

Plan Underwriting/Installation

Initial Concept

In General

The self-funding process is basically a modification of how the employer pays for the plan costs and, as with any plan, the benefits, expenses, administration, and reserves must be considered.

The usual advantages to self-funding are these:

- Avoiding premium taxes and risk charges
- Avoiding onerous state-mandated benefits
- Cash flow advantages
- Greater control of design and administration
- Funding with tax advantageous trusts
- More efficient use of cost containment programs.

Decisions by Employer

Employers down to 50 in size are viable self-funding candidates so long as other factors are considered:

- Business objectives
- Cash flow condition
- Ability and willingness help manage the plan
- Degree to which cost containment provisions are to be adopted
- Risk management consideration.

Risk Management Considerations. There are numerous risk management considerations: Design, administration, financing and claims/cost containment control. Specifically, the employer should contemplate such factors as these:

- Employees to be covered.
- Excluded benefits
- Preexisting conditions
- Benefit caps

- Medical necessity
- Basic benefits
- Cost containment and wellness (managed care, e.g.)
- Administration (claims, lives covered, multiple locations, participant turnover, risk spreading, e.g.)
- Financing (trust, MEWAs, stop-loss, captives, e.g.).

Plan Administration. These administrators may be used:

- Employer (i.e., self-administered)
- TPA (i.e., third party)
- ASO (i.e., insurer-administered, HMO-administered or Blue Cross-administered).

Communicating. As with any enterprise, communicating is important. The self-funded plan will be communicated by:

- Legal requirements (booklet, document, etc.)
- Other (handbook, video, handout, etc.).

Consultants and Administration Firms. Consultants and administrative firms (TPAs) offer a broad range of services to self-funded plans:

- Plan design and review
- Risk management
- Cost containment (precertification, billings, audits, etc.)
- Underwriting
- ERISA compliance
- Funding and accounting
- Dispute resolution
- Managed care COBRA compliance
- COBRA compliance
- Communication
- Claims processing
- Cafeteria plan administration.

Proposal Request

Introduction

The Proposal Request is discussed under three readings:

- The Parties Involved.
- Research and Background
- Sample Proposal Request Outline.

Parties Involved

The proposal request is a package which the consultant sends to the administrative firm for a feasibility study (or proposal). This is the beginning step of the self-funding marketing process. The authority for the consultant to submit such proposal request is provided by the employer. Employer is used in the narrow sense; plan sponsor is used in the broader sense.

Administrative Firm

There are typically two types of administrators which will be requested to quote on a self-funded plan:

- TPA
There are many advantages to having the self-funded with a TPA: flexibility, closeness to community and employer, ability to shop the stop-loss independently, having claims usually reviewed by *arbitrary and capricious* and not the more onerous *de novo* standards.
- Insurer – ASO Arrangement
There are advantages to having the self-funded with an insurer: name, stability, instant money, depth of management and skills, supportive services and/or products. Insurer includes Blue Cross and HMO plans.

Format of Requested Proposal

There are generally two types of proposals which are furnished by administrators:

- Elaborate
These take the form of feasibility studies and may be very involved and lengthy.
- Traditional
These take the form of group medical proposals and are briefer and more to the point showing benefits, costs and a brief capsule of administration and services.

For practical purposes, a proposal and feasibility study are synonymous.

Research and Background Information

In General

The consultant has either the obligation or the opportunity of doing a considerable amount of preparation before the proposal request is sent to the prospective administrators. It is not expected, nor will it be found (except rarely), that the broad scope of background information will be developed. Nevertheless, the outline of possible background data is offered, if nothing else, than to remind the reader of all of the

possibilities. It is expected that the stop-loss carrier will be provided only a portion of the background information. Note: the stop-loss carrier should be given what they need to obtain the best terms quote and nothing more. The administrator firm, however, will find a large portion of the background information useful in providing the best terms self-funded proposal.

The background information may be done under a number of profile headings which would indicate the characteristics of each topic:

- Employer
- Plan
- Participants
- Administration
- Historical
- Financials (previous year's claims, e.g.)
- Support Sources
- Risk Management
- Stop-loss
- Cost Containment and Managed Care.

The depth by which the analysis is done by the consultant will vary widely.

- In a very large plan, a highly skilled and aggressive consultant with a separate consultant's agreement might spend many days doing the research on their topics.
- A consultant with a small plan and no separate consultant agreement might send only the booklet, the previous year's claims, the census and the shockers and do little more.

