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CORRESPONDENCE MEMORANDUM

DATE: October 31, 2012

TO: Group Insurance Board

FROM: Bill Kox, Deputy Administrator
Roni Harper, Manager, Optional Insurance Plans and Audits

SUBJECT: Analysis of Employee Trust Funds (ETF) Administration of Optional Plan Contracts

Staff recommends the Board maintain the current Optional Plan practice, unless it is determined that employers and employees generally have significant concerns with the current system and that the benefits of addressing those concerns outweigh the costs of changing the method of administration. The potential costs range from negligible to significant, depending upon the method of administration that is implemented.

Issue:

This memo discusses the August 28, 2012, Group Insurance Board (Board) request that Employee Trust Funds (ETF) prepare a report to provide options and recommendations concerning administration of the optional insurance plans, including an analysis of the administrative responsibilities ETF would assume in administering the master contract with the optional insurance plans, and any resources that may be needed.

This memo outlines the background of, and the current structure for, offering optional insurance plans to state employees through their employers, and examines four options concerning the future administration of these plans.

Background:

Under the authority granted to the Board by Wis. Stats. 40.03 (6) and pursuant to Wis. Stat. 20.921(1)(a)3 and Wis. Admin. Code ETF 10.20, the Board is responsible for approving optional group insurance plans that seek to be offered via payroll deduction. Per ETF 10.20, when making recommendations to the Board, ETF considers whether

Board	Mtg Date	Item #
GIB	11.13.12	4

Reviewed and approved by Lisa Ellinger, Administrator, Division of Insurance Services.

Signature: [signature] Date: 11/2/12

there is an important need for this type of coverage, and whether there is adequate oversight of the plan.

To further outline the functional administrative requirements, the Board adopted "Guidelines for Optional Group Insurance Plans Seeking Group Insurance Board Approval for Payroll Deduction Authorization" (see Guidelines: Attachment 1), last revised in 1999. Under the Guidelines, optional insurance plans must meet the following requirements:

- Offer true group insurance,
- Offer coverage that is not adequately offered through other plans,
- Retain no more than 25% of premium income.

The Guidelines state in item 6.f:

> Approval by the Group Insurance Board under these guidelines authorizes a plan for premium collection through payroll deduction only; it does not guarantee access to all state agencies. <u>Plans that have been approved by the Board will be expected to execute Group Master Contracts with each state agency that wishes to offer the coverage to its employees</u>." (Emphasis added)

ETF staff manage the evaluation of newly proposed optional insurance plans and prepare a recommendation for the Board. The evaluation includes an analysis by the Board's actuary, and an opportunity for review of the written proposal by members of the Fringe Benefits Committee, a subset of the State Payroll Council. [The Payroll Council formalized its bylaws in 1984; the bylaws included the duties of the Fringe Benefits Committee as "the Council's communication link with the Department of Employee Trust Funds and the Department of Administration Risk Management." Its charge included regular meetings with ETF to exchange information on benefit program policies, rules and regulations, providing feedback on program issues.]

In many ways, ETF staff currently act as an arbiter of the insurance plans. Once a new or updated plan is approved, ETF works with state payroll and insurance company representatives to assist in the roll-out to state agencies. ETF reviews the insurance certificate, the contract language, and any marketing materials that will be distributed to state employees or annuitants, for compliance with the Guidelines. ETF may also review any online representation of the insurance product, and recommend refinements to these various communication methods to ensure that they represent the plan as approved by the Board. ETF staff may act as intermediary with the state agencies, and as an interpreter of the contracts and certificates throughout the plan year.

Each insurer holds the "system of record" for its policyholders—the official record of enrollments, demographic information, and claims. ETF houses *no* enrollment data about which employees are enrolled in the optional plans. Each state agency administers enrollment through its own payroll offices. Payroll offices at the agency and worksite level maintain any paper records, including copies of applications and waivers, and are responsible for resolving enrollment errors.

The agencies submit enrollment information to the plan through one of six payroll centers, which remit premiums to each insurer along with enrollment data for members. Regular enrollment and payment reconciliation reports are handled by agency payroll staff—the procedures and associated issues vary by insurer.

