LIMITED MEDICAL BENEFIT PLANS—WHAT INSURANCE COMPANIES, EMPLOYERS AND REINSURERS NEED TO KNOW

by Michael L. Frank

Why the Interest in this Product?

With the medical insurance market experiencing health care inflation of 10 to 13 percent and medical costs averaging above $8,000 per year per employee (less for single employees and more for employees with families), employers are looking at alternative options. Politicians and regulators are as well.

Health insurers and reinsurers are focusing on where the growth opportunity is for members. One area is the baby boomers and the industry is looking at Medicare and retiree-based products. The other area is the uninsured, which will be our focus for this article.

Based on a study from Goldman Sachs, the number of uninsured people (currently estimated at 47 million) is growing. Fewer employers offer health insurance coverage (approximately 60 percent today as compared to about 70 percent in 2000). Since 2000, the economy has added five million jobs, but the number of commercial covered lives has declined.

As a result, insurance companies and Health Management Organizations (HMOs) are developing new products while employers are searching for new products to provide lower cost solutions. Benefit offerings are focused either on catastrophic benefits or preventative care (both together are not an option).

One avenue approached is consumer-driven health plans, which would result in higher deductibles and increased cost sharing with employees. There is some traction in the market with these benefit plan options, however, the price point (cost savings) in certain markets and industries is not material enough (low enough) for certain classes of employees and industries.

The private equity and investment banking community is also interested in this space since it is a growing market and previous acquisitions in this arena (e.g., SRC by Aetna, Star HRG by Cigna, and others) have created interest for new entities to enter the market.

What Types of Benefits are Offered?

In the limited benefits arena, which some refer to as the "mini-med" market, there are two types of programs. One type is the Expense Level Reimbursement (ELR) and the other is an Indemnity/Fee Schedule Reimbursement (IFSR). For ELR, this closely resembles a traditional preferred provider organization (PPO) plan offering. It will include a deductible and coinsurance and an annual benefit maximum. The benefits become limited in nature since the benefit maximums are $10,000, $15,000, or $25,000 as an example. Some of the benefits could have inside limits (e.g., maximum hospitalization benefit, maximum surgical limit, etc.).

Two of the major players in this market are Aetna through its Strategic Resource Company and Cigna through its Star HRG acquisition. Additional players are entering the market (e.g., American Wholesale Insurance, others).

The majority of the ELR programs in the market are passive PPO network arrangements with no financial incentive or penalty for out of network usage (or

no cost incentive to go in-network). The advantage of incorporating a PPO network is to provide additional discounts especially to individuals that go in-network. Since products have a deductible and a coinsurance element, this reduces the cost to covered members that use a provider, since claims are discounted. The PPO network helps reduce claim costs to the health plan (hence lowering premium rates to the consumer) and reducing the out of pocket expenses to the covered member. The balance of incorporating the PPO network is the access fees charged for the network offset by the savings it can generate. Remember premium rates are lower so the per employee per month cost of a PPO network has to be evaluated further to make sure it is appropriate for the coverage offered.

For IFSR, the coverage is more of a fee schedule reimbursement whereby coverage for employees is a certain dollar amount per office visit or per hospital day reimbursement schedule. Fee schedules for outpatient surgery are based on a fee schedule by procedure cost. As an example, below is an illustrative plan design.

There are a variety of plans, some of which are richer and some not as rich for IFSR plan offerings. Some of the programs carve-out prescription drug coverage completely, or offer a discount card only. Typically the prescription drug benefits for this type of coverage have low maximums with many limited maximum benefits on a monthly basis (e.g., maximum of $25 to $50 of benefits per month).

A market has opened up for stand alone prescription drug coverage with a focus to offer complementary products to the limited benefits medical market. One company, Medco Health Solutions, along with their insurance carrier partner Nationwide, has developed a fully insured prescription program focused for the limited benefits market. Program is a $10.00 co pay (i.e., member cost per prescription) and covers generic drugs only (several thousand drugs are currently available on the program). The $10.00 co pay includes most 90 day generic prescriptions at Medco by Mail. It is a generics only program, but has significant discounts for brand and specialty medications. The program has no formulary or plan maximum.

