

# **The Role of the TPA in Self-funding**

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## **Overview**

This article is meant to explain in clear terms the various types of work that a third party administrator (TPA) performs. A TPA is generally defined as a company that administers self-funded employee benefit plans (such as health, welfare, workers' compensation, and retirement plans) on behalf of an employer or plan sponsor. This article will focus on defining the work spectrum of TPAs that administer health and workers' compensation plans.

The term Third Party Administrator is broad, and is defined differently by various sectors of the employee benefits industry. For the purposes of this article we will define a TPA as a state-licensed organization that adjudicates claims and provides administrative services on behalf of another organization's self-funded benefit plan. A TPA may administer a variety of health and workers' compensation benefits including: medical, dental, vision, life, Rx, disability, voluntary benefits, consumer-directed health plans, and flexible spending plans. TPAs can also assist their clients with designing and implementing benefit plans, managing plans, and with billing/collecting of funds (or premiums) for distribution to the vendors involved.

TPAs work on behalf of employers or plan sponsors as administrators and facilitators to outside vendors such as managing general underwriters, direct stop-loss writers, PPO networks, EPO networks, POS providers, utilization review companies, pharmacy benefit managers, specialty pharmacies, home healthcare agencies, re-insurers, case managers, dental providers, life insurance companies, long- and short-term disability providers, nurse lines, customer service centers, specialty sub-acute care hospital networks, and other ancillary providers.

TPAs may be independently owned and operated or can be owned by an insurance company, multi-employer group, or association.

While many TPAs fit into this broad definition, there are no standard practices or procedures that TPAs follow in regards to administration, work flow, or client servicing. Each TPA works to the demands of its particular clients. Additionally, each TPA tends to define industry terms and even the role of a TPA differently. Fred Hunt, President of the Society of Professional Benefit Administrators (SPBA) has often said, “When you’ve seen one TPA, you’ve seen one TPA.” Factors of intense corporate “individualism” across the TPA arena have caused confusion and misunderstanding regarding TPAs, the nature of their work, and the terms used to describe their work. This article defines the work that TPAs perform and is written for employers, benefit professionals, and those in the employee benefits arena.

## **Size and Scope of the TPA Market Place**

The Employees Benefit Research Institute (EBRI) issued a report in the year 2000, indicating that approximately 50 million workers and their dependents receive benefits through employer-sponsored, self-insured plans. According to the Self-Insurance Institute of America, Inc., (SIIA), this represents about 33% of the 150 million total participants in private employment-based plans nationwide.

## **Self-funded Benefits**

TPAs administer self-funded benefits for employers. This section will discuss and define self-funded benefits. Employers that elect to offer benefits to employees have two options for paying, or funding, those benefits. The two funding arrangements are:

- 1) **Self-funded benefits:** In this arrangement the employer (assisted by a consultant, agent, broker, or TPA) creates, defines and establishes a benefit plan (schedule of benefits) for its employees. Employee payroll deductions and employer contributions that would normally be used to pay an insurance policy premium are placed in a special fund for the sole purpose of paying employees’ medical bills and fees as they are incurred. In this arrangement the employer assumes the financial risk, as it must pay the medical bills of its employees that fall within the scope of the plan. The employer must calculate and create reserves to support the benefit plan. (Technically speaking, “self-funded” is a term that describes an employer that is responsible for 100% of the medical bills of its employees.)
- 2) **Partially Self-funded benefits:** In this arrangement the employer self-funds, but purchases aggregate stop-loss coverage or specific stop-loss coverage to protect against cases of catastrophic employee injury or illness which might create medical bills that are in excess of the funding that the company has on hand, and aggregate stop-loss to maximize the total exposure of the health plan. Additionally an employer may choose to self-fund or partially self-fund dental and prescription drug benefits while opting to provide fully insured coverage for life, AD&D, and other ancillary benefits.

Self-funding differs from fully-insured benefits (insurance policies) in many ways. Fully insured policies require monthly premiums to an insurance company in exchange for a

predefined (and limited) set of services, such as healthcare. Typically the employer will deduct money from an employee's pay to cover some or all of the premium costs. In this arrangement the employer assumes no financial risk, beyond premium payments, for the healthcare or benefits provided to its employees.

Companies tend to choose a funding arrangement for their benefits based on what option will provide the most amount of coverage for the least expense. Generally companies with less than 100 employees find that fully insured benefits are the most cost-effective route, while companies with over 100 employees have an economy of scale that can make partial self-funding a more cost-effective option. And companies with thousands of covered lives tend to find that fully self-funding their health plan is the most cost-effective option.

## **How Is a Self-Funded Plan Created?**

To create a self-funded benefit plan, an employer typically meets with a broker, consultant, and/or TPA to discuss the needs of the company and to help the employer decide if self-funding is appropriate. If the financial circumstances are such that the employer would benefit by being self-funded, then the employer can work with an agent, broker, or TPA to custom build a benefit package. The companies involved in setting up a self-funded plan are as follows:

**Agent and Brokers:** Agents are licensed by the states they work in and they “write” or sell fully insured insurance products (such as stop-loss insurance or ancillary benefits) which are underwritten by insurance carriers. The terms “agent” and “broker” are frequently used interchangeably, and will be for the purposes of this report, too.

**Broker of Record:** A person who is chosen by the employer group to exclusively represent them in the benefits marketplace. Typically, brokers represent more than one employer. All necessary employee demographic and medical information and data is gathered for underwriting purposes. The party who writes the final policy is responsible for explaining all the terms of the policy to the employer. The broker of record is the person recognized by the TPA and the insurance company and is the conduit to the employer.

**Consultants:** Individuals from a variety of firms (TPAs, brokers, law firms, accounting firms, benefits consulting firms, etc.) who may be involved in guiding the employer in setting up a self-funded program.

**Carriers:** Insurance companies that are regulated by the states in which they do business. A carrier employs actuarial and underwriting practices to evaluate and assume risk for insurance policy coverage.

**Wholesaler:** Someone who works as a distribution channel for insurance products, policies and services. Most wholesalers specialize in a particular type or line of insurance. A wholesaler creates networks of agents, brokers and carriers. These companies produce quotes for the wholesaler's healthcare coverage and provide education and

assurance relative to the rates and services. Some wholesalers are so diversified that they offer underwriting and managing services as well as risk management and consulting.

