. 1, 2019 and end on Dec. 31, 2019.

Significant updates to the 2020 criteria include the evolution of two Direct Trusted Agent programs (DTAAP-CA, DTAAP-RA) to accreditation offerings by DirectTrust. DirectTrust Privacy & Security (DT P&S) accredits against HIPAA Privacy and Security requirements for organizations pursuing DirectTrust accreditation as a HISP, Certificate Authority and/or Registration Authority.

EHNAC Privacy & Security (EHNAC P&S) accredits organizations against EHNAC's core criteria including privacy and security, customer service, business practices, personnel requirements, third-party cloud service providers, and more. This program is applicable for organizations with stakeholder-specific services that are not addressed by any of EHNAC's other accreditation programs.

In addition, 2020 criteria updates include those for the recently announced Trusted Network Accreditation Programs (TNAP), designed to address alignment with TEFCA and 21st Century Cures Act: TNAP-Participant/Participant Member and TNAP-QHIN. Details on those programs can be found here.

"A wide range of enhancements have been made to each program based on feedback from accredited organizations and approved recommendations from the EHNAC Criteria Committee," said **Ron Moser**, EHNAC Senior Site Reviewer/Auditor. "During the 60-day review period, all interested stakeholders are encouraged to provide EHNAC with opinions, comments and suggestions that will prove helpful in determining the necessity, appropriateness and workability of the criteria versions proposed for 2020."

The 18 enhanced criteria programs and the new version numbers associated include: (*The self-funded community might be most interested in **bold listings**.)*

- 1. ACOAP - Accountable Care Organization Accreditation Program (V3.5)
  2. DRAP - Data Registry Accreditation Program (V3.5)
  3. DT P&S - DirectTrust Privacy & Security (V1.1)
  4. ePAP-EHN - e-Prescribing Accreditation Program (V8.5)
  **5. EHNAC P&S - EHNAC Privacy & Security (V1.1)**
  6. EPCSCP-Pharmacy - Electronic Prescription of Controlled Substances Certification Program - Pharmacy Vendor (V3.5)
  7. EPCSCP-Prescribing - Electronic Prescription of Controlled Substances Certification Program - Prescribing Vendor (V3.5)
  **8. FSAP-EHN - Financial Services Accreditation Program for Electronic Health Networks (V4.5)**
  **9. FSAP-Lockbox - Financial Services Accreditation Program for Lockbox Services (V4.5)**
  10. HIEAP - Health Information Exchange Accreditation Program (V3.5)

**11. HNAP-EHN - Healthcare Network Accreditation Program for Electronic Health Networks [Includes Payer] (V12.5)**
12. HNAP-Medical Biller - Healthcare Network Accreditation Program for Medical Billers (V3.5)
**13. HNAP-TPA - Healthcare Network Accreditation Program for Third Party Administrators (V3.5)**
14. MSOAP - Management Service Organization Accreditation Program (V3.5)
15. OSAP - Outsourced Services Accreditation Program1 (V3.5)
16. PMSAP - Practice Management System Accreditation Program (V3.5)
17. TNAP-Participant/Participant Member - Trusted Network Accreditation Program - Participant/Participant Member (V1.1)
18. TNAP-QHIN - Trusted Network Accreditation Program - QHIN (V1.1)

Visit www.ehnac.org for more details or to review the latest EHNAC criteria and submit feedback during this comment period through the Criteria Comment Form.

**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.

EHNAC was founded in 1993 and is a tax-exempt 501(c)(6) nonprofit organization. Guided by peer evaluation, the EHNAC accreditation process promotes quality service, innovation, cooperation and open competition in healthcare. Contact **Debra Hopkinson** at 860.408.1620, dhopkinson@ehnac.org and visit www.ehnac.org.

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**Imagine Health and Orlando Health Partner to Offer Local Self-insured Employers Powerful Alternative to Traditional PPO Plans**

MyHealthGuide Source: Imagine Health via Business Wire, 10/30/2019

ORLANDO, FL -- Imagine Health, a healthcare services company for self-insured employers, announced a new partnership with Orlando Health to bring a new health plan to employers and employees in Central Florida. A powerful alternative to traditional PPO plans, the plan will lower healthcare costs by giving members access to Orlando Health's world-class medical professionals at a fair and reasonable price. Plan members will also be supported by care navigation services to help them make informed healthcare decisions.