Employer Considerations

- Name
- Address
- Phone Number
- Employer EIN
- Structure (corporation, Subchapter S, partnership, e.g.)
- Affiliates/Subsidiaries and Locations
- Fiscal Year End
- Financial/Cash Flow Stability
- Nature of Business (SIC Code)
- Employer Contacts (plan coordinator, e.g.)
- Union Involvement.

Plan Considerations

- Legal Name of Plan

- Existing Plan Benefits (booklet, e.g.)
- Proposed Plan Benefits
- Plan Year
- Plan Number (Department of Labor Purposes)
- Ancillary Benefits (LTD, STD, conversion, life insurance, e.g.)
- Recent Form 5500 Filings (also recent trust filings).

Participant Considerations

- Traditional Census
- COBRA Profile
- Retirees
- Part-time or Temporary
- Late Entrant Practices (or open enrollment, e.g.)
- Original Effective Date (optional)
- Independent Contractors Specially Designated
- Key Persons Specially Designated (optional)
- Indicate Class if Appropriate (hourly, e.g.)
- Special Case Participants (owners, e.g.).

Administrator Considerations (See Due Diligence Section)

- Experience
- Access to Quality Stop-Loss
- Ancillary services (COBRA, cafeteria plans)
- Quality of Management and Staffing
- Reputation and References
- Reporting Capabilities.

Proposal Request Outline

A transmittal letter, in brief would cover these three major areas:

1. Support Information

a. Minimum

- Booklet
- Request Plan Changes
- Financials (last two years experience)
- Shockers
- Census (last two years by month ideally)

- b. Maximum
The minimum plus any/all of the background information developed by the consultant.
2. Comments on Proposal
The following are illustrative of the type, scope and format of such comments:
- Quote Should Be Based Upon
- Current level of coverage with proposed changes
 - Direct claim filing
 - Separation of the claims administration costs from carrier list premium/enrollment maintenance costs
 - An enrollment of X number of employees with single coverage, Y number of employees with parent/children coverage, W number of employees with husband/wife coverage and Z number of employees with family coverage.

Qualifying the Stop-Loss Carrier

While applicants are accustomed to completing questionnaires for stop-loss carriers, the reverse is not so often the case. However, should the applicant wish to know the practices of a stop-loss carrier, or its underwriter and the terms of the stop-loss agreement, the questionnaire shown in the Due Diligence Section may be useful.

Underwriting Process

Overview

As used herein, the underwriting process encompasses the plan en toto; both the employer's and the stop-loss carrier's interests must be considered. This presents an interesting dilemma because the plan's benefit costs are divided so that the smaller claims fall on the employer, but the larger claims fall on the carrier.

With this division in mind, the employer may well view underwriting factors differently:

- Trending. The trend factor may be x % for smaller claims (employer) and y % for larger claims (carrier) because of the high tech nature of many large claims.
- Sex and Age. The spread by sex and age may be quite pronounced for smaller claims, but nearly the same for larger claims.

The logic of underwriting a plan from both the employer's and the carrier's

point of view is dealt with in one discussion. The reason is that while the factors are to be measured differently, such factors do affect the financial of the plan in total.

There are six factors which must be considered:

1. Plan benefits
2. Demographics
3. Industry
4. Trending
5. Claims history
6. Administrative.

Plan Benefits

The richer the plan is in benefits, the more costly it will be. The term plan benefits is broad in its meaning, encompassing benefits, exclusions, cost containment provisions, funding methods, etc., use of an HMO, PPO, EPO, etc. would also be deemed to be a plan benefit.

Demographics

The primary factors are age (older people are most costly); sex (women are more costly); dependents (if all family units have 9 or more children it could be costly); geography (all persons living in Orange County, Calif., would be costly); retired or COBRA (retired lives or COBRAs are more expensive than regular participants); independent contractors (a plan with a heavy concentration of long-haul truck drivers, e.g. presents claims, legal and administrative problems); mix of smokers (non-smokers have better claims experience, e.g.).

The demographics needed by the underwriters to analyze the claims experience are participants by month split between individuals and families. These numbers are often made part of the monthly claims experience report.

Where the group has divisions, with participants in different geographical locations, such breakdown is helpful, if not absolutely necessary.

Industry

Some groups have inherently poor experience, either because of employer instability (entertainment groups, e.g.); participant instability (hotel management groups, e.g.); occupational hazards, even though the coverage are non-occupational (asbestos removers, e.g.); inherent financial bias (physician-owned hospitals, e.g.); size of groups (a large group is generally preferred over a small group, e.g.); financial instability (an employer experiencing poor cash flow, e.g. is a poor candidate especially for self-funding); employer's track record (an older employer in terms of years in business is better than a new employer, e.g.); employer loyalty (an employer which has had six carriers in past six years is not a good risk, e.g.); ERISA status (for

self-funding, a non-ERISA plan such as a government or a church plan is not as preferred as an ERISA plan, e.g.).