**Third Party Administrator:** Some TPAs have elected to work directly with an employer to set up a self-funded plan, while other TPAs work through agents, brokers and consultants on the setup of the self-funded plans. In both instances, the TPA administers the health plan that has been created.

The first step for an employer that is considering self-funding is to consult with a TPA representative or an employee benefits consultant/broker. TPAs and consultants use defined parameters to determine whether or not self-funding is a suitable option for a given employer. See Appendix 2 for the information an employer would need to present to a consultant, broker or TPA when looking to establish a self-funded plan.

## **Why Choose to Self-Fund?**

An employer may choose to self-fund its benefit plan for several reasons:

- 1) By being self-funded, the employer can create “custom-made” benefits to suit the needs of its work force as opposed to accepting a “cookie cutter” bundled insurance policy, which does not allow for flexibility in benefits.
- 2) The employer, not an insurance company, has the financial benefit of the interest income generated from the funds allocated for health care.
- 3) Cash flow for the employer increases due to the elimination of costly premiums that are paid in advance of both provider services and inflation. Money held in reserve for healthcare benefits can be placed in a tax-free trust that is controlled by the employer.
- 4) Employers who self-insure are not subject to the health premium taxes normally paid on the state level. These taxes can be as high as 3% of the total premium dollar value.
- 5) Administrative fees are usually lower than the administrative fees that are hidden or built into fully insured benefits. Part of the plan expense in fully-insured benefits are costs related to utilization review, insurance marketing, medical underwriting, agents’ commissions, premium collection, claims processing, insurer profit, quality assurance programs, risk management, and premium tax.
- 6) Employers who self-fund get reports that detail exactly how all of their healthcare expenses were allocated. These reports help the employer learn how to save money on health costs. Fully insured employers have no idea how the insurance company spends the money they pay in premiums.

Typically an employer chooses to self-fund its benefits so that it can save money, and customize healthcare offerings to its employees' needs. In a well-managed self-funded plan the total potential claims cost, including TPA fees and reinsurance premiums, should be lower than an equivalent fully insured premium. Estimated savings run from 15 to 25% in the first year of self-funding.

## **Potential Risks of Self-Funding to the Employer**

Employers that self-fund have both financial and legal risks. While self-funded plans are not subject to state mandates, the employer has the legal responsibility to ensure that their health plan benefits and policy are in line with one another and comply with federal Employee Retirement Income Security Act (ERISA) regulations. Financial risks center around the ebb and flow of cash flow, as costs associated with the plan may not be evenly distributed throughout the plan year.

Employers can mitigate their legal and financial risk in several ways.

- 1) The plan documents should carefully and clearly define the specific coverage and limitations of the plan. Plan documents should note services that are not covered as well as services that are covered. It is extremely important to ensure that the policy pays consistently with the health plan.
- 2) Stop-loss coverage can aid the employer in the event of unexpected claims whether it applies to a single claim (specific stop-loss claim) or the employee group as a whole (aggregate stop-loss). The assessment of past claims and current medical underwriting is vital to determining the fiduciary responsibility of the employer and deciding whether stop-loss is appropriate and if so, at what limits (see more about stop-loss coverage below)
- 3) Programs such as utilization review and case management monitor the expense, efficacy, and cost of healthcare, with the ultimate goal of reducing those costs.

## **Stop-Loss Insurance**

Large companies or employers who fully self-insure usually have the financial resources and reserves to cover just about any amount of healthcare costs. However, many average-size employers purchase stop-loss coverage to prevent depletion of their reserved funds. There are two types of stop-loss coverage:

**Specific:** limits the dollar amount on one specific case or claim, and

**Aggregate:** limits the overall dollar amount on the entire population.

Employers have a responsibility to fund the specific deductible for stop-loss coverage and typically are not responsible for payment after the limit is met. The contract (policy) for coverage is between the employer and the stop-loss carrier.

Stop-loss premiums are calculated based on the size of the employer, benefit plan, financial status, risk tolerance, employee demographics, and members' health status.

Many consultants, brokers, or TPAs will secure stop-loss insurance from an MGU (Managing General Underwriter) or a direct carrier writer. While a direct writer assumes most, if not all, of the risk, an MGU most often takes no risk. An MGU may partner with several stop-loss providers. Those carriers give the MGU guidelines for pricing and marketing the insurance. MGUs work for both insurers and self-funded employers. For insurers, the MGU prescreens the employer's risks before submitting policies to the stop-loss carriers they work with. For employers, the MGU gives guidance as to which carrier and what type of coverage would be acceptable for a given group.

Both a direct writer and a MGU are insurance-licensed entities. The policies they sell are directly to employer groups, but they work with licensed agents/brokers and/or TPAs who sell the stop-loss insurance to employer groups. Both require their licensed agent to provide proof of licensure and proof of good standing with the insurance commissioner for the state in which they are doing business before issuing stop-loss coverage quotes to them. Each state has different insurance-testing guidelines and requirements. Agents must have either a residence or a non-residence license giving them the ability to do business legally in the respective state.

## **Plans Available to Self-Funded Employers**

Self-funded employers have the option to choose HMO, PPO, EPO, POS, and indemnity plans, all with managed care and cost containment programs. PPO plans are the dominant plans in the self-funded arena. To the employees of a self-funded group these plans often "feel and function" like a fully insured or traditional health plan which offers doctor or hospital access on a regional or nationwide basis.

Note: A common misconception is that TPAs are healthcare providers, or that they are a network of providers, or that they manage providers. A TPA is not a healthcare provider. TPAs pay the claims that arise from an employee's visit to a health provider. The money to adjudicate the claim comes from the employer's bank account—a special trust account that is setup and monitored by the plan trustees. TPAs also manage and bill for other fees (such as stop-loss premiums) associated with the benefit plan. TPAs also help negotiate pricing, terms, and benefits with managed care vendors. In a self-funded health plan, TPAs set up the arrangements and mechanisms for the employees to receive healthcare benefits.

## **HMO, PPO, EPO, POS, and Indemnity Plans**

Following is a description of the most common health plan types:

An **HMO** (Health Maintenance Organization) offers prepaid, comprehensive health coverage to members for both hospital and physician services. An HMO contracts with a

full range of healthcare providers (e.g., physicians, hospitals, and other health professionals), and members are required to use the HMO participating providers for all health services. Health care services outside of the network are not reimbursable except for true emergency care. There are several different HMO models, including staff, group practice, network, and IPA.