"Nationwide, employers and their employees are overburdened by skyrocketing healthcare costs. We are transforming healthcare through collaboration between health systems and national and local employers in the communities they serve," said **Chris Cigarran**, CEO at Imagine Health. "This is the type of direct connection we've established with Orlando Health, allowing us to offer employers in Central Florida a new kind of health plan. By pairing a distinguished health system with a cost-containment solution that benefits both local businesses and the employees who depend on them for health coverage, we're empowering employers to take back control of their healthcare costs."

**About Orlando Health**

Orlando Health is a comprehensive private, not-for-profit healthcare network, providing care to nearly 2 million patients in Central Florida annually. Featuring state-of-the-art facilities and a skilled staff, Orlando Health's primary care clinics and inpatient and outpatient medical services bring high quality healthcare

to residents throughout Orange, Seminole, Osceola, and Lake Counties. The system's specialty areas include cancer, cardiovascular, general surgery, neuroscience, orthopedics, pediatrics, and women's health.

**About Imagine Health**

Imagine Health offers self-funded employers an alternative to traditional healthcare plans. Through partnerships with high-quality health systems, built-in cost controls and advanced member advocacy services, Imagine Health delivers immediate and long-term savings, lowering an organization's healthcare spend up to 30% in the first year. Visit www.imaginehealth.com.

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**ERISAPros Joins Vertafore's Orange Partner Program Collaboration to Streamline Data Integration and Reduce Compliance Risk for Brokers**

MyHealthGuide Source: PRWeb, 10/24/2019

ATLANTA -- ErisaPros, LLC announces its membership in Vertafore's Orange Partner Program, which will allow ERISAPros to retrieve client data from Vertafore's benefits management system, BenefitPoint®, and utilize it to prepare Wrap Plan Documents using its proprietary document builder, Wrap-Tight(sm). Vertafore is the leader in integrated software for independent agents, MGAs, carriers, and states and regulators.

The Orange Partner Program provides open access and integration opportunities with Vertafore application programming interfaces (APIs) for customers and partners. The program also extends to third-party technology providers, such as ERISAPros, which is joining the program to streamline solutions for agencies and brokers.

The ability to transfer client data directly from BenefitPoint® to Wrap-Tight(sm) will alleviate multiple data entry efforts, saving time, and improving accuracy. Using the same preparer for the Wrap Plan as for the Form 5500 reduces risk for the agency and broker that may arise when the description of benefits, plan name, plan number, and/or the plan sponsor reflected on the Form 5500 is inconsistent with the information provided in the Wrap Plan Document and SPD.

"We envision our Agency Partners improving their efficiency in regulatory-related account management practices with the BenefitPoint integration inside "Wrap-Tight(sm)," said **Michelle Lewis**, BenefitPoint Product Manager.

ERISAPros' proprietary Wrap-Tight(sm) compliance and document system allows an employer to save time and money by integrating all of its benefit plans into one document rather than preparing a document for each separate plan. This approach permits an employer to file one Form 5500 and distribute a single SPD, Summary Annual Report (SAR), and Summary of Material Modifications (SMM). If amendments are required in response to benefit or regulatory changes, the employer only needs to make changes to one document, rather than for each separate component benefit plan.

**About ERISAPros**

ERISAPros is a premium provider of ERISA reporting and disclosure consulting and compliance services, such as Form 5500s, Wrap Plan Documents, SPDs, and Premium Only Plans (POPs) for welfare benefits including group life, medical, dental, and disability insurance plans. The integration of Wrap-Tightsm with Vertafore's client management system, BenefitPoint®, reinforces ERISAPros' dedication to being an industry-leading, cutting-edge provider in the ever-evolving and fast-paced U.S. health and welfare benefits industry. ERISAPros has preferred partnership agreements with six of the top ten U.S. benefit brokers. Contact **Michael Eaton**, Vice President of Sales, at 678-443-4009, meaton@erisapros.com and visit www.erisapros.com.

