



BLACK, GOULD & ASSOCIATES, INC.

Agent Update

OCTOBER – NOVEMBER 2025

Broken No Surprises Act Arbitration Drives Up Premiums

BenefitsPRO, by Kristen Smithberg, October 28, 2025

IN THIS ISSUE

NO SUPRISSES ACT DRIVES UP PREMIUMS	1
BANNER AETNA UPDATES	2
BCBSAZ - NEW AUTO GROUP RENEWALS	3
HUMANA UPDATES	4
UHC—LP PLANS HELP MANAGE COSTS	5
HUMANA—NOTICE OF CHANGE	6
CONTESTS & BONUSES	7
BGA NEWS	8

Nearly 40% of disputes submitted to the federal Independent Dispute Resolution (IDR) process in 2024 were identified as ineligible, yet many still advanced through arbitration—forcing employers and health plans to pay unnecessary or excessive claims, according to a new survey from America’s Health Insurance Plans (AHIP) and the Blue Cross Blue Shield Association (BCBSA).

The report cites a [growing number of out-of-network claims from certain providers](#) and private-equity-backed firms as one of the most persistent abuses of the IDR system. The Georgetown University Center on Health Insurance Reforms estimates that misuse and inefficiencies in the process have led to roughly \$5 billion in wasteful spending since the system launched in April 2022 under the No Surprises Act.

“When this arbitration process was established, CMS estimated 17,000 disputes would be resolved annually,” said BCBSA President and CEO Kim Keck. “In reality, within months, volume exceeded ten times that amount as a small percentage of providers — particularly private-equity-backed organizations — drove the majority of disputes.”

Keck said claims submitted through the IDR process have resulted in payments averaging 400% above contracted rates, with some exceeding that amount. “Unchecked, these wasteful practices drive up everyone’s premiums,” she said. “It’s time to restore balance and transparency to this process, and the Blues stand ready to work with policymakers on commonsense reforms.”

In 2024, about 20 million qualified IDR claims were submitted across all provider types, with emergency services accounting for roughly 61% of the total.

According to the report, common ineligible claims included those for services payable under Medicare or Medicaid, disputes already resolved or resubmitted through IDR, disputes involving in-network providers, and claims covered by state surprise billing laws. Other reasons for ineligibility included incorrectly batched or bundled items, failure to initiate the required open negotiation process, missing or insufficient information that prevented plan identification, lack of dispute justification, or instances where providers later reversed or corrected the claim.

Despite nearly 40% of submissions being ineligible, the report found that only 17% were ultimately deemed ineligible by IDR entities, meaning that more than half of such cases still resulted in binding payment determinations.

Air ambulance services — typically high-dollar claims — represented less than 1% of all qualified IDR submissions but were the most likely to enter arbitration.

AHIP and BCBSA urged policymakers to address what they described as “misaligned incentives” that allow IDR entities to advance unnecessary disputes and to increase accountability and oversight in the process.



FROM THE GROUP DEPARTMENT

BANNER|AETNA: Aetna Standalone Dental

Dental Coverage Designed to Deliver

Dental insurance remains one of the most sought-after employee benefits, offering real value to employers and employees. With standalone dental plans from Aetna, brokers can provide clients flexible, high-quality coverage that's easy to sell and simple to manage.

Why Consider Aetna's Standalone Dental Plans

- **Strong Dental Networks** – Access to one of the nation's largest dental networks
- **Competitive Plan Design** – Options that balance affordability with robust benefit structures.
- **Enhanced Employer Appeal** – A smart addition to help employers attract and retain top talent through a more complete benefits package.

These plans are designed to make standalone dental sales simple, competitive, and rewarding—allowing brokers to focus on what matters most: growing their business and supporting their clients.

BANNER|AETNA: New Enhancements to Digital Experience

New digital enhancements are now available on Aetna HealthSM. The following enhancements allow members to easily search for mental health providers that meet their specific needs:

- Simple search terms where members can use everyday language like “I feel anxious” or “Find care for depression”
- Step-by-step guided search helps members find the right provider
- Matching capabilities to in-network providers using enhanced technology to find the right fit for member needs
- Mental health virtual providers page where members can filter by age, specialty, and location

Please reach out to your BGA Group Representative with any questions.