Hospital Room & Board	$	500	(per day, up to 90 days a year)
Inpatient Surgery	$	1,500	(maximum surgical schedule)
Inpatient Anesthesia	$	150	(per procedure)
Outpatient Surgery	$	500	(surgical schedule)
Outpatient Anesthesia	$	50	(per procedure)
Doctor's Office Visits	$	35	(up to 4 visits per year)
Radiology & Cardiovascular	$	70	(up to 4 visits per year)
Pathology	$	35	(up to 4 visits per year)
Phys. Medicine & Chiropractor	$	35	(up to 4 visits per year)
Wellness	$	50	(up to 2 visits per year)
Emergency Room	$	50	(up to 3 visits per year)
Ambulance	$	100	(maximum 1 per year)
Prescription Drugs	$	35	($10 generic copay; $20 brand copay)
(max benefit amount per month)			

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The limited benefits medical market is growing. Some of the insurance companies and underwriting organizations that participate or have participated in the limited benefits medical market are Pan American, Elite Underwriters, Aegis, EXL, HM, American International Group (AIG), AEGON, American Medical & Life Insurance Company, Fairmont Specialty Group, etc. (There are others so my apologies for excluding any names from the list.) Two organizations, HM, a division of Highmark Blue Cross Blue Shield of Pennsylvania, and AIG have recently designed new products.

Reinsurers should be aware that when evaluating these programs, to keep in mind that the expense levels (as a percentage of premiums) might be higher than a typical first dollar medical program.

Target Market

The population interested in purchasing limited benefits plan is traditionally a younger population with targeted employee contribution rates equivalent to one to two hours of wages per week. Based on market feedback, this appears to be the target price point for employees to afford, especially among organizations such as food chains, blue collar industries, hotels, nursing, etc.

These same industries also have administrative challenges since these groups have higher turnover (one driver for this might be access to better benefits).

What Opportunities Exist for Reinsurers?

The opportunities for reinsurers historically have been limited. The majority of limited benefits medical business risk (and premium) have been retained by the issuing carrier. In healthcare, reinsurers have served a purpose in providing coverage for catastrophic claims risk. This opportunity has not presented itself since benefits are limited or capped so exposure for large claim cost was not a factor.

However, with a growing market and potential entrants (new insurance companies are entering the market), a growing demand exists for a reinsurance partner on a first dollar quota share reinsurance basis. This is both from a risk transfer and risk-based capital (RBC) basis.

What Challenges do Insurance and Reinsurance Companies Face in Underwriting This Business?

As actuaries, we like to look at historical experience on the group when pricing individual renewals as well as a block of business. For groups with limited benefits plans, there are several challenges that need to be managed through.

First, for the specific group, is there credible historical data? Typically employer groups that participate in limited benefits plans have higher turnover, so data becomes less credible plus sources and/or access to data is limited. Underwriters in the limited benefit market tend to focus on the characteristics of the group (e.g., age/sex, industry, funding level amounts or percentages by employer) rather than the experience of the group.

Second, carriers may not share historical claims experience (monthly claims, lag tables, utilization data) with its distribution (assuming the carrier even has) and distribution may not provide access to claims experience to the underwriters, including insurance carriers and reinsurers. They may restrict providing data unless a minimum group size (e.g., 500 lives, $3 million in annual premium) and if they provide, it will be limited in scope which will limit an underwriter's usage of it. As a result, companies focus more on manual rating with age/sex adjustments, if opportunity presents itself with data and regulatory environment, and industry.

Third, even if experience is available, and if it is adjusted for changes in population (low participation/high turnover) and plan design (e.g., a group with major medical going to a limited benefits plan, a group on an IFSR going to an ELR, etc.), then is the experience very credible?

Fourth, the industry does not have a lot of empirical data in this market. As a result, assumptions for plan design changes and rating adjustment becoming more art than science. The market will push for benefit enhancements (e.g., improving prescription drug benefits, increasing limits on surgical schedules, richer lab/radiology benefits, adjusting the pre-existing conditions requirement, etc.). The balancing act is that these adjustments will have potentially material selection issues beyond traditional plan changes (and traditional plan design factors), so actuaries and risk managers should be cautious and prudent in understanding the aspect of such changes.

Last, but not least, we have the industry rating dichotomy. As actuaries and underwriters, we have been trained that certain industries are a challenge and many companies for traditional major medical and stop loss have declined industries such as:

- Associations (especially Associations of "Air Breathers")
- Hotels/Restaurants
- Trucking Companies
- Companies with high concentrations of seasonal employees
- 1099 Employees
- Multiple Employer Trusts (METs)
- Multiple Employer Welfare Associations (MEWAs)
- Employees Leasing
- Medical Service Providers

These groups are normally rated up or declined due to selection issues and their lower participation levels. Typically these employers were found to have low amounts or percentages of benefits so low that participation resulted in significant anti-selection.