**About Vertafore**

For over 50 years, Vertafore, the leader in modern insurance technology, has built and supported superior InsurTech solutions to connect every point of the distribution channel. Vertafore's agency management, ratings, regulation, compliance, and connectivity products streamline workflows, improve efficiency, and drive productivity for more North American insurance professionals than any other provider – including more than 20,000 agencies, over 1,000 carriers, and 23 state governments. Through a continual focus on operational excellence, development of innovative solutions, and alignment with key industry partners, Vertafore is leading the way for customers of all sizes by delivering results that make a difference. Visit www.vertafore.com.

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## Market Trends Studies, Books & Opinions

### Justices Show Supreme Reluctance When They Get ERISA Assignments

MyHealthGuide Source: **Robert Steyer**, 10/28/2019, Pension & Investments

U.S. Supreme Court rulings on ERISA cases have a profound impact on retirement and other benefits, but that doesn't mean the justices enjoy reviewing them or issuing opinions.

**William Rehnquist**, the late former chief justice, once referred to ERISA cases as "dreary," adding that the court agrees to review them based on "duty, not choice."

Former **Justice Sandra Day O'Connor** called ERISA cases "tedious," counseling a colleague to "just do it" and to take steps to reduce the risk of being assigned another one by the chief justice.

Her colleague was **Justice Ruth Bader Ginsburg**, who said ERISA is a "candidate for the most inscrutable legislation Congress ever passed."

During her first year on the court in 1993, Ms. Ginsburg recalled hoping to receive as her first opinion-writing assignment an "uncontroversial, unanimous opinion," a common practice for newcomers.

Instead, she was "dismayed" to receive "an intricate, not at all easy" ERISA case decided by a 6-3 vote. That's when she asked Ms. O'Connor for advice.

Their comments are contained in an annual analysis of Supreme Court employee benefits cases prepared by law firm Eversheds Sutherland Ltd.

"Taxes and ERISA cases seem to be regarded as the least sexy part of their docket," said **Mark Smith**, a Washington-based partner, in an interview.

Mr. Smith has been gathering comments via "conventional research techniques," ranging from biographies and law review articles, as well as media-reported remarks, all carefully footnoted in the firm's report.

The Supreme Court's "recurring interest in employee benefits issues is mystifying," said the report, which was issued in early October.

The court keeps taking these cases even though it has reduced its total docket from about 180 merits cases in 1975 to 75 during the last term, the report said.

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## Legislative News

### Gene and Stem Cell Therapy for Self-funded Plans

MyHealthGuide Source: **Jennifer M. McCormick**, 10/30/2019, Benefits Pro

Both gene therapy and stem cell therapy could treat certain genetic or other diseases. The techniques are relatively new and exciting to explore. Understanding the differences, however, is important.

Generally, **gene therapy** is an experimental procedure which utilizes genes to treat diseases. Scientists are investigating various methods to apply gene therapy. For example, future gene therapy may be an option to replace a mutated gene with a healthy gene, inactivate a dysfunctional gene, or even introduce a new gene to fight against a disease.

**Stem cell therapy** techniques, however, repair dysfunctional tissue using stem cells. Using stem cells, scientists can create specialized cells which, when implanted, could repair the diseased cells. Generally, stem cell therapy involves moving cells with a specific function to an individual while gene therapy involves moving genetic information into cells.

**Implications for self-funded plans**

Therapies that could potentially repair or correct genetic or other rare diseases where no current treatment is available is very encouraging for those impacted personally. A self-funded plan, however, must contemplate the impact inclusion (or exclusion) may have for the plan.

These new technologies could have a large impact on employers who have self-funded plans. After understanding what these therapies may offer to individuals, employers should then ensure that the health plan design and any other plan materials fully communicate their intentions. For example, the plan must contemplate the plan language changes, costs, and other related agreements.

**Plan language**

Whether the employer wants the plan to cover (or exclude) these therapies, the documentation and communication to plan participants should not be confusing. As medical treatments evolve, it is expected that the plan design may not be in absolute sync with the latest science. For example, years ago a robotic arm assisted surgery was considered a medical breakthrough and only over time did they become more common. This newer surgery created a new method to overcome certain surgical limitations, however, this type of surgery had not been contemplated in many self-funded plan designs.