Trending

The particular geographic, benefit and managed care variables will affect the trending percentages which the underwriter will use.

Claims Experience

The historical claims experience is of significance to the underwriter. While one year's experience will be accepted by the underwriter, two years is preferred. The applicant should always be mindful that if the applicant submits only one year's experience, a competitor applicant may come in also with two year's experience and be given a better quote. Note: many underwriters do not limit their quotes to one quote-one per employer. As pointed out in the previous section on demographics, it is needful to have the claims experience matched with the enrollment on a month-to-month basis. Because of its impact on experience, a profile of shockers is essential; a shocker is usually one which exceeded 50% of the specific or \$10,000 if less. A separate supportive page showing the shockers should be attached. Note: for convenience and consistency, the Disclosure Statement is the best way to display shockers. The Disclosure Statement will serve the applicant's best interest on the majority; reason: with a good Disclosure Statement, the underwriter will give better numbers where they are deserved; where not disclosed, much mischief will eventually emerge anyway, so it is prudent to do an early and complete disclosure.

When the underwriter reviews the claims experience, the level of claims, enrollment fluctuations, benefit levels, effect of shockers, etc., are all factored in and the claims projected for the next plan year. This logic applies to claims below the specific (reflected in the aggregate funding factors) and the claims above the specific (reflected in the specific premiums).

Other factors which the underwriter is called upon to estimate from the submitted statistics are these:

- Run-in if aggregate is paid. Usually there is a dollar cap on the run-in.
- Additional to specific if such is paid or if it is a 12/15, e.g.
- Alternate quotes (different specific amounts, or different plan benefits, e.g.).

Some debate may be had on shockers as to whether or not they are needed for the same period as the claims experience. For example: claims for last two years, but shocker for last year. The best position is to give shockers the same period as claims experience; otherwise, the underwriter will possibly misinterpret the claims experience.

Administrative

All manner of administrative choices abound which, if handled aggressively or non-aggressively, will alter the plan's financial outcome.

Examples:

- Recordkeeping (late applicant underwriting, open enrollments)
- Extent of claims investigations
- Extent of participant contributions (a 100% of employee-pay-all plan would be a poorer group than a 100% employer-pay-all plan). How costs are shared is significant to underwriter.
- Funding (MEWAs, employee leasing, groups without a legitimate employee-employer relationship, e.g., are often on the excess loss carrier's *do not accept* list.

Special Problems

These are a few of the special problems which arise in underwriting the plan:

- Dual Choice
Participant can elect an HMO or an indemnity plan.
- Cafeteria Plan
Participant can elect a health care plan or cash or a high or a low benefit plan.
- COBRA
Some underwriters want the reason for COBRA as well as the months to run.

Underwriting Made Simple

What is the irreducible minimum needed in order to obtain a stop-loss quote (both specific and aggregate)?

- Booklet
- Recent billing indicating dates of birth or ages
- Most recent available claims experience (ten months, e.g.)

Note: a low quality quote will be provided. What the underwriter will lack and eventually need in order to make its proposal 100% firm are these items:

- Details on shockers and disabled (i.e., disclosure statement)
- Prior plan's renewal rates (prior rates if a renewal was not offered)
- Balance of the plan year's claims (i.e., full twelve months) or even the prior plan year
- Indication of any benefit changes.

Underwriter Discounts

There are many reasons why the underwriter will discount the rates:

- Good utilization review
- Limit on preemies
- Cost containment provisions
- Benefit *fish hooks*
- Strong employer contribution
- Organ transplant limits.

Disclosure Statement

The Disclosure Statement is a very significant document in that it sets the stage for the risk assumption by a new stop-loss carrier. The reader should note that it is *not* applicable where the plan is renewed because the present carrier already is in possession of most of the information through the 50% Notices and the Shock Loss Notices.

The Disclosure Statement should be completed scrupulously, providing all of the information requested, but not a bit more. The disclosure is usually *not* a risk or underwriting appraisal where the judgment of the employer/TPA is needed. It is merely a statement of *name, rank and serial number* and must be accepted as such. The employer/TPA should be careful to determine the extent, if any; which the stop-loss carrier requests information of a *subjective* nature.

Due Diligence Matters

In the sub-site entitled Other Plan Matters, the reader will find two Due Diligence Questionnaires:

One: TPA is the subject.

Two: Stop-loss carrier is the subject.