Following are approximate numbers of agencies holding contracts for 2013 for each of the major optional plans approved by the Board:

Plan	Number of agencies 2013	Number of enrollees 2012
EPIC Benefits+	57	34,000
EPIC Dental Wisconsin	20	12,650
VSP	55	16,500
Anthem DentalBlue	56	7,450
Hartford AD&D	32	Not available
Total	-	70,600

Outside the Board approval process, the University of Wisconsin System and UW Hospital and Clinics each have other optional insurance plans which have been in place since the 1980's. Both offer UW Employee's Inc. Term Life. In addition, the UW System offers payroll deduction for two other life insurance plans through Minnesota Life, and an Accidental Death and Dismemberment (AD&D) plan administered by Zurich American Insurance. The UW Hospital and Clinics offers three separate plans: additional supplemental Life, also administered by Minnesota Life, a separate AD&D plan through Zurich, and Delta Dental.

In addition to what is typically considered an eligible state agency for insurance programs, as defined in Wis. Stat 40.02(54), eligible entities also include Authorities and Corporations of varying size, such as the UW Hospital and Clinics Authority, the Wisconsin Housing and Economic Development Authority, and the Wisconsin Economic Development Corporation.

If a participant has a complaint about a particular optional plan benefit, he or she may seek assistance from agency payroll staff or ETF to gain better understanding or to resolve an issue. However, if the issue cannot be easily resolved, the member would have to file his or her grievance with the Office of the Commissioner of Insurance. ETF ombuds staff is not usually involved, and complaints are not appealable to the Board.

Options for Future Administration:

This memo presents four options for the Board's consideration: a) establish mandatory participation across all state agencies, b) require ETF to manage the various contracts, c) require ETF to manage the various contracts and administer enrollment and premiums, and d) maintain current practice, pending receipt of additional information from major payroll systems and employers. The chosen approach should be driven by consideration of the problems the Board is seeking to address and the costs of addressing them. Although concern has been expressed that the availability of these

plans varies by employer, ETF is not aware of how significant this concern is for employees and major employers.

A. Mandatory Statewide Participation of All State Agencies

The Guidelines could be amended to mandate that each optional plan be available to all state agencies through contracts administered at the agency level. If the primary intention of the Board is consistency and conformity of offering access to all employees, this approach could be appropriate. The Board could also consider whether to offer all optional plans to retirees, if this were negotiated with insurers.

Advantages

- Personnel considering job offers in state service, or making transfers from one agency to another could have a consistent set of optional insurance choices.
- The insurance premium structure could anticipate a consistent, broad risk pool.
- No need for additional ETF resources, and therefore a low-cost option, compared to options B and C.

Disadvantages:

- Large agencies such as the UW System and UW Hospital and Clinics have a history of offering optional insurance that is different from the plans approved by the Board. Some of these plans are “grandfathered.” If participation is mandated, the status of these existing plans must be considered.
- State agencies, including the various Authorities, would lose the autonomy to select the optional insurance plans offered, and may lack timely resources dedicated to facilitating new insurance offerings.
- Very large agencies, such as the UW System, would lose the ability to develop and oversee insurance plans with attributes designed to fit their unique population of employees, some of whom are not eligible for WRS benefits. UW System administration has commented that they feel it is important to offer benefits that help recruit and retain staff, which may differ from other public employee groups.

B. ETF Contract Management

For central contract management in ETF, the Guidelines could be amended to provide that the Board and ETF take a stronger, defined role in plan design, managing contract negotiations and contract administration, and in member issue resolution. This strategy could be considered if a goal of the Board is to remove this responsibility from state agencies, or to strengthen the negotiating position of the State in defining optional insurance plans. As in option A, the Board could consider whether to expand eligibility to retirees.

ETF legal counsel has advised that under Wis. Stat. 40.03(6)(b) and (d), the Board currently has the authority to provide other insurances, including negotiating the terms of the contracts, though such contracts must provide that the employer is not liable for obligations except as agreed to by the employer. Agency payroll staff and the insurers

have increasingly looked to ETF to coordinate logistics and negotiate “gray areas,” so Option B would formalize that responsibility. Insurance coverage complaints would come through ETF ombuds staff, and the departmental determination process would be used for grievances.

Central contract management, without mandatory agency participation, could be accomplished as soon as plan year 2014.

Advantages:

- ETF would have authority to negotiate plan design with a given insurer, and to manage the number of options within each plan. This could make the options clearer for members and their benefits advisors, who have commented that the current complexity of benefits and choices is confusing.
- ETF could work with insurers to offer plans that complement the dental component of Uniform Benefits, if the Board moves forward with that effort.
- Option B *could* include an ETF “portal” to the enrollment data for each insurer, but each insurer would retain the “system of record.”

