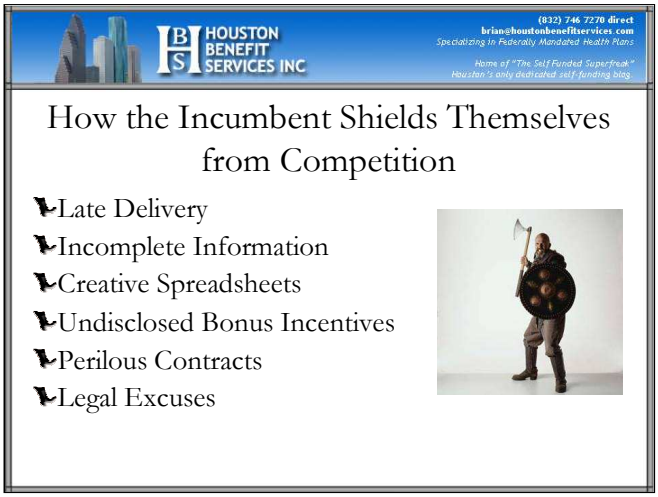
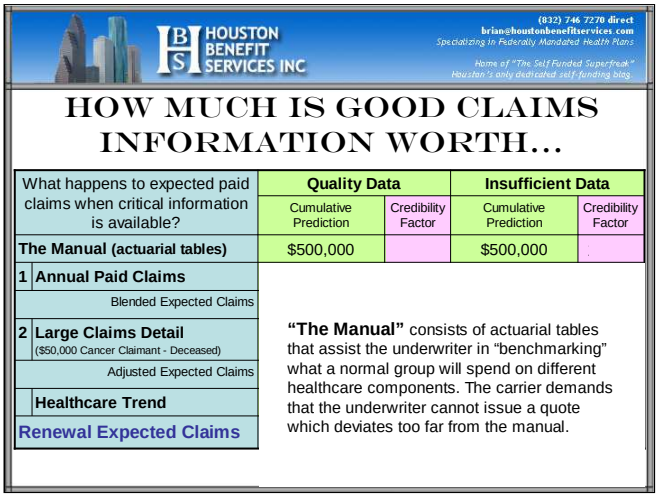
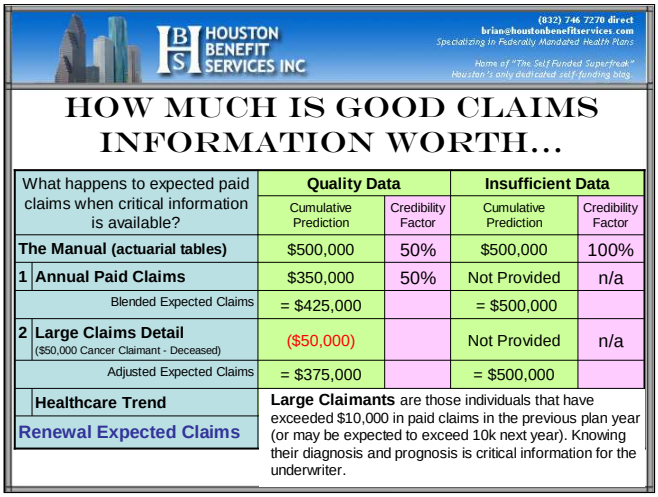


One of the most important concepts to understand about this process is how the incumbent shields themselves from competition. For your insurance company, most profits are realized in the second or third year of the contract, so it is in their best interest to reduce or eliminate competition. Today account protection is the game with the highest stakes. The situation is so serious that in 2004 the attorney general of the state of New York filed a lawsuit against a number of big industry players claiming that they illegally shielded themselves from competition with bid rigging schemes. One large brokerage house **settled** their portion of the suit for a whopping $850 million dollars. So, if you want a great quote you need to be aware of the crafty strategies which will be used to secure your renewal.