FROM THE GROUP DEPARTMENT

BCBSAZ: NEW! Auto Group Renewals Beginning November 1, 2025

Starting with November 1, 2025, renewal effective dates, AZ Blue will introduce automatic renewals for eligible pooled (2–99) group accounts — streamlining the renewal process for employers and their brokers.

Here's what you need to know:

1. For small and mid-sized group commercial customers who are renewing “As Is,” with no plan or open enrollment census changes, AZ Blue will automatically renew these accounts upon receipt of the group’s November 2025 premium payment.
2. Groups renewing with no plan or census changes should make premium payments before November 1, 2025, to ensure services are not disrupted.
3. **For groups who have not renewed their coverage by submitting a signed intent to renew AND have not paid their November renewal premiums, AZ Blue will place these accounts on a medical and pharmacy claims hold. The claims hold will be released upon receipt of the group’s renewal premium payment.**
4. Groups can pay their premium online or by mail.
 - Online payments can be made through the AZ Blue Employer portal located at azblue.com. All November renewing groups **MUST RE-ENROLL in AUTO PAY**.
 - Payments by mail must include the group number and "November 2025 Premium Payment" on the check.
 - Payments should be sent to:
BCBSAZ
PO Box 52143
Phoenix, AZ 85072-2143

If a group will be renewing but has plan and/or census changes, please notify your Client Services Manager by **October 20th, 2025, and ensure the group signs and returns their Intent to Renew in a timely manner.**

FROM THE GROUP DEPARTMENT

HUMANA: Life Benefits are There When You Need Them Most

Humana offers [life insurance benefits](#) to give members peace of mind, knowing their finances will be well-protected for loved ones when they need them most.

- Basic life is available for groups of 2+ with a minimum benefit amount of \$15K.
- Voluntary life coverage is available for groups with 5+ employees electing the benefit.
- Upon plan anniversary each year, employees can increase their voluntary life benefit by \$25K without EOI, even if the benefit amount exceeds the GI amount, or the employee has previously waived coverage.
- Life insurance can help ensure employees' loved ones have financial protection for a wide range of expenses such as funeral costs, estate taxes, medical expenses, funding a child's education or daycare needs, supplementing retirement funds and more.
- Humana's specially trained staff handles claims to ensure payments are made promptly.

HUMANA: Positioning Humana Group Benefits: Vision Differentiators

[Humana's vision coverage](#) provides members with comprehensive eye care benefits, including savings on low-cost eye exams and an average of 80% off retail prices with their fixed copays and allowances.

- Humana members have more than 175,000 access points nationwide, including retail options such as Walmart, Sam's Club, Target and more.
- Humana's Vision PLUS plans offer a \$0 annual eye exam and an additional \$50 materials allowance when the member receives treatment from a PLUS provider, a subset of the Humana Insight Network. Please note Vision PLUS is not available in NC, OR, RI, TX and WA.

Humana

FROM THE GROUP DEPARTMENT

UNITEDHEALTHCARE: Four Ways Level Funded Health Plans Help Manage Costs

Level funded plans are designed to offer employers predictability with the potential for upfront savings and a surplus refund.¹

Level funded plans continue to gain traction in the health care marketplace. In fact, 42% of small firms in 2024 reported having a level funded plan, compared to just 7% in 2019, according to the Kaiser Family Foundation Employer Health Benefits Survey.²

What's driving the increased adoption of these plans? As health care costs continue to rise and broader economic uncertainty persists, plan sponsors are seeking more cost-effective plan designs. Enter level funding.

Level funded plans may reduce costs by passing savings to the plan sponsor—unlike fully insured plans, where any savings remain with the insurer. With level funding, plan sponsors may earn a potential surplus refund for their health plan that can be applied to the following year's plan.¹ As a result, they may pay an average of 22% less with UnitedHealthcare Level Funded plans compared to fully insured plans.³

Understanding level funded plans

While there's been increased adoption of level funded plans, experts find that there's confusion about how they work.² This is understandable, given the complexity around how they're funded and their regulatory requirements. However, at their core, level funded plans are generally self-funded plans with three key differences (though certain plan components may vary based on the carrier):

- Stop loss insurance to help mitigate claims risk
- An opportunity for a surplus refund¹
- A third-party claims administration agreement

Level funded plans can also include monthly reports with data that plan sponsors can use to track health care usage, as well as wellness programs that may increase plan participant engagement and reduce costs.