Disadvantages:

- Health insurance program administration is mandated in Chapter 40, but optional insurance has no source of funding for the staff and other resources required.
- ETF would need additional resources to develop RFP’s, negotiate premiums and coverage, and address complaints and appeals.
- An administrative fee structure would need to be implemented.

C. <u>ETF Administration of Enrollment and Premium Disbursement</u>

Option C includes contracting as discussed in Option B, as well as centralization of administration of the optional insurance plans within ETF, in a structure analogous to the current operation of the state employee health insurance program. This would remove responsibility from agencies to work directly with insurers on premium and billing issues. ETF would be the intermediary between members and insurers.

A key role of payroll and benefits advisors at each state agency level would remain: facilitating access to information for new hires and during open enrollment in the fall, assuring that enrollment is timely, and assisting employees with electronic or paper applications as needed.

Under Option C, ETF would house the “system of record,” which would include the following responsibilities:

- Operate a central system housing eligibility and enrollment information.
- Facilitate a daily data exchange with insurers regarding enrollment and demographics.
- The ETF call center and Insurance Administration Bureau (IAB) would field contacts from members and employers related to enrollment issues.

- ETF would serve as the central point for premium collection and disbursement to insurers, manage refunds, collections, and monthly file reconciliations for each insurer.
- ETF would need to explore further whether existing insurers have capacity for automation and the ability to interface with ETF systems.

The Board would need to consider whether to offer all optional plans to retirees, which would also require negotiation with the insurers. ETF estimates January 2015 as the earliest Option C could be effective, provided the Legislature addresses the funding and position needs. Factors affecting that date include development of IT capacity, timing of the insurance contracts, and the timing of introducing and passing changes in Administrative Rule, if needed.

Advantages:

- Members, employers, and ETF service staff would have a central point of contact, and an integrated view of total insurance coverage, with easy access to enrollment status online throughout the year.
- ETF could develop and improve consistency in applying rules for eligibility.
- ETF and the Board would have integrated information regarding utilization of insurance opportunities.

Disadvantages:

- ETF would need significant resources to implement automated systems that track member enrollment and premiums, and exchange information with insurers. ETF currently houses *no* information about which members are enrolled in the optional insurance plans. ETF would need to build, test, and maintain interfaces with each insurer. Additional costs would include:
  - Annual costs to house data as the system of record. Currently there are over 70,000 policyholders (with some overlap) in the optional plans.
  - If retirees had annuity deductions for premiums, that would require a project to add this functionality to ETF's Benefits Payment System.
  - Insurers would incur costs to develop an interface capacity.
  - Implementation would involve training of state payroll staff, ETF staff, and member education.
- Additional ETF staff in the Division of Insurance Services for ongoing policy oversight, issue resolution, enrollment logistics and problem-solving.
- Additional workload for ETF staff in Retiree Services and Accounting.
- An administrative fee structure would need to be implemented to pay for the combined costs of implementation and of ongoing management.
- As part of its strategic plan, ETF's IT staff are largely focused on a multi-year, agency-wide modernization initiative. Depending upon the resources the Legislature would provide, Option C risks significantly disrupting that initiative.

D. Maintain current practice, pending receipt of additional information from major payroll systems and employers

ETF could continue the basic current practice as outlined in the Background section of this memo. This would include ETF review of proposed optional insurance plans or changes to existing plans, with input from the Payroll Council Fringe Benefits Committee, recommendations to the Board, and approval by the Board for payroll deduction. Each State employer would have the ability to choose whether to offer the available plans. Large employers could continue to offer their "grandfathered" plans that meet their human resource needs.

Meanwhile, ETF would gather more formal input from state payroll system administrators and employers, to explore their most common concerns or interests in making adjustments to the current system of plan approval, contract management, and/or management of enrollment and premiums. ETF could bring an updated proposal to the Board if it is determined that major employers and payroll systems have significant issues with the current system.

The goal of mandatory participation could be accomplished *within* the current structure of Wisconsin state agencies by having the decision to offer supplemental insurance plans made at the level of the existing six payroll centers:

- Central Payroll through DOA
- UW System
- UW Hospital and Clinics
- Wisconsin Economic Development Corporation
- Courts
- Legislature

In addition, the Board could consider making minor updates to the existing 1999 Guidelines. For instance, the Guidelines could more clearly give ETF the ability to review and exclude some plan proposals, and could firm up parameters and timeframes under which agencies or insurers propose new plans.