HMO members are pre-enrolled and make payments on a per-member-per-month (PMPM) basis. These payments cover specific services and are defined by the provider's specialty. The payments, called "capitation," put the provider (the doctor or hospital) "at risk," meaning that the provider can collect only a certain amount of money per-member-per-month no matter: A) how much or little treatment the insured person received (read: no matter how big or little the bills were that they incurred), or B) how many members utilized the provider's service in a given month. Members choose a Primary Care Physician, (PCP), who assumes the role of gatekeeper to ensure that medical care is rendered when necessary and in the most effective manner. Additional diagnostics or referrals to a specialist are also directed by the PCP, and these additional services are performed by another doctor within the HMO.

Recently HMOs have changed their business practices. They have sought to reduce their risk by creating a "fee for service" schedule in which PCP or specialist referrals may not be mandated, but the care given may require added costs above and beyond the member's monthly payment. HMO networks (also known as "panels") contain fewer doctors and hospitals than PPO networks. HMOs offer the full scope of medical services under their plans; can be local, statewide, regional, or nationwide; and may serve commercial members, self-funded employers, city/county/state governments, and Medicare and Medicaid recipients.

A **PPO** (Preferred Provider Organization) is a three-way arrangement between an intermediary (PPO Network), purchasers of care (e.g., employers, insurance companies), and health care providers (doctors, hospital, labs, etc.). Members of the PPO network (insured or self-insured) get discounted rates on healthcare (doctors visits, hospital visits, surgeries, etc) and are given incentives (such as low deductibles and copays) to use preferred providers (hospitals and doctors within the PPO network). Members who use providers outside of the network (also known as non-preferred providers) do so at a higher cost. PPOs contract with independent providers for a lower than Usual and Customary (discounted) rate for services. In exchange for the preferred status the healthcare providers gain more business, but are required to comply with PPO guidelines.

Most PPOs do not assume risk for the services and contract a common fee schedule with the providers. PPOs charge self-funded employers using their network a per-employee-per-month (PEPM) fee or per-member-per-month (PMPM) access fee. There are a few PPOs that prefer to charge a percentage of savings. For instance, if the billed charges are \$80 for a physician office visit and the contracted rate is \$50, the PPO will bill the payor 30% of savings or \$9.00. Provider networks, or panels, contain more healthcare providers (doctors and hospitals) than HMO panels. PPOs offer the full scope of medical services under their plans; can be local, statewide, regional, or nationwide; and may serve

commercial members, self-funded employers, city/county/state governments, and Medicare recipients.

An **EPO** (Exclusive Provider Organization) is a managed care organization, similar to a PPO. Providers (physicians and hospitals) are paid via a fee schedule (they do not receive capitation or per-person-per-month payment). Members must choose medical care from the network providers, and not from independent providers. As with an HMO, when a member seeks care outside of the EPO network, he/she will not be reimbursed for the cost of the service.

There are two different types of EPOs. The first is risk-bearing and closely resembles a Health Maintenance Organization (HMO), employing Primary Care Physicians (PCPs), referrals, authorizations, and possibly capitation, while the provider panel is somewhat limited. Many states have provisions preventing these types of arrangements and they are classified by such states as an HMO. The second type of EPO is a pared-down Preferred Provider Organization (PPO). The network is much smaller, thereby driving volume to the few participating providers, who have most likely given a deep discount on their fee schedule. EPOs offer the full scope of medical services under their plans; can be local, statewide, regional, or nationwide; and may serve commercial members, self-funded employers, city/county/state governments, and Medicare recipients.

A **POS** (Point of Service) plan is a hybrid of a Preferred Provider Organization (PPO) and a Health Maintenance Organization (HMO) plan. POS plans encourage, but do not require, members to utilize a primary care physician. As in a traditional HMO setting, the primary care physician acts as a "gatekeeper" when making referrals. When members opt to use non-network providers they pay higher deductibles and copays than those using in-network providers.

In an HMO, services rendered outside of the PCP or referred/authorized providers are not covered, while in a POS plan a portion of the services rendered by outside providers may be covered at a contracted rate (e.g., 70%).

An **Indemnity Plan** is a traditional insurance plan where a group or individual pays a premium and a specific set of services are allowed as defined in the issued policy. None of the managed care controls as noted in the other types of plans exist within an indemnity plan. The only type of control employed is to establish a Usual & Customary fee that will limit the claim payment to that amount, thereby protecting the payer from exorbitant provider billing. The member makes the choice as to where they will receive care and there is only one level of benefits/reimbursement.

## **Alternative Plans and Ancillary Networks**

Other types of plans have developed over the years. These alternatives often complement existing managed care programs or are utilized when managed care has not been able to intervene in the treatment process. These options take many forms and impact or target different areas.



**Prompt Pay Discounts:** Many facilities and occasionally physician practices offer TPAs and insurance carriers a discount for payment within a specified period as outlined in their agreement. The time frames are usually from five to twenty days. Many payers do not utilize this provision, as it does not allow for claim review against medical records to verify the accuracy of the billing.

**Out-of-Network Claim Negotiation:** When a claim is incurred outside of the contracted provider network, sometimes a TPA or case management firm will attempt to negotiate a discount or package pricing to help limit the cost. A claim review is typically performed and this is usually a successful endeavor.

**Transplant Networks/Management:** Transplant management services are specific to organ and bone marrow transplants covered by benefits programs. These highly specialized companies negotiate package rates with providers that include pre- and post-operative care in addition to the actual organ transplant. Patients are assigned to a case manager knowledgeable in organ and bone marrow transplants for support and monitoring. Protocols and clinical pathways are used as guidelines by the transplant management vendor. Periodic reporting is provided to the TPA or self-funded employer to verify billing and report patient progress. The prescription portion of the patient's care is usually not included, as the transplant center and physicians do not control the distribution of the drugs associated with transplants; however, some vendors include networks of specialty pharmacies that provide the medication pre- and post- transplant. Transplants are costly, and the entire process can take years even after a patient has been identified as a candidate. Furthermore, transplant patients will take anti-rejection drugs for the rest of their lives to maintain optimal health.

**Discount Cards:** Discount cards are frequently used in conjunction with a health plan, often for vision benefits and occasionally in place of the prescription drug program. Discount cards are not insurance, and they are not indemnified plans. Discount cards simply offer prearranged discounts at participating providers.

