General Underwriting FAQ

What types of group's are eligible for coverage?
Eligible groups are corporations, partnerships, and sole proprietorships where there is a clear employee - employer relationship.

What kinds of groups are considered ineligible?
Ineligible groups include but are not limited to entities that band together for the purpose of obtaining insurance such as multiple employer trusts (MET's), multiple employer welfare associations (MEWA 's), associations, religious organizations, Taft-Hartley Trusts, and employee leasing firms. In addition, the following is our **ineligible industry list**:

Asbestos Manufacturing	YES	3292
Associations	YES	8611, 8640, 8641
Casinos	w/approval	
Co Ops	w/approval	7000-7199
Employee Leasing	YES	8600-8699
Explosives (MFG and Handling)	YES	2892
Hospitals	conditional	8060-8069
Long Haul Trucking	conditional*	4200-4214
MET	YES	
MEWA	YES	
Mining	YES	1000-1499
Non-Taft Hartley Health and Welfare	YES	
Nursing Homes	w/approval	8050-8059
Oil and Gas Exploration	YES	1300-1389
PEO (Profesional Employee Organization)	YES	8600-8699
Petroleum and Coal Refining	YES	1300-1389,2900-2999
Short Haul Trucking	w/approval	4200-4214
Towing and Tugboat Service situs in Louisiana	YES	4492

Long Haul Trucking Conditions: No PT or independent drivers; must have greater of 100 ee's or 75% participation; Min deductible allowed is $75,000;
We have an understanding with Cottingham and Butler: they will only send us trucking firms where the drivers are employees of the company (no independent drivers).

Are any industries subject to special requirements?
Hospitals are subject to a minimum $75,000 specific deductible. In addition, the lesser of the current domestic reimbursement percentage cannot exceed 80% of claims incurred at the plan sponsor's / employer's facilities or with the employee providers thereof are eligible to accumulate toward or for reimbursement under the aggregate and / or specific excess loss contracts.

Will MRM offer a proposal to a group that has a history of frequent carrier changes?
Groups should have a stable history of carrier and TPA relationships. Cases with more than 3 stop loss vendors in the most recent 3 plan years may be declined unless there are clear reasons for the changes (i.e. carrier no longer in the market).

Are there any limitations on COBRA participants or retirees?
COBRA participants and Non-Medicare primary retirees may comprise no more than 10% of the group.

Can the aggregate margin be specified in the request for proposal?
Aggregate margin (corridor) is the underwriter's determination and is subject to minimums defined by agreement with our carrier. It is not open for modification or request.

When does MRM require claims experience?
MRM requires claims experience when any of the following conditions exist:

- ❖ The group must include 100 or more employee lives
- ❖ The group is currently self funded
- ❖ Experience is available

What types of claims and enrollment data is required
The information that is needed is:

- ❖ Monthly paid claims, corresponding enrollment figures and time periods (preferably by line of coverage)
- ❖ Detailed shock loss data (claims greater than 50% of current or lowest proposed specific deductible) including individual paid claims (from first dollar) and diagnosis information by plan period
- ❖ If claims are not provided by line of coverage, a explanation of benefits included in the experience is necessary
- ❖ Details of changes to benefits, provider networks, specific deductible / contract type, aggregate contract type or any other change that would have impacted the payment of claims.

How much experience is needed?

❖ In order to quote, it is recommended that there be at least 21 months of experience (12 months of the prior year and 7 months of the current) (If more years of experience is available, we can typically use up to 4 years or 48 months). Should this not be available at the time of proposal, it will be at the underwriter s'discretion as to whether a proposal will be offered. If there is a special situation, call an underwriter prior to submission.

❖ No coverage can be bound on a case that requires experience without at least 22 months of data (12 months of the prior year and 10 months of the current). (If a further extension is needed, request must come from the Underwriter, 90 days & 120 day locks).

Will MRM use HMO claims experience?

- ❖ We are unable to offer a proposal based on HMO data or experience that includes significant amounts of capitation.

What about groups that have less than 100 lives and do not have claims experience?

- ❖ Unfortunately manually rated quotes are no longer available. Contact one of our staff for more information.

When a proposal requests additional medical information on an individual, what is needed in order to satisfy the contingency?

- ❖ You should submit updated case management or pre-certification notes, medical records, individual paid claims reports with diagnosis and procedure codes or other records that might be pertinent. We will let you know in writing if they are insufficient with which to make a determination.

Are higher individual specific deductibles (lasers) mandated on new or incumbent business?
Specific excess loss premium is for risk that is truly unknown. That being said, we never mandate that a group take a higher specific deductible on a particular individual for new business or incumbent groups, but we do offer it first because we believe it to the most prudent option for the employer in most cases.

When a situation comes to light that presents a high probability of a relatively significant claims event, underwriting action is necessary. The premium must be altered or other action taken to account for the heightened risk. Accounting for such a situation under the premium requires that the expected claims for the condition be included in fixed costs. When this course of action is selected, the ultimate premium increase is for the amount of the predicted treatment plus the additional premium tax and expense loads that are part of every dollar of premium.

Often, the best course of action for the plan sponsor is to place a higher specific deductible on the particular individual to account for the expected treatment. In this manner, the employer only assumes the risk of the actual predicted dollars, not the additional expense loads and premium taxes. Whether or not the anticipated event occurs, the employer is in a much better position than they would have been if the additional premium route was chosen.

Are aggregating specific deductibles (corridors) available?
MRM does offer aggregating specific deductibles (ASD's). There are two types of ASD's:

- **Pricing** - premium is traded for the plan sponsor's assumption of additional risk in excess of the group's specific deductible. These are an excellent opportunity for the plan sponsor to save on fixed

Does MRM have a minimum participation requirement?
We will offer quotes for groups that can demonstrate 75% net participation or greater. Net participation is defined by the following formula:

Enrolling Employees

(Total Eligible Employees – Eligible Employees waiving due to other coverage)

How does MRM require that eligible employees be defined within the plan document?
Eligible employees should be defined as those individuals who minimally work 30 hours per week (on average) within the scope of the employer's business. Consultants, contractors, employees for whom income is reported on a 1099 form and other non-traditional employees should be excluded from the plan.

Can groups with a rich plan of benefits be quoted?
Plans with extremely rich benefits can be quoted as long as there is sufficient credible claims experience due to potentially volatile utilization patterns. Groups without satisfactory experience may be quoted as long as there is a minimum $500 individual out of pocket maximum (deductible and coinsurance).

What does MRM require to be in the plan document?
Plan documents must clearly state the coverage granted to the participants. Eligibility, termination provisions, exclusions, limitations and restrictive covenants such as pre-certification and non- network utilization penalties should also be specified. In addition, the plan document is expected to exclude coverage for the treatment of infertility (with the exception of surgical correction of anatomic structures, i.e. blocked fallopian tube), coverage for medical treatment, surgical treatment and drugs that are experimental, investigational or not approved by the FDA for the particular condition, coverage for injuries and conditions that are a result of wars and acts of war (declared or undeclared), coverage for occupational injuries, coverage for injury or condition arising from the commission of a felony, coverage for claims for which an individual has no obligation to pay, coverage for cosmetic surgery or eye surgery for a condition that can be corrected with contacts or eye glasses and coverage for claims incurred more than 12 months prior to the date that it is presented for payment. The preceding list is not all inclusive. MRM must review and approve the plan document prior to stop loss coverage being bound.

IMPORTANT: The above are meant to be a brief overview of MRM underwriting guidelines and is by no means all inclusive. Contact one of our underwriting staff with any questions.