Advantages:

- This is a no-cost option and would not divert resources from ETF's current strategic plan.
- Agencies have direct information on worksite locations of their staff, and may be in a better position to decide the merits of offering a particular optional insurance plan.
- The degree to which there are multiple choices among vision and dental plans, and the variations within plans can be seen as a positive opportunity for those who wish to tailor their choices to their expected care needs.
- Insurers pay the actuarial fees (from $5000 to $12,000) when they propose changes in their premiums or benefits. Maintaining current structure leaves this cost as the responsibility of the insurer.

- Maintaining the current practice would not disrupt ETF's current agency-wide modernization initiative.

Disadvantages:

- Availability of optional insurance would likely remain inconsistent across agencies.
- Any of the points outlined as "Advantages" of options A, B, or C would not occur or at least would be put on hold pending further assessment.

Summary and Recommendations:

Option A, mandatory agency participation, offers the advantage of consistency of the benefit options for all state employees. In addition, this option, together with option D, is a low cost option and would risk the least disruption to ETF's modernization initiative. However, this option requires further discussion with state employers at their highest administrative levels, because it may include unintended consequences, such as removing agency flexibility in determining benefits for their unique set of personnel.

Option B, ETF contract management of optional insurance plans, is a concept with support from several stakeholders. It has the advantages of bringing efficiencies to the selection, negotiation of premium and benefits, and to interpretation of administrative intent for members and human resource staff across the state. However, a significant issue that would require more formal investigation is the likelihood that some may object to the loss of autonomy for certain agencies or institutions such as the UW System. In addition, this option would require additional funding and staff.

Option C anticipates that ETF contract management would present an opportunity to centralize enrollment and premium management within ETF, along with call center functions. Payroll offices would continue their role to instruct new hires, and facilitate employees' selections during open enrollment season. However, a structure with central administration would require costly IT design, coding and testing and additional staff. In addition, given the focused IT resources this option would require, it may significantly disrupt the agency-wide modernization initiatives ETF is implementing pursuant to its strategic plan.

ETF staff recommends Option D, which would maintain the current system for facilitating the availability of optional insurance plans, with possible minor modifications, pending receipt of further information. This option, together with Option A, is a low cost option and would risk the least disruption to ETF's modernization initiative. Unless it is determined that significant issues exist with the current system, staff recommends the current system continue, while including an update of the 1999 Guidelines to reflect current annual timing and clarify parameters for consideration of new plans.

ETF staff will be available at the Board meeting to answer any questions.

Attachment: Guidelines

GUIDELINES FOR OPTIONAL GROUP INSURANCE PLANS

SEEKING GROUP INSURANCE BOARD APPROVAL

FOR PAYROLL DEDUCTION AUTHORIZATION

Department of Employe Trust Funds
Group Insurance Board

801 West Badger Road
Madison, Wisconsin 53702

July, 1999

Unless specifically provided for under a collective bargaining agreement under Subchapter V of Chapter III, Stats., The Group Insurance Board is charged by s. 40.03 (6), and s. 20.921 (1) (a) 3., Stats., with approving any optional, employee-pay-all group insurance plan that requires premium deduction from state payroll. The Board has established the policy under which it will review each plan in ETF 10.20, Wis. Adm. Code.

The guidelines describe the requirements of the Board, the procedure followed in reviewing a proposal for state payroll deduction authorization, and the requirements for plans that are approved in their on-going relationship with the Board. Plans that fail to meet these requirements may have their payroll deduction request denied or authorization suspended.

Consistent with the Administrative Code, the Board's intent is to approve only those plans that can demonstrate financial stability and broad based community support, and provide coverage that is not readily available through other plans already provided state employees. The Board may approve a plan which provides coverage similar to one already available to state employees if the Board determines that by so doing, the new plan will provide competition resulting in better benefits and/or lower cost.

I. Application Procedure

1. Plans that wish to be considered for payroll deductions must submit a proposal to the Board in the format described in these guidelines under section II "General Requirement."

2. Applicants must provide twenty (20) copies of the proposal.

3. Section 10 of the guidelines requires that statistical information be provided as an exhibit. This exhibit must be complete and the information provided may not be deviate from the format of the addendum to these guidelines. The Board reserves the right to request additional information as necessary.

4. The rest of the guidelines allow responses in text to be free form, but each applicant should be as concise and topical as is possible.

5. Proposals that are received 45 days prior to the next scheduled meeting of the Board shall have their proposal considered at that meeting. Proposals received less than 45 days prior to the next meeting shall be considered at the next following meeting of the Board.