However, since benefits are limited in nature, organizations can have success underwriting these non-preferred industry classes. The limited benefits offering will likely discourage high cost groups from purchasing the coverage and may mitigate a material portion of the selection concerns. Insurance companies are typically able to charge a higher risk charge (e.g., 4 to 10 percent of premium) for limited benefits plans as compared to the 2 to 4 percent for traditional comprehensive medical plans.

How Do Pre-Existing Conditions Impact Underwriting?

An important area for limited benefits plans are pre-existing conditions. They assist in limiting the cost exposure due to adverse selection by reducing or excluding coverage if the condition is pre-existing.

What is a pre-existing condition? According to the Department of Labor, a pre-existing condition is a medical condition present before your enrollment date in any new group health plan. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the only pre-existing conditions that may be excluded under a pre-existing condition exclusion are those for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period before your enrollment date (i.e., first day of coverage, or if there is a waiting period to get into the plan, the first day of the waiting period.)

If you had a medical condition in the past, but have not received any medical advice, diagnosis, care or treatment within the six months prior to your enrollment date in the plan, your old condition is not a pre-existing condition to which an exclusion can be applied. There are exceptions to what you can apply or not apply as a pre-existing condition. For example, pre-existing conditions typically are not applied to pregnancy, new born care, or children adopted under age 18. Also, genetic information may not be treated as a pre-existing condition in the absence of a diagnosis.

Application of pre-existing conditions may vary by state. For more information on this subject matter, visit the Department of Labor website at *http://www.dol.gov/ebsa/faqs/faq_consumer_hipaa.html* as well as your local state insurance departments.

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Other Underwriting Considerations

A strategy for limited benefit plans is to naturally limit the benefits. The hope with limiting the benefits is to exclude those higher cost individuals (high utilizers of cost). As an example, a limitation on prescription drugs of $25 to $50 per month in benefits means that the plan with participants that are high maintenance drug utilizers (those individuals that incur higher costs for prescriptions due to high utilization and may also incur higher medical expenses) will not be attracted to these types of plans.

In addition to age/sex underwriting, some organizations will establish underwriting guidelines on the allowable percentage of population over age 55 (for example) or limit/cap average age (e.g., groups with average ages over 50). This strategy is to attract a younger population that will have less utilization.

Some underwriters and insurance companies are trying to encourage greater participation and spread of risk by encouraging employers to contribute a portion of the cost. However, the majority of plans and participants in these programs still have no company subsidy (i.e., employee-pay-all benefits). As a result, participation in these plans is more likely to be in the 5 to 25 percent participation level (with 25 percent being on the very high end) as compared to the traditional medical market with participation rates in the 50 to 100 percent range (most commonly above 70 to 75 percent).

The employer purchasing decision is different for limited benefit plans than with traditional comprehensive medical plans. For traditional medical plans, the employer funds the majority of the cost. However, in limited benefit plans, the employees typically fund the majority, if not all, of the benefits. As a result, the economics of the lower cost medical plan are less of a factor (although they are still a factor).

Seamless administration is also a critical purchasing requirement since employers implementing a limited benefit plan for the first time do not budget for the potential maintenance and headaches that may come with these kinds of plans. As a result, a partnership with an insurance carrier and its administrator are critical, and can be as important as price for the product.

What Other Items Should Reinsurers Be Concerned with?

Reinsurers should be aware that when evaluating these programs, to keep in mind that the expense levels (as a percentage of premiums) might be higher than a typical first dollar medical program. First, some of the fixed expenses on the program are now being amortized over a lower premium amount.

The administration of the program is also more involved. The underlying population has more volatility (higher turnover) so there are more eligibility adjustments and transactions being done. Administrators of these programs may assume additional responsibilities such as COBRA administration, member communication, and handling of open enrollment (typically this is done by the employer but in the limited benefits world it is commonly handled by either the carrier, its administrator or TPA).

Participation in these programs is typically lower due to limited employer funding plus turnover of employees is high, so a significant amount of additional communication is required.

Finally, brokerage commissions are higher. For example, the traditional major medical and HMO markets tend to see commissions in the range of two to six percent depending on the group size and market segment. Naturally, the larger the group (and the higher the premium amount), the lower the commission rate since commission rates may be on a sliding scale based on number of lives and/or premium volumes.

In the limited benefits environment, commission rates are more commonly in the 10 to 20 percent range. One reason for this may be due to the fact that brokers are assuming some of the administrative functions highlighted above. Other reasons might

be due to the higher distribution costs. While the market is pushing for lower commissions, the norm is still around 10 percent.