As a result, when participants were undergoing this type of surgery -and the underlying self-funded plan was silent on the issue- plan fiduciaries were unsure of how to address the surgery. Instead of being aware of potential trending medical advancements, these plan sponsors waited for the issue to arise and were caught by surprise. The same should not be the case for these newer therapies. While the plan design may not need to be modified, the employer should understand the potentially relevant plan provisions.

For example, since these therapies are newer, the impact or effectiveness measures may not be entirely clear. It is possible that a gene therapy suggested by a plan participant's physician is experimental, investigational or not medically necessary. This would mean that the therapy would not qualify as an eligible expense under the current terms of the plan and should be excluded.

The key to understanding with respect to plan language is that employers should be aware of the therapy and be aware of the current plan provisions. For example, some questions for employers to consider may be:

- Does the plan contain an experimental and/or investigational provision? If so, would that operate to exclude the procedure?
- Does the plan contain a medical necessity provision that would operate to exclude the procedure?
- Does the plan contain a specific exclusion that would operate to exclude the procedure?

Employers can be prepared for 2020 by understanding what the plan design currently contemplates,

then adjusting accordingly. After knowing the employer's position on the new therapies, the plan should adjust to ensure those intentions are captured.

**Costs**

It should not be a surprise that medical advancements, particularly those involving genes and cells, are expensive. Stories of gene therapy treatments costing more than a million dollars can easily be found in the news.

With a potential cost this high, it re-iterates the need for a clear action plan for employers. While the pool of individuals benefiting from such therapies may not be large, the cost for coverage could still be very high if the employer does not properly prepare. Further, these therapies could eliminate the need for future treatment of symptoms or care by addressing the root cause of a disease, which could be more cost effective.

Companies aware of the benefits (and costs) of such therapies are developing targeted programs. For example, entities such as CVS and Cigna are offering options for employers looking to cover some gene therapies by offering stop loss programs and per month fee options.

Employers can prepare for costs by planning in advance and being aware of options that might suit their demands for flexibility and budget.

**Related agreements**

Prior to implementing a program or benefit, however, employers should ensure coverage (or exclusion) would not create a gap with any current agreements or plan materials. For example, if an employer opted to modify the plan document to cover "gene therapy" could that create a gap with the stop loss policy if the stop loss carrier had a varying definition of experimental and/or investigational?

**Next steps**

Do what is right for the employer and communicate this action plan accordingly. Employers should understand what these therapies are, and what advantages or disadvantages may exist. Plans should then be adjusted to address the specific desires of the employer. It is highly recommended that employers work with their benefit advisors and consultants to make changes for their plans to ensure such modifications are done in a correct and compliant fashion.

**About the Author**

**Jennifer M. McCormick, Esq.**, is senior vice president of Phia Group Consulting, McCormick concentrates on a variety of health care and regulatory issues facing employee benefit plans and their administrators, including health benefit plan regulatory compliance services, including but not limited to self funded health plan consulting, health plan exclusions, health plan limitations, health plan revisions, defining key items such as usual and customary fees, and the entire health plan summary plan description and summary of benefits and coverage.

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## Medical News

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**Most Premies Survive to Mid-Adulthood without Major Comorbidities**

MyHealthGuide Source: **Casey Crump, MD, PhD**, et al, 10/22/2019, JAMA Network

Among persons born preterm, the majority survived to early to mid-adulthood without major comorbidities. However, outcomes were worse for those born extremely preterm.

In this population-based cohort study of more than 2.5 million persons born in Sweden from 1973 to 1997,

- 54.6% of those born preterm (gestational age <37 weeks) and 22.3% of those born extremely preterm (22-27 weeks) were alive with no major comorbidities at ages 18 to 43 years, compared with 63.0% of those born full-term.
- The prevalences were statistically significantly lower in those born at earlier gestational ages vs full-term.