   5a. Effective June 29, 1999, the Group Insurance Board will accept Long-Term Care Insurance proposals once each calendar year at the June Board meeting. Proposals must be submitted at least 45 days prior to the Board meeting. If the proposal is approved, the insurer may offer coverage to state eligible on the following January 1.

6. The staff of the Department of Employe Trust Funds, in consultation with the Board's actuary shall prepare a report on the proposal and a recommendation for the Board. A copy of this report will be available to the applicant no later than seven calendar days prior to the meeting at which the Board will consider the proposal.

7. At the meeting, the Board may wish to ask questions about the proposal. Plans which are being considered should have knowledgeable representatives available at the meeting to respond to these questions.

II. General Requirements

1. Statutory authority to conduct business of insurance.

   The Board will only consider those plans which have received State of Wisconsin Insurance Commissioner approval to conduct the business of insurance in this state. Plans should indicate when this authority was received and under which section of state statute the insurer is licensed.

2. Operating experience.

   The Board will consider only plans that have at least one year of operating experience. The Board may waive this requirement, providing the plan can demonstrate that it was designed specifically for the state employe group to fill a need for coverage that is not already available (or adaptable) to state employes.

3. Broad-based community support.

   Unless a plan has successfully demonstrated under #2 above that it was designed specifically for the state group, each proposal must include a list of current corporate (or public employer) clients and the total number of subscribers.

4. Types of plans that are eligible.

   a. The plan must be true group insurance. A plan which consists of individual policies marketed on a group basis is not eligible. This provision does not apply to Long-Term Care Insurance.

   b. The plan must offer coverage that is not adequately provided through other plans currently available to state employes. The Board may waive this restriction in those instances where it is deemed appropriate to have competing plans, when such competition may result in higher quality benefits and/or lower price.

   c. Plan must provide a high premium to payment ratio. Plans that retain more than 25 percent of premium income for purposes other than claim payments will not normally be eligible for consideration unless the high retention ratio is justified.

5. Financial requirements.

   Any organization desiring approval must demonstrate that it has adequate financial resources necessary to carry out its obligations to state employes and dependents who choose to be covered under the plan.

   In determining financial stability, the Board will consider:

   a. Financial soundness of the sponsoring organization. Each organization will be required to submit the initial proposal, information on its current financial condition. Documentation required includes a balance sheet, statement of operations, an

audited financial statement by a certified public accountant in accordance with generally accepted accounting principles, and utilization statistics. (This information shall remain confidential insofar as permitted by Wisconsin law.)

b. Incorporation and regulation under the provisions of Chapter 185 and/or 600 through 646, Wis. Stats., pertaining to insurance plans.

c. Insolvency protection for subscribers consisting of, for example; financial bonds, third party guarantees, reinsurance deposits, automatic conversion rights, or other arrangements which are adequate to the satisfaction of the Board to provide for continuation of benefits until the end of the third month following the month in which insolvency is declared.

6. Marketing and enrollment.

a. Each plan shall submit a general description of its marketing plan. Any promotional material or literature that the plan proposes to distribute to state employes shall first be approved by the Board.

b. Each plan will be required to supply all necessary application forms and reporting forms. State agency payroll representatives will accept applications from enrollees and transmit new applications to the plan. In addition, the payroll representatives will audit the membership lists and report any changes to the plan. The plan should submit a monthly membership list to each state agency to assist the payroll representatives in this task.

c. State agency payroll representatives will be responsible for entering premium deductions into the payroll system. Premium deductions shall take place once each month for coverage in the following month for those on a biweekly payroll, and the next following month for those on a monthly payroll. Each agency shall submit the total premium from that agency to the plan not later than the first calendar day of the coverage month for which that premium is due. Other premium collection schedules may be approved by the Board if there is a demonstrated need.

d. Approved plans will be required to hold an initial open enrollment period for a period of not less than one month nor longer than two months. During this period, any eligible employe shall be allowed to enroll in the plan. No plan will be allowed to apply underwriting standards or restrictions during this open enrollment period. Therefore, each new eligible employe shall be afforded the same opportunity to enroll provided application is made within 30 days of first becoming eligible. (This provision does not apply to Long-Term Care Insurance.)

e. Employes who do not enroll when initially eligible, may be afforded the opportunity to enroll in an open enrollment period specified by the plan or through the application of underwriting standards, provided those standards have been approved by the Board.

f. Approval by the Group Insurance Board under these guidelines authorizes a plan for premium collection through payroll deduction only; it does not guarantee access to all state agencies. Plans that have been approved by the Board will be

expected to execute Group Master contracts with each state agency that wishes to offer the coverage to its employes. A state agency may, at its discretion, choose not to offer a plan even though that plan has received payroll deduction authorization from the Group Insurance Board.