How are the brokers selling the product?
The broker selling strategy for these types of limited benefit plans have taken two avenues. First, the lower the price, the easier the sale. If the premium is 25 to 50 percent of the cost of a traditional medical plan, it will be attractive to many employers. Employers should be aware that since the benefits covered are lower (25 to 50 percent of the traditional benefits), the costs are lower.

Employers and insurance carriers should considering exploring some additional strategies when purchasing or entering these product lines. First communication is key success factor. Employers and their members need to understand what is covered and not covered. Covered insureds or members are not great at reviewing their benefits and may not know what they are buying until after the fact.

Implementing a Two Prong Strategy—Offensive & Defensive Strategy for Communications

It is strongly recommend that brokers and insurance companies offer a complimentary product to go along with these benefit plans. For example, offer a buy up medical or a critical illness plan. The buy up medical plans are not easy to find and may be very costly or limited in scope. Another alternative is providing a critical illness plan. It creates an offensive and defensive strategy for employers and carriers.

First, the offensive strategy is that it provides an additional level of benefit, although limited, but important for certain high cost medical categories. For example, it will pay a fixed benefit for certain cancer, cardio or other pre-defined catastrophic medical costs. It does not coverage all of the costs for the benefits, but the benefit will augment potentially a material cost of care (not dollar for dollar though).

Some states are more advanced in the limited benefits market than others. Insurance companies and reinsurers entering a market should do their homework about the local state regulatory jurisdiction that they are interested in offering product.

The defensive strategy of offering the benefit is the educational impact. Individuals typically do not read their benefits or they may not thoroughly read it. However, it may induce some individuals to review their medical benefits or generate the question in their mind of the following:

- Do I need this extra benefit?
- Does my medical plan cover me for this?

The defensive strategy focuses on getting employees to read their benefits.

What other products are available to the consumer markets buying limited benefits medical? In addition to critical illness above, insurance carriers are offering benefits in life insurance, accidental death & dismemberment (AD&D), disability, dental, vision, legal and other voluntary benefits.

Due to the industry classes that buy these coverages and the potential selection issues, especially around the life and health benefits (e.g., part time employees eligible for benefits), the benefit amounts are limited in scope. For example, life insurance coverage may be a flat face amount of $5,000, $10,000 or $25,000. Similarly, disability and dental benefits may have limitations as well.

These additional benefits may create opportunities for insurance companies and reinsurers interested in expanding their product lines and obtaining additional premium or income opportunities.

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What About Requirements as Credible Coverage?

Some brokers are getting creative and marketing these limited benefits plans as a bridge plan. Employees join the plan and are able to accumulate coverage credit or accumulating credible coverage to avoid pre-existing conditions with the next plan that they will join (e.g., comprehensive medical plan). In order to avoid a pre-existing condition or waiting period, one would need to show evidence of credible coverage. The brokerage community may be looking at these plans as a way of dealing with this provision since an individual on a limited benefits plan may be perceived as credible coverage by a comprehensive medical plan. (We are not claiming that this is valid and is credible coverage, but limited medical plan brokers and administrators may be marketing as such.)

Regulatory Approval

Since these benefit plans are limited in scope and the industry does not have a significant track record with them, those companies entering the market should be aware of the regulatory hurdles of these benefits. For example, some state regulators may not be comfortable with the benefits due to their limited nature and would want proper communication and documentation highlighting the differences from a comprehensive medical plan.

Some states are more advanced in the limited benefits market than others. Insurance companies and reinsurers entering a market should do their homework about the local state regulatory jurisdiction that they are interested in offering product. Items to review should include but not be limited to the following:

- Filing requirements
- Rating restrictions (e.g., community rating, minimum loss ratios, ability to adjust rates and frequency they can be adjusted, etc.)
- Mandated benefits—Will these benefits be deemed comprehensive medical benefits?
- Local players in the markets approved to date
- Local programs sponsored by state regulators which may complement or compete with various products.

For example, some state regulators may require minimum statutory benefits to be included such as mental health or substance abuse, maternity, etc., while other states have developed programs to support the uninsured market including Medicaid, Child Health Plus, Family Health Plus, etc. New York State, as an example, also has a program called Healthy New York to address medical business for lower income individuals. Insurance companies should evaluate how their programs for limited benefits medical compete with plans offered in their local market.

Insurance companies and reinsurers should also take notice of loss ratio requirements for pricing. Limited benefit medical plans may have higher administrative expenses resulting in higher reinsurance ceding allowances. If an insurance company or reinsurer is writing a limited benefits medical line of business, then they should ensure that enough room exists to meet the insurance carrier and reinsurance profit objectives after expenses, and are not restricted by regulatory requirements for minimum loss ratios. ✺

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