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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

**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.

**January 23-24, 2020**
*2020 Onsite Employee Health Clinics Summit* presented by WCForum. The Leading Forum on Building & Expanding On-Site Health Clinics – Incorporating Strategies that Reduce Costs, Ensure Employee Satisfaction and Positively Impact Patient Behavior. Arizona Grand Resort. Phoenix/Scottsdale, AZ. Information and Registration

**February 24-25, 2020**
*HCAA Executive Forum 2020* presented by Healthcare Administrators of American (HCAA). Keynote: ***"Election 2020: The Future of Health Care in America,"*** from **Jason Altmire**, U.S. House of Representatives (2007-2013), Healthcare Policy Expert, Business Executive, Author and **Jason Chaffetz**, Fox News Channel Contributor, Former U.S. Congressman (UT), Chairman of Oversight & Government Reform Committee and Fellow, Harvard Kennedy School of Government. Together, they will share their expertise and experiences, offering informed insights into the coming trends and potential changes in the health care industry, along with what will occur following any possible outcome of the 2020 elections. 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). wwww.SPBATPA.org

Advanced Medical Strategies (AMS), the industry leader in strategic intelligence software for clarity into complex claims, is proud to announce its

**June 9-11, 2020**
*7th Annual AMS Claims Symposium* presented by Advanced Medical Strategies (AMS). The Symposium will commence with the *Predict Suite Member Workshop*. Wentworth by the Sea in New Castle, New Hampshire. Contact **Stephanie Belschner**, Vice President of Client Relations, at stephanie@mdstrat.com and 781-224-9711.

**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)**.** wwww.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)

**Cigna Seeks Stop Loss Underwriting Position**

MyHealthGuide Source: Cigna, 10/9/2019

- It's fun to work in a company where people truly BELIEVE in what they are doing!

We're committed to bringing passion and customer focus to the business.

**The Risk Management and Underwriting Advisor** – Stop Loss Underwriting is responsible for developing and executing stop loss rating strategies with stop loss P&L accountability for the assigned market(s). Partners closely with medical underwriting and sales to drive profitable stop loss growth and position Cigna as a stop loss carrier of choice among clients and brokers.

**Responsibilities**

- Develop and apply expertise in benefit design, product knowledge and large claim risk assessment. Partner with sales/underwriting at a case- and market-level to manage risk and achieve enterprise/stop loss financial goals.
- Engage sales and underwriting partners to monitor rate execution and financial results relative to financial goals.
- Drive stop loss strategy related to market competition, products and pricing for both existing and new prospects.
- Interact with brokers and clients in both CE (Continuing Education) and non-CE settings to educate the market on stop loss products. For non-CE discussions, provide consultative expertise to determine the stop loss solutions to address the broker's/client's needs while differentiating Cigna's stop loss offering.

**Preferred qualifications**

- Demonstrated success in risk assessment with strong analytical skills.
- Demonstrated success in developing highly respected, value-add business relationships through partnership and expertise.
- 5+ years of stop loss underwriting experience.
- Ability to work effectively in a dynamic, rapidly changing, team-based environment.
- Ability to foster collaboration across a team with diverse backgrounds and perspectives.

**Location:** This position can be located anywhere in the U.S., including Work at Home.

How to apply: Please apply via our careers website.

**About Cigna**

We're a global health service company dedicated to helping people improve their health, well-being and sense of security. But we don't just care about your well-being, we care about your career health too. That's why when you work with us, you can count on a different kind of career – you'll make a difference, learn a ton, and share in changing the way people think about healthcare. Visit cigna.com.

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**BCS Financial Corporation Seeks VP, Accident & Health Claims**

MyHealthGuide Source: BCS Financial Corporation, 10/14/2019

**Position:** VP, Accident & Health Claims
**Location:** Oakbrook Terrace, IL

**Position Overview**

The VP of Accident & Health Claims will provide operational and strategic direction to the Stop Loss, XOL and Provider Excess Claims department. This role will be a key leader in the organization and will be a key contact by other departments in working through escalation of items. Additionally this role will provide critical insights and direction on the High Cost Claimant solution, creating a road map of future capabilities and competitive advantage insights.

This position will report to the VP of Service and Operations.