7. Reporting.

Each plan will be required to annually submit enrollment and utilization statistics and any other requested financial information to the Board in an agreed-upon format. This information will normally be required no later than May 1 of each year, and shall cover the previous coverage year. Failure to submit this information, may at the discretion of the Board, constitute grounds for termination of the plan's payroll deduction authorization.

8. Benefits.

a. Each plan is required to submit a clear, complete, and understandable description of benefits.

b. The description of benefits must include a detailed listing of exclusions and limitations.

c. Benefits may not be changed or added to the plan during the coverage period, unless such change is necessary to comply with state or federal regulations.

d. Each plan will be required to file with the Board a detailed description of how member complaints will be resolved. In addition, each plan must specify the name and telephone number of the person who will initially receive member complaints.

9. Notification of significant events.

Each plan shall notify the Board of a "significant event" within thirty (30) calendar days after the plan becomes aware of it. (In the event of insolvency, the Board must be notified immediately.) As used in this provision, a "significant event" is any occurrence or anticipated occurrence which might reasonably be expected to have a material effect upon the plan's ability to meet its obligations, including, but not limited to, any of the following: disposal of major assets; lost of 15% or more of the plan's membership; termination or modification of any contract or subcontract if such termination or modification will have material effect on the plan's obligations; the imposition of, or notice of the intent to impose, a receivership, conservatorship or special regulatory monitoring; the withdrawal of, or notice of intent to withdraw, state licensing, HHS qualifications or any other status under state or federal law; default on a loan or other financial obligations; strikes, slow downs or substantial impairment of the plan's facilities used by the plan in the performance of its contract. The Board shall reserve the right, by contractual agreement, to institute action as it deems necessary to protect the interest of its employes and dependents, as the result of a "significant event."

10. Rate-making process.

Each plan must submit in its initial proposal, premium rates and a detailed description as to how premium rates are determined. The proposal should also include an explanation of how adverse or favorable experience will be reflected in future rates. The specific rate-

making information requirements are listed as an addendum to these guidelines. This form must be completely filled out and the content may not deviate from the listed requirements. This information will be considered confidential by the Board insofar as is permitted by Wisconsin law.

Future premium rate adjustments shall be considered by the Board subject to the following conditions:

a. No rate change shall take effect without approval of the Board.

b. Rates should remain in effect a minimum of one year from date of effectiveness.

c. Plans will be required to notify the Board in writing no later than 60 days prior to the meeting at which the rate change will be considered.

d. A completed rate-making information form shall accompany the notification.

e. The Board will not consider any request for rate change that does not arrive complete and within the time period specified above.

f. The Board will not approve a rate increase that it deems excessive or unreasonable.

11. Fees.

Each initial proposal, will in addition to analysis by the staff of the Board, be reviewed by the Board's consulting actuary. Plans should expect that a fee will be charged for the staff and the actuary's time and expenses. <u>In addition, all actual costs of the staff and the Board's actuary in reviewing claims and premium and other relevant information concerning that plan on an on-going basis after Board authorization is granted may be charged to the insurer</u>. If the time required for this review is minimal, the Board may waive the fee.

State of Wisconsin Group Insurance Program

Information Required for

Preliminary Review of Proposal

Proposed Plan: ______________________________ Date: ____________________________

Carrier: ____

Summary description of proposed plan (100 words or less):

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Enrollment statistics for this plan as of _________________________________:

	Madison Area	Wisconsin	Nationwide
Number of participating groups			
Employer supported			
Employe pay-all			
Number of individuals covered			
Two largest participating groups			
Group 1 - Name			
- No. of participants			
Group 2 - Name			
- No. of participants			

Five year claim experience for this plan (year 1 is most recent year):

	Year 1	Year 2	Year 3	Year 4	Year 5
Number of participants					
Annual premium income					
Number of claims					
Amount of claims					

Required attachments:

- Financial statement of carrier for last 2 years
- Sample adoption agreement
- Premium schedule
  - When was it last revised?
  - For how long are rates guaranteed?
- References – Name, address and telephone number of 3 largest groups in Wisconsin currently in this plan.