## **Why Use a TPA?**

Employers (or plan sponsors) who self-fund their healthcare benefits have the responsibility of paying the covered health claims of their employees regardless of what type of healthcare plan they assume. Employers (or plan sponsors) have three options for handling claims. They can:

- 1) Administer claims in house. Self-administration, as it is known, tends to be laden with problems. The employer may not be properly educated in correct methods of administering a health plan, and the employer may find it costly to invest in these areas. Additionally, employer privacy is always a concern, as some employees have access to the health information of other employees.

- 2) Subcontract claims administration to an insurance carrier under an ASO (administrative services only) arrangement.
- 3) Hire a TPA. TPAs are the preferred route for several reasons: a) TPAs are specialists at adjudicating claims and servicing employer needs; b) TPAs have specific knowledge of proper self-funded health plan administration; c) TPAs have invested money in computer systems, costly software, and employee training to create a high level of efficiency in plan management; and d) TPAs safeguard sensitive personal-health information that might otherwise be available to company personnel.

## Costs of Self-Funding

Employers have four main costs associated with maintaining a self-funded health plan. These costs are listed below.

- 1) **Claims:** The employer, not the TPA, provides the money for all claims that the TPA pays on behalf of the employer. TPAs will only adjudicate claims as covered and allowed under the ERISA document defining the health benefit plan up to the specific and/or aggregate stop-loss limits.
  - a. When switching from a fully insured plan to a self-funded plan, the employer may charge (salary deduct) the employees the same cost share they had charged when using the fully insured plan. All charges to employees go into a bank account. From this account the TPA pays claims to the doctors, hospitals and providers.
- 2) **TPA Fees:** Employers typically pay TPAs on a fee-for-service basis. Fees are typically presented as a per-member per-month format but can be structured in many different ways. Generally, TPAs' fees are substantially lower than the retention (overhead) costs assigned by a health-insurance carrier. TPA fees usually include the following services: eligibility management and dissemination, claims adjudication, maintenance of documentation, plan setup, enrollment materials, identification cards, reporting, coordination of documentation for reinsurance claims, and a scope of managed care services that may be selected by the employer. While each TPA is different, the core functions of maintaining eligibility and adjudicating claims remain constant.
- 3) **Stop-Loss Premium:** The employer, not the TPA, pays a premium to the stop-loss carrier for the specific and/or aggregate stop-loss insurance. These premiums are usually paid through the TPA as part of the monthly billing services provided. This premium is lower than a fully insured health plan premium, since the employer is bearing the majority of the risk. Premiums are based on the claim history and on an assessment of each group member's current medical condition.
- 4) **Other fees:** These fees include any PEPM fees for PPO network access, UR and case management fees, wellness products, and broker/consultant fees.

In well-run plans, the sum of the fees associated with a self-funded plan will represent a 25 percent savings for the employer over a fully insured plan.

## **Services Provided by TPAs**

The major services provided by TPAs to self-funded employers are as follows.

**Access to real-time eligibility and claims history reports:** Most TPAs allow employers to view and possibly control some eligibility functions. Claim history reports are provided monthly to all employer groups, frequently broken down into data groups to allow employers to make educated decisions about the future of their health plan.

**Accounting Support and Reconciliation:** While each employer maintains its own bank account for its health benefit plan, TPAs frequently supply backup financial reports to help with account reconciliation on a monthly basis.

**Ancillary Benefits Administration:** TPAs will frequently bill for, collect, and forward the premiums on ancillary benefits such as life insurance, AD&D, voluntary products, etc. Dental benefits are most often adjudicated as part of the health plan, but not covered under the aggregate stop-loss contract due to the predictability of their annual expense.

**Billing/Premium Billing:** A standard service of all TPAs is to provide a detailed monthly bill to each client. This bill consolidates all the premiums from all the vendors, and allows the employer to make one payment to cover all the premium payments.

**Eligibility:** Eligibility refers to the ongoing maintenance of the data: additions, terminations and changes on employee data files. TPAs collect eligibility electronically from each employer group. If the employer group does not have electronic capabilities the TPA can manually convert hard-copy data to an acceptable electronic format.

**Enrollment:** TPAs provide enrollment services both initially and in conjunction with the plan year renewal.

**Capitation Payment Management and Processing:** Calculation, management, and distribution of the monthly reimbursement methodology for PCPs within an HMO. The payment amount is based on age, sex, and plan of every member assigned to that physician for that month. Specialty capitation plans also exist but are little used.

**Case Management\*:** The process by which all health-related matters of a case are managed by an appropriately trained clinician (physician, nurse, or designated health professional). The case manager coordinates the components of health care, such as appropriate referral to specialists, hospitals, ancillary providers and services. Case management focuses on ensuring continuity, appropriate intensity, quality, and

accessibility of services to deter under- or over-utilization of healthcare resources. Patients are typically managed against established criteria or “clinical pathways” specific to their diagnosis. Case managers focus on specific diagnoses, high-cost cases, patients whose care is expected to be a certain length of time, catastrophic medical conditions, and other highly complex cases.

**Claims:** A claim is essentially the information submitted by the provider of healthcare services to a healthcare plan or claims administrator, such as a TPA or insurance carrier, for payment of services rendered. A “clean” claim fully details the patient’s demographic information, benefits information, the date of service, and coding which represents patient’s diagnosis and the type of treatment received by the employee. In addition, a clean claim is unencumbered by coordination of benefits (COB), subrogation, or other issues.

**Claims Adjudication:** Once a healthcare provider submits a claim to the TPA, the TPA adjudicates the claim by taking the following action. They review it for accuracy of information, current coverage including eligibility verification, provider status, and contracted rates. They then verify other information such as pre-certification requirements and medical records. The process of adjudication also includes clarification of information presented on the claim. Most TPAs use computer programs that check all the information needed to adjudicate the claim. If no irregularities are found, the claim is paid promptly. Note: Regardless of the process within each TPA, the end result remains that the TPA adjudicates the claim and then notifies the employer of their funding responsibility. The client then “funds” the claim by releasing payment for it.

**Claims Auditing:** A qualitative or quantitative review of services rendered or proposed by a health provider. Most audits are retrospective and may be a comparison of patient records with any of the following: claim-form information, a patient questionnaire, a review of hospital or practitioner records, a pre- or post-treatment clinical examination of a patient, or a fee verification.

**Claims Investigation:** Investigating all circumstances, events, and facts surrounding an illness or injury. Claims investigators compile detailed reports that may include reports from attorneys, physicians, insurance experts, or other qualified experts, to help resolve the claim. Fraud and medical necessity are the primary reasons for claim investigation. Typically, claim investigation is most widely used to determine liability in worker’s compensation and disability claims.