**Essential Elements**

- Provide strategic direction to the claims department, using management by performance metrics
- Lead by example in their process improvement and continuous learning direction
- Work directly with Blue Plans, TPAs, High Cost Claimants (HCC) Specialty Vendors and BCS clinical resources in the application of cost savings initiatives
- Drive the expansion of relationships within the BCBS Plan structure in Claims, Medical Management, and Provider Contracting

**Requirements**

- Education and Certifications
- Bachelor's Degree required
- Master's Degree preferred
- Six Sigma Certification preferred

**Experience**

- Minimum of 10 years claims experience with at least 5 years in Stop Loss or Large Claims area required
- Stop Loss/Excess of Loss experience required

**Travel Required**

- 15 – 20% Travel required for onsite relationship building with Plans and Specialty Providers

Click here full information and apply.

**About BCS**

BCS Financial has a long-term Blue focus with nearly 70 years of service to the Blue System.
Long-term Blue focus with nearly 70 years of service to the Blue System. BCS Financial
Rated A- (Excellent) by A.M. Best. Visit bcsf.com.

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**PartnerRe Health Open Positions**

MyHealthGuide Source: PartnerRe Health, 10/7/2019

PartnerRe's U.S. Health team is growing. We have open positions in the following areas:

**Manager, Claims – Maple Grove, MN**

This position will be responsible for process improvement, team efficiencies, reporting and leadership of the Claim Analysts and Claim Associates. The position will collaborate with the VP, Claims to identify and implement strategies to improve claim performance and develop relationships with both producers and clients.

**Claims Specialist – Maple Grove, MN**

This position will be responsible for training within the Claims team and conducting quality audits. Additional responsibilities include supporting the Manager, Claims as a subject matter expert and assisting in adjudication of claims.

**Claims Analyst – Maple Grove, MN**

This position will be responsible for accurate and timely adjudication of claims for assigned clients. The position will build and maintain relationships with clients and producers.

**Clinical Consultant, PULSE + Plus™ – Maple Grove, MN**

This position will work with clients and producers to educate, validate, collaborate and solve complex and costly medical reimbursement issues. This position will work with a variety of specialty service providers to generate optimal financial and clinical outcomes. They also will provide clinical expertise to PartnerRe's underwriting and claims departments.

**VP, Employer Stop Loss Underwriting – Maple Grove, MN or Overland Park, KS**

This position will manage our underwriting team, monitor and manage the block of business, build relationships with our clients and producers, and provide underwriting support.

**Senior Underwriter, Employer Programs – Maple Grove, MN, Overland Park, KS or San Francisco, CA**

This position will assess risk, quote and bind coverage for assigned accounts, manage daily interactions and pipeline activity for assigned producers, and build relationships with our producers.

**Pricing Actuary – Maple Grove, MN, Overland Park, KS or San Francisco, CA**

This position will maintain our pricing models, performing research for new product development and standard pricing assumptions, develop rate filings for insurance products, performing analysis related to product line profitability and provide support to the underwriting team.

**How to Apply**

Please apply directly to our career site which will further request you to fill out additional information. Please do not send your resume via e-mail as this will not be acknowledged.

**About PartnerRe Health**

PartnerRe has been a leading accident and health reinsurance platform for over 25 years. Our products offered cover the full spectrum of health risks. We are committed to and focused exclusively on accident and health and are well-positioned to take advantage of new and unique growth opportunities.

PartnerRe is committed to being preeminent and predominant in target markets and has a reputation for innovation, technical excellence and industry knowledge that drive client-focused solutions. Our values include striving to provide the highest quality of expertise, products and services with transparency, honesty and integrity. Visit www.partnerre.com/health.

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## Editorial Notes, Disclaimers & Disclosures

- Articles are edited for length and clarity.
- Articles are selected based on relevance and diversity.
- No content in this Newsletter should be construed as legal advice. All legal questions should be directed to your own personal or corporate legal resource.
- Internet links are tested at the time of publication. However, links change or expire often.
- Articles do not necessarily reflect views held by the Publisher.
- Should you stop receiving the Newsletter, here are some items to check:
  - Is the Newsletter email in your junk or spam folder?
  - Have your IT team "whitelist" sender (Clevenger@MyHealthGuide.com)
  - Provide another email address.
  - Access the Newsletter online at www.MyHealthGuide.com/news.htm.

  Our email servers inactivate an account (email address) after three successive failed attempts to deliver the Newsletter. Failures to deliver occur when your email server "bounces" our Newsletter because your server views our email as spam because of anatomical terms often referenced in our "Medical News" section and for other reasons.

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