

Henry C GrosJean

In view of the fact that the majority of employers are experiencing double-digit rate increases to their health plans many are proactively looking for viable and cost-effective alternatives.

Unfortunately, the process of qualifying for an alternative can be a challenge.

This is partly due to the current underwriting “standards” for the dwindling list of “accountable health plans” that are writing business in Arizona.

The change process is becoming more and more **problematic** as these “standards” seemingly change on a daily basis as insurers attempt to write more business while attempting to avoid, **I mean “manage,”** any inherent risk.

The issue of “risk avoidance” or “**managing risk**” is frustrating to those who market and/or purchase health plans. There doesn’t appear to be a happy median.

Consumers need to have a basic understanding about the underwriting process, in black and white, as, oftentimes, they are not informed of the realities, or forget what they are told, in looking for an alternative.

The following factors will affect all employers in one form or another. I would like to refer to them as an underwriting “reality check list” for an employers’ efforts to procure or change their health coverage.

They are not to be construed as the final list, but will cover the vast majority of employer scenarios.

The “initial” premium that will be charged for employees or dependents is based on the following criteria:

- Your business SIC code.
- The zip code of your business location’s.
- The residence zip code’s of your employee’s
- The number of “eligible” employee’s to be covered.

- The demographics of your eligible employee's or dependent's as to gender and age.
- The health histories, if applicable, of your eligible employee's or dependent's. And, if applicable, the health histories of those employee's or dependents **who** are in their waiting period and soon to become eligible.

The "final" premium that will be charged may be affected by the following.

- The number of eligible employee's or dependent's who actually enroll in the health plan.
- If there is any difference between the original census that was quoted and the final enrollment. The final rate could be affected just by adding one employee or one family.
- If there is a "demographic" change as to dependent status from the original quote or bid to final enrollment.
- If there are gender or age changes from the original quote to final enrollment.
- If applicable, any changes in the health status or a newly disclosed health condition(s) from the original quote to final enrollment.
- And finally, any undisclosed "internal" underwriting and/or rate changes that are made by the insurer prior to or at policy issue.

It is self-evident from this listing of criteria that making a transition to an alternate benefit package may not be a "smooth" process and takes some care and deliberation.

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