**Claims Repricing:** Repricing is done in a variety of ways, but the three most prominent are automatic at-point-of-claim adjudication, internet re-pricing, and vendor repricing. Repricing is the process of converting (applying discounts or adjusting for predetermined rates) the initial billed charges into the amount to be paid.

**Claims Runoff:** This can be in the form of run-in or run-out claims adjudication. When a TPA is taking over an employer group from another TPA, they may adjudicate the run-in claims (those incurred prior to the transfer date, but received after that date). Likewise, if

a self-funded group were to convert to a fully insured plan, the run-out claims (those incurred before the transition date) would continue to be administered by the TPA.

**Claims Subrogation:** The recovery of the cost of services and benefits provided to the insured of one health plan when other parties are liable for the claim incurred. For example, where one insurer pays damages that may also be covered by another insurer's policy, the paying insurer will obtain a subrogation right from the insured to pursue the claim against the insurer who has not yet paid.

**Concurrent Review\*:** Review of a procedure or hospital admission done by a healthcare professional (typically a nurse) other than the one providing the care. The process involves ongoing data collection, data review, and the issuance of a denial or authorization of care. The ongoing review (concurrent review) is performed against established, defined criteria specific to the service and diagnosis of the patient. Utilization review will monitor the progress of the patient to assure effective, quality care. Generally focuses on all in-patient admissions and occurs during the patient's stay.

**Coordination of Benefits (COB):** Provisions and procedures used by third-party payers to determine the amount payable by each payer when a claimant is covered under two or more health plans. COB is a uniform order of benefit determination under which plans pay claims. COB rules for determining the first payer (order of determination) and adjudication of the claim can be quite complex.

**Customer Service/Call Center:** TPAs provide customer service in the form of call centers for employees to call and receive information about their claims and how they were adjudicated. Providers can also call in to the center to receive benefit information and the status of an individual claim within the adjudication/payment process.

**Disease Management\*:** A system of coordinated health care interventions and communications for groups with chronic conditions, where patient self-care efforts are significant to the success of treating and managing the condition. Program components are patient identification, evidence-based practice guidelines, collaborative practice models, patient self-management education, outcomes measurement, medical resource access, and community information, as well as routine reporting and feedback to all involved parties. Disease management focuses on chronic diseases, which may include asthma, COPD, diabetes, heart failure, and ischemic heart disease. Disease management programs are generally conducted over the telephone by a trained nurse who provides advice, counsel, and encouragement to patients coping with chronic illnesses. Patients are encouraged to take an active role in managing their diseases.

**Flex Plan Administration:** When a TPA administers a flex plan, they are performing all functions of the flex plan, including but not limited to discrimination testing and claims. Read more about Flex plans in the next section titled *Ride-Along Benefit Products*.

**Identification Cards:** TPAs issue identification cards to plan members. On occasion the Rx vendor (PBM) will issue ID Cards.

**Issue employee materials:** The TPA provides copies of the Summary Plan Description, enrollment forms, health plan benefit grids, etc. throughout the plan year, but most frequently during the renewal.

**Member Education/Communication:** Ongoing member education is supplied by the TPA throughout the year.

**Legal expertise:** Monitoring employee benefit law for new requirements.

**Payment Structure Support:** Defining, reporting, and consolidating payments such as capitation, withholds, fee for service, per diems, and case rates.

**Pre-Admission Review\*:** Reviewing a case for medical necessity prior to the patient's admission to the hospital. The process involves data collection, data review against established guidelines, and the issuance of a denial or authorization.

**Pre-certification\*:** (also known as “pre-cert” or pre-authorization) applies to inpatient and outpatient procedures, drugs, durable medical equipment (DME), diagnostic testing, etc. Any service or item for which a health plan feels a determination of medical necessity is warranted may be subject to pre-cert. The review is performed prior to the procedure or service against established, defined criteria specific to the service and diagnosis of the patient. The pre-cert will assess for appropriateness of treatment and length of stay/duration/quantity. The process involves data collection, data review, and the issuance of a denial or authorization. Procedures and services that require pre-cert will be outlined in the ERISA documents that define the plan. Financial penalties are levied when pre-certification is not obtained in advance of the service. Generally, pre-cert focuses on elective inpatient admissions and specified outpatient services such as diagnostic testing and day surgery and may include drugs, durable medical equipment, etc.

**Recovery/Collections Management:** Typically audits uncover issues that require further research and may require recovery and/or collections management. Most often these items are related to the inaccurate eligibility of employees or their dependents. Other opportunities are: claims paid incorrectly, duplicate payments, provider offsets, Coordination of Benefits provisions, and the discovery of fraud.

**Reporting:** TPAs compile reports for their clients which include information on: pricing, utilization, trend analysis, finances, enrollment, clinical program effects, IBNR, outcomes, provider profiling, capitation analysis, modeling, network access, and member satisfaction. Employers typically want online access to recent data in standard report formats to be available electronically upon demand.

**Reporting for claim funding:** With self-funded plans, employers have “claim runs” on specified days or dates of each month. The TPA provides the necessary reporting to the employer so they can properly fund their account.

**Reporting to the stop-loss carrier:** Data and reports outlining a claim's current status as it pertains to the terms and conditions as well as limits of the stop-loss policy.

**Retrospective Review\*:** A review conducted after health care services have been provided to a patient. The review focuses on determining the appropriateness, necessity, quality, and reasonableness of healthcare services provided. These reviews generally focus on in-patient admissions where pre-certification or pre-admission review did not occur. Retrospective reviews are considered a method of last resort and are not a preferred method of review, as all control over the utilization is lost.

**Risk Management:** Risk management is the acceptance of responsibility for recognizing, identifying, and controlling the exposures to loss or injury or the possibility of loss associated with a given population. Stop-loss coverage and utilization management programs can be put in place by a TPA on behalf of a self-funded employer and are only part of an overall risk management program.

**Second Surgical Opinion\*:** Referral to another provider (of the appropriate specialty) for evaluation of a patient and confirmation of the necessity for surgery.

**Stop-Loss administration:** TPAs bill for the stop-loss premiums in the monthly billing cycle, and then remit the premium to the stop-loss vendors each month. Additionally, TPAs file the specific and aggregate stop-loss claims as they occur, and provide monthly reports to the stop-loss vendor.