To take a closer look at how level funded health plans help manage costs for plan sponsors, here's how they compare to self-funded and fully insured plans:

1. Level funded plans offer predictability and mitigate the risks of self-funded plans

Similar to a self-funded plan, level funding allows plan sponsors to assume the financial risk of providing health services to their workforce by directly paying for plan participant medical claims.

How do these plans mitigate risk? Plan sponsors with level funded plans pay a fixed monthly fee, which covers the maximum claims liability, administrative fees, and stop loss insurance to protect against unexpectedly high claims costs and utilization.

[Click here for footnotes and to continue reading this article](#)



FROM THE MEDICARE DEPARTMENT

HUMANA: Notice of Change

Forwarding Announcement from Humana

As we approach this year's Annual Enrollment Period, we are notifying you that Humana has made the difficult decision to not use agents to sell our Prescription Drug Plans (PDP).

This Notice is to inform you that pursuant to the terms of your contract, Section 5.7, Products and Distribution Channels of the Humana Producer Contract (if applicable), or Section 1.1, Products, of the Marketing and Distribution Agreement (if applicable), effective November 9, 2025, all Humana Prescription Drug Plans will be removed from enrollment tools, with the exception of Humana.com and Medicare.gov for beneficiary self-service. Please note that there is no impact on existing PDP renewals or Humana plan-to-plan changes.

We are confident in your ability to deliver exceptional results with the sale of Humana's Medicare Advantage Plans, Medicare Advantage Prescription Drug Plans, and Medicare Supplement Plans. We are grateful for your continued commitment to excellence and look forward to shared success this AEP.

Sincerely,

Doug Teff
Vice President



Humana

CARRIER BONUSES, COMMISSIONS & INCENTIVES

OSCAR: 2026 New Member Bonus Program

Earn more with Oscar! Your clients enjoy quality care and an industry leading member experience, while you get rewarded for making it happen.

Appointed agents can earn a one-time, per member bonus for eligible new members who are enrolled between November 1st and November 30th. Together, let's get your clients enrolled with a carrier designed for the ACA market.

2026 New Member Bonus		
State Tier	Payment Per Member	Number of New Members
Alabama, Arizona, Iowa, Illinois, Michigan, Missouri, Mississippi, Nebraska, New Jersey, Ohio, Oklahoma, Tennessee, Virginia	\$50 per new Member	25-49 New Members
	\$100 per New Member	50+ New Members
Florida, North Carolina, Texas	\$50 per new Member	50-99 New Members
	\$100 per New Member	100+ New Members



Scan the QR code to refer to the 2026 Oscar Health New Member Bonus Program Rules for specific bonus payout details and full program rules.

oscar

BGA HOLIDAY CLOSURE

Both BGA offices will be closed for the Thanksgiving Holiday
Thursday, November 27th and Friday, November 28th.



BLACK, GOULD & ASSOCIATES, INC.

PHOENIX OFFICE:

3800 N. CENTRAL AVE. , 9TH FLR
PHOENIX, AZ 85012
(602) 277-2144 ~ (800) 407-0376

TUCSON OFFICE:

4516 E. CAMP LOWELL DR.
TUCSON, AZ 85712
(520) 290-8822

WWW.BLACKGOULD.COM

VERIFY YOUR BROKER INFORMATION WITH BGA

Please verify your “broker information” shown in AGB on our website www.blackgould.com. Please include your name, taxpayer identification number, and address.

Specifically, your individual or business name must match your taxpayer identification number. Please do this at your earliest convenience. This is required for proper IRS reporting, so it is essential this is confirmed **AS SOON AS POSSIBLE**. The IRS changed the reporting of commissions from 1099MISC to the Form 1099-NEC starting for the 2020 reporting tax year.

Important Note—You cannot change the information directly but must submit a signed Form W-9 and BGA’s Update Broker Information form to our Commission Department by email at commissions@blackgould.com, or by telephone at the commission hotline at 602-776-1310.