**Stop-Loss provision:** The sourcing and purchasing of insurance coverage that pays for claims or dollar amounts above and beyond set limits. There are two types of stop-loss insurance: specific, which limits the dollar amount on one specific case or claim, and aggregate, which limits the overall dollar amount on the entire population. The contract for coverage is between the employer and the stop-loss carrier, not between the TPA and the carrier. Stop-loss premiums are calculated based on the size of the employer, benefit plan, financial status, risk assessment, employee demographics, and members' health status.

**Summary Plan Descriptions (SPD):** SPDs are booklets that are provided to each employee covered under the health plan. These booklets outline the benefits of the plan and they state the eligibility requirements along with customer service phone numbers for the network and other vendors.

**Utilization Review/Utilization Management (UR/UM)\*:** Meant to impact the rate of utilization of healthcare (not the price tag of the service), UR/UM is a systematic means for reviewing and assessing patients' use of medical care services for the appropriateness and quality of that care. The process involves data collection, data review, and the issuance of a denial or authorization. The ongoing review (concurrent review) is performed against established, defined criteria specific to the service and diagnosis of the patient. Utilization review will monitor the progress of the patient to assure effective,

quality care. UR is generally focused on specialist referrals, emergency room use, and hospitalization services.

**Voluntary Benefits Administration:** See section entitled “Other Ride-Along Benefit Products” for more information on Voluntary Benefits.

\* These services are typically outsourced by smaller TPAs to Utilization Management firms and performed in house by larger TPAs.

## **Ride-Along Benefit Products (Voluntary Benefits)**

Ride-along products, also known as voluntary benefits, are typically fully insured policies that give employees added coverage above basic health benefits. Some common ride-along benefits are:

**Life and Accidental Death and Dismemberment (AD&D):** A policy that protects against the loss of income resulting from the insured’s death or loss of limb/eyesight. Many health plans automatically include a \$10,000 life insurance benefit and a varied AD&D benefit. A pre-designated beneficiary receives the proceeds and is safeguarded from the financial impact of the death or disability of the insured.

**Short-Term Disability (STD):** STD is a policy of protection in the case of disability that prevents the insured from working for up to six months. The definition of disability varies but consistently states “inability to perform with reasonable continuity the material duties of your own occupation.” The illness or injury may be incurred on or off the job. Typically the policy pays from 50 to 70% of the insured’s current salary up to a maximum dollar amount. At the 180-day limit, these claims revert to Long-Term Disability.

**Prescription Benefit:** A prescription plan can be self-funded or fully insured. The plan usually covers both acute and maintenance medications. TPA claim systems today do not have the capacity to process pharmacy claims, so a separate vendor such as a Pharmacy Benefit Manager (PBM) or a Pharmacy Benefit Administrator (PBA) is engaged to automate the process. The TPA can feed information to the PBM or PBA, to allow it to process the prescription claims just as the TPA processes the health claims. As with health plans, PBMs employ prior authorizations, clinical reviews, network pricing, and a host of clinical programs to encourage the use of lower-cost generic drugs. Data is reported back to both the TPA and the employer. Employers can work directly with TPAs or PBMs to set up prescription benefits.

**Dental:** Dental plans are generally fully insured and provide benefits for dental services, including general dentistry (most plans include regular cleanings /check-ups/x-rays) and may include periodontal, orthodontic, endodontic, oral surgery, dentures, or other services. Most benefits are structured so that after the routine annual services are performed, a coinsurance and deductible may be collected from the member.



**Vision:** Vision plans are generally fully insured and provide benefits for vision services, including eye exams, frames, and lenses. Optional benefits may include contact lenses and ophthalmic surgery for vision correction. Typically, all the ‘extras’ such as bifocal lenses and UV lenses, sunglasses, coatings, and colorings are not included, but can be purchased at an additional cost.

**Flexible Compensation** (also known as: Cafeteria Plans, Section 125 Plans, Flex Plans, Flex Spending, Flexible Spending and Flexible Spending Plans): This plan type allows an employee to choose benefits not covered by the employer’s health plan, and pay for those benefits via salary-deducted pre-tax dollars. Employees can pay group health premiums, unreimbursed medical expenses, disability, accident and sickness benefits (other than a medical savings account/long-term care benefits), group term life insurance, dependent-care assistance plans, adoption assistance, vacation pay, or 401(k) plan funding, all with tax-free dollars. Employers use flexible compensation to get away from providing expensive, benefit-rich employee benefit plans to all employees. Flexible compensation allows employers to offer numerous benefits such as dependent care, dental, or vision coverage without increasing employer costs.

Flex plans exclude long-term care insurance, deferred compensation other than 401(k) plans, and life insurance products that build up cash values or investment accounts. Any amounts which are allocated to be used to pay medical expenses (including health insurance premiums) must be used for medical expenses during the plan year or be forfeited—a "use it or lose it" rule.

Although complex to administer, flexible compensation plans can be highly beneficial to both the employer and employee in terms of providing highly customized benefits.

**Flexible Spending Accounts (FSA)** These accounts are set up in conjunction with Flex Plans to reimburse employees for health-related expenses or “pay as you go benefits.” Employees may choose to deposit cash into their FSAs by electing employer contributions and/or salary deduction. Employees can use money in FSAs during the coverage period to pay out-of-pocket medical or dependent care expenses but not insurance premiums. The advantage to the employee is that pre-tax dollars can be used to pay out-of-pocket expenses that would normally be paid with after-tax dollars. FSAs can only be used to pay for medical or dependent care costs. They operate on a yearly "use it or lose it" rule.

## **Consumer Driven Health Plans**

Consumer driven health plans (CDHP) usually take the form of a high-deductible health insurance plan combined with a tax-free health savings account. Employees or individuals with these plans typically pay an insurance premium. Sometimes a percentage of that premium is deposited into the participant’s savings account; the participant may also elect to contribute pre-tax dollars to the account.

This type of plan often forces employees to be more cost aware when seeking medical services. The employee will save money if they don't seek medical treatment, or if they seek lower-cost medical treatment. This plan creates a cost-conscious plan participant, which employers and insurers think will keep premiums low. Employers benefit by paying lower premium rates for a higher deductible plan and help their employees become better consumers of health care.

The two types of CDHPs are listed below.

**Health Savings Account (HSA):** A medical savings account available to taxpayers in the United States who are enrolled in a High Deductible Health Plan (HDHP). Contributions to the account are made with pre-tax dollars. The funds in the account can only be used to pay for qualified medical expenses. HSAs have recently replaced Medical Savings Accounts (MSA).

The dollars in an HSA can be carried over from year to year. This gives consumers an incentive to use less medical care if they realize that spending reduces the funds they will have later and to view the account as a means of saving for retirement health issues. The fear of losing the accrued amount could cause less spending on current health issues. To meet the requirements for an HSA, policies must carry deductibles of at least \$1,000 for individuals and \$2,000 for families. Maximum deductibles are \$3,000 for individuals or \$6,000 for families, whichever is lower. Employees must be under 65, not be claimed as someone else's dependent, and cannot have other "first dollar" health insurance coverage. (Specialty insurance coverage such as vision, dental, or long-term care is allowed.)

The maximum annual contribution that can be made to an HSA is \$2,650 for individuals or \$5,250 for families—or the deductible from the health insurance plan, whichever is lower. Participants aged 55 to 64 can make an additional \$600 contribution.

HSA holders can contribute pre-tax dollars directly into their HSA plan or the contribution can be made by the employer. All deposits to an HSA are the property of the employee regardless of the source of the deposit. If the employee ends participation in the HSA, they lose eligibility to deposit further funds, but funds currently in the HSA remain available for use.

Employees can change their contributions to an HSA on a monthly basis. (FSA plans require that the monthly contribution to be set at one point during the year. Additionally, FSA plans do not roll over to the next year.) Because HSAs allow an end-of-year balance rollover into the following year, they are highly popular with both employers and employees. Employees can also take an HSA with them when they leave a company. They can invest the funds in their HSA just as they invest IRA funds. In the event of a death, HSA funds go to the employee's beneficiary or estate.

**Health Reimbursement Accounts (HRAs)** are medical insurance plans that are either completely funded by the employer using pre-tax dollars or funded with a combination of employee and employer funds. HRAs are offered in conjunction with high-deductible,

lower-premium health care insurance, allowing employees to use HRA funds to pay all or part of the medical expenses not covered by insurance. Funds also roll over into subsequent years.

To employees, the health plan appears to be a traditional medical insurance plan with a network, physician co-pays, drug-card co-pays, and deductibles. HRAs can only be funded by employers. Employers are allowed to deduct HRA distributions as business expenses. An HRA participant qualifies for funds from an HRA only while employed and subject to the terms of the governing plan document. The employer may cancel or amend a HRA at any time.

HRAs vary from Health Savings Accounts (HSAs) in that no separate savings account is involved. HSAs are designed to place the responsibility of the cost of health care on the insured, not solely on the employer.

## **Additional Services**

Each of these services may or may not be offered by a TPA. All are highly complex endeavors, subject to intricate federal and state laws, and require meticulousness in their administration.

**Underwriting:** Analyzing the risk and assigning premiums for annuities and life insurance policies, disability income insurance policies, accidental death and dismemberment insurance policies, and health and medical insurance policies. Analysis of a group's claim data is performed to assess the risks and determine premium rates or whether the group should be offered coverage. A related definition refers to health screening of each individual applicant for insurance and refusing to provide coverage for pre-existing conditions. The by-product of underwriting is that a cost estimate or premium is established which directly corresponds to the level of risk identified.

Most actuarial data used to support and guide the underwriting process in risk selection is developed according to NAICS/SIC coding. The Standard Industrial Classification (SIC) codes indicate a company's type of business. SIC codes have recently been replaced by the new North American Industry Classification System (NAICS), but several data sets are still available and used in the marketplace employing SIC-based data. Both SIC and NAICS classify establishments by their primary type of activity and industry. (NAICS was developed jointly by the U.S., Canada, and Mexico to provide new comparability in statistics about business activity across North America.) NAICS guides the insurance industry with regards to (1) underwriting (assuming the risk, assigning premiums annuities and insurance policies) or (2) facilitating such underwriting by selling insurance policies and by providing other insurance and employee-benefit related services. The SIC/NAICS classifications were not designed as risk-assessment mechanisms, and underwriters do not always use them as a general guideline. However, underwriters may surcharge an employer based upon its classification code or particular industry.

**EDI Compliance:** Electronic Data Interchange is standardized data methodology for cataloging, coding, and transferring data and datasets (including the use of CPT, DRG

and ICD-9 Coding). EDI allows for the easy interchange of information and reporting across the continuum of vendors. ANSI has approved a set of EDI standards known as the X12 standards that cover the entire spectrum of health insurance transactions in a common format.

**COBRA Administration:** The Consolidated Omnibus Budget Reconciliation Act, (COBRA), a health benefit provision passed in 1986, grants terminated plan participants (and plan participants who lose coverage due to divorce/legal separation, death, reduction of work hours, or becoming eligible for Medicare) the right to buy group coverage for themselves and their families (within 60 days of termination) for a period of 18 months to three years depending on the circumstances. Coverage includes inpatient and outpatient hospital care, physicians' care, surgery and other major medical benefits, prescription drugs as well as dental and vision care.

TPAs that administer COBRA do so on behalf of plan sponsors, and they handle the following: track enrollment and premium payments of COBRA participants, inform participants of all premium rate changes, verify participants' eligibility, monitor election periods and participant time frames, provide certificates of coverage, produce and issue letters and communications to participants, and provide plan sponsors with monthly eligibility and participation reports.

**HIPAA Compliance:** The Health Insurance Portability & Accountability Act of 1996, Public Law 104-191 (also known as the "Kennedy-Kassebaum Act") protects employees' health insurance coverage when they change or lose their jobs under Title I. Title II, the Administrative Simplification (AS) provisions, provides standards for patient health, administrative and financial data interchange and governs the privacy and security of health information records and transactions. Title II requires the establishment of national standards for electronic health care transactions and national identifiers for providers, health insurance plans, and employers as well as addressing the privacy and security of health data. Developed by the Department of Health and Human Services, HIPAA took effect in 2001 with compliance required in phases up to 2004. The standards are meant to improve the efficiency and efficacy of the nation's healthcare system by encouraging the widespread use of electronic data interchange in the U.S. health care system. All TPAs are required to comply with HIPAA regulations.

**401(k) Administration:** A 401(k) plan (whose name derives from section 401(k) of the Internal Revenue Code) refers to an employer-sponsored retirement plan that allows an employee to save for retirement while deferring income taxes on the saved money and earnings until withdrawal. The employee elects to have a portion of their wage "deferred" into their 401(k) account. In the majority of plans available, the employee selects from a number of investment options, usually an assortment of mutual funds that emphasize stocks, bonds, money market investments, or some mix of securities. Occasionally employers offer the option to purchase the company's stock within their 401(k) plan. Employees can generally reallocate money among these investment choices at any time. In the less common *trustee-directed* 401(k) plans, the employer appoints trustees who decide how the plan's assets will be invested. With the enactment of the Roth provisions

in 2006, participants in 401(k) plans that have the proper amendments can allocate some or all of their contributions to a separate designated Roth 401(k) account. Qualified distributions from a designated Roth account are tax-free, while contributions to them are on an after-tax basis (i.e., income tax is paid or withheld on the income in the year it is contributed).

Many TPAs of health plans will also administer 401(k) and group retirement plans.

## In Closing

The functions of a third party administrator in relation to self-funded plans are multifaceted and complex. There are dozens of services needed to create and administer a self-funded plan and nearly as many ways to accomplish that goal. While we know that we have not answered every question and discussed every possible scenario, we do sincerely hope that the information above leads to a better understanding of some of the common issues and requirements regarding self-funding.

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*The Third Party Administrator Alliance (TPAA) is an alliance of the nation's top independently owned third party administrators. The TPAA was founded to drive business to member TPAs and supply them with aggressive lead-generation programs and superior marketing tools. In addition, members enjoy discounts provided by TPAA-selected partners in stop-loss insurance, PPO networks, pharmacy benefits management, medical management, out-of-network repricing, plan design, debit/smart cards, subrogation, fraud and more. The TPAA is headquartered in Atlanta, Georgia. For more information, contact Al Allison at 888-454-TPAA (8722) or [aallison@thetpaa.com](mailto:aallison@thetpaa.com) or Peggy Wolford at 407-657-5659, or [peggyw@theTPAA.com](mailto:peggyw@theTPAA.com). Please visit [www.theTPAA.com](http://www.theTPAA.com) to learn more.*

*Judy Diamond Associates publishes the Standard Directory of Third Party Administrators, the Directory of Self Funded Group Plans as well as numerous other employee benefit related databases. For more information about Judy Diamond Associates visit [www.judydiamond.com](http://www.judydiamond.com) or call 800-231-0669.*

## Appendix 1 Insight

A recent survey of TPAs, brokers, and employers conducted by an independent marketing firm showed that TPAs, though fiercely individual, have many similar concerns. The survey found that the responding TPAs had been in business for an average of 24 years. 40 percent had fewer than 12,000 total lives under administration, 30% had between 12,000 and 120,000 total lives, 18% had 120,000 to 400,000 total lives, and 12% had more than 400,000 lives. 63% receive the majority of their business from brokers/consultants while the other 37% work directly with employers and receive only a minority of their business from brokers/consultants.

The TPAs were asked to self-assign a letter grade (A-F) to all of the services they offered. The vast majority of responding TPAs gave themselves similar grades for similar services. Those grades were:

“A” for paper claims processing, member enrollment, customized services, and adjudication;

“B” for provider services, EDI, Utilization review, and case management and,

“C” for wellness programs, disease specific programs, member/client/broker/provider satisfaction measurement, HSAs, and HRAs.

The survey also found that 30% provide extended hours, only 50% offer HSAs, 30% did not offer disease-management programs, 25% did not offer wellness, and 50% had no benchmarking systems in place.

### **TPA Concerns**

The TPAs listed their concerns, expressed below as percentage of TPAs concerned about:

Seeking new clients: 100%

Losing existing clients: 72%

Cost of personnel: 33%

IT Issues: 28%

Exit strategy (merger/acquisition): 28%

Finding and keeping clients are the biggest concerns for independent TPAs, primarily because of their competition.

### **What do brokers look for in a TPA?**

The most common items cited by brokers when looking for a TPA were:

Years in business

Hours of operation

Billing/payment processes

Geographical reach

Electronic claims processing

Turnkey services (even if some outsourced)

Offering HSAs

Benchmarking data

Wellness/disease management important

Member/payer/broker/provider satisfaction data

Brokers want experienced TPAs with service centers close to their clients. They most often prefer TPAs that are one-stop shops for all employee benefit needs, similar to what the fully insured carriers offer, but with significantly more flexibility.

## **Appendix 2**

### **Starting a Self-Fund Plan: the Information You Will Need to Provide to a Broker or TPA**

Self-funding has both an administrative and a stop-loss insurance component (assuming it is a partially self-funded plan). In order to satisfy the data requirements for both, employers are typically asked to provide the following information:

#### **Name and Address**

Full name and address of the business as well as a brief description of the nature of the business. SIC or NAIC code is very useful.

### **Census**

Employee census including:

- Date of birth
- Gender
- Coverage, single or family
- Zip code

The census should include all eligible employees, even those who have met the eligibility requirements but have waived coverage. It should also show those on COBRA, retirees, and disabled, if any. Ideally, data should be provided in an Excel spreadsheet format.

Monthly enrollment, showing the number of single members and families on the plan, by month, for at least two years is also helpful. Monthly enrollment lets the carrier know that enrollment is stable, which is worth a discount. Billing statements usually contain such data.

### **Rates**

The current rates (single and family) and premium history going back three years for the fully insured plan now in place are also necessary. Copies of premium remittance statements are ideal. Renewal rates, when they become available, are extremely helpful.

### **Plan Design**

Elements of the health-benefit plan now in place also are provided. The Schedule of Benefits in any Plan Document concisely shows the co-pays, deductibles, in- and out-of-network charges and out-of-pocket maximums for routine care, office visits, and hospitalization for easy reference. The schedule is an absolute necessity, as are any planned changes for the coming plan year. A copy of the schedule alone will suffice, but a copy of the entire plan document may be useful. If the plan has changed significantly in the past few years, the various schedules showing the differences should be provided.

### **Facilities and Physicians**

Stop-loss carriers pay very close attention to where care is provided, by whom, and at what discounts. Key hospitals, hospital systems or networks to which the group needs access should be noted, so that underwriters may rate the plan and apply discounts properly.

### **Experience**

Any monthly paid claim and/or large claimant data are extremely useful. With such information, underwriters can apply sizeable discounts if the experience is favorable. The more information the carrier has, the more comfortable it can become with a risk.