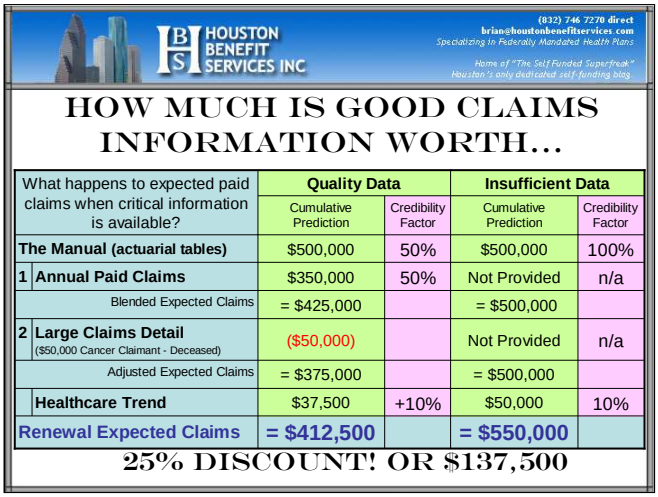
First, insurance companies know that late delivery of renewal information will make the decision to move harder. Renewal information should be delivered about 60-90 days prior to renewal. Second, your insurance company will be reluctant to release information that is easy to understand or evaluate. They often “creatively present” or outright inflate data by using loose definitions of plan components, so it is very to know what the terms used actually mean. The healthcare risk financing industry has also been known to employ undisclosed bonus and commission tactics designed to buy business. Remember commissions increase in proportion to the renewal. Fear tactics & perilous contracts have also been employed to make it very expensive to change administrators. As a result of HIPAA privacy, incumbent carriers also attempt to avoid releasing large claims information citing privacy concerns. The bottom line is that the data belongs to you and it is perfectly legal to use it to obtain a competitive quote.



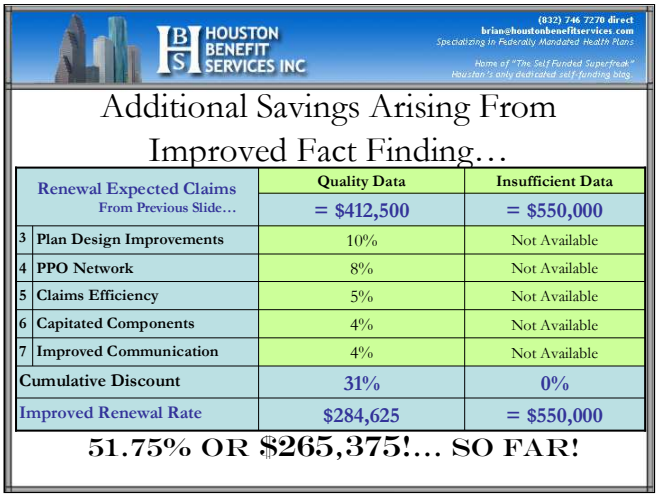
Let's take a look at how quality information affects your quote. The following slides illustrate next years claims projections for the same group in the same year. The amount of **information** available about the group is the only difference between the quality data file and the insufficient data file. The process is simplified but it still illustrates the point. Based on the census alone a manual rate is calculated. The manual rate is almost always higher than the actual spend. In this case, the manual places expected claims at $500,000. (42)However, as mentioned, the quality file contains an annual paid claims report which indicates that the group actually spent $350,000 last year. Larger groups assign less credibility to the manual and more credibility to past experience. Smaller groups are less credible so the underwriter assigns more credibility to the manual than to claims experience. So far, in this illustration, the group that provides last years paid claims report is starting out with a $75,000 risk advantage over the group that doesn't provide this information.



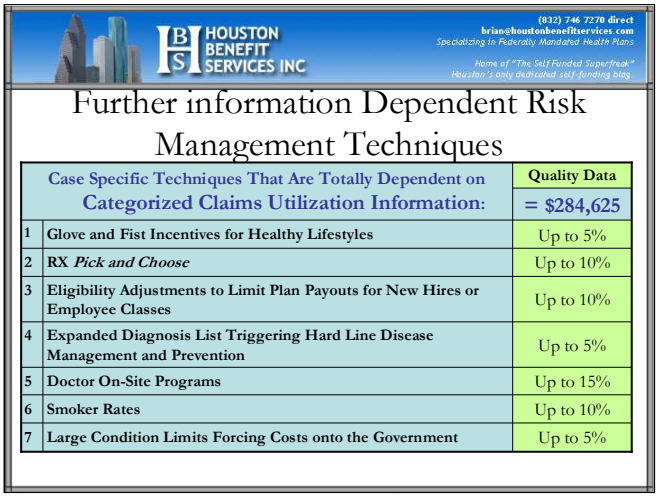
The second piece of information that is provided in the quality file is an updated prognosis and diagnosis report on large claimants within the group. In the quality data file, the underwriter determines that out of the 350k in paid claims last year, $50,000 was spent on a cancer claimant who is now deceased. Therefore, the underwriter gives the quality data file a $50,000 credit resulting in adjusted expected claims of $375,000.



Next he adds an annual trend increase, which for simplicity is projected at 10%… This results in a $37,500 increase for the group with the quality data but $50,000 is added to the quote that has insufficient data. As you can see, these two pieces of information are worth a 25% discount to the plan or a total of $137,500 in savings. Now that alone is valuable information, but there is other information which can be discovered in an appropriate fact finding interview which can save the plan even more.



So far, we've assumed that the group is going to continue doing the same plan the same way which will inevitably get the same results. A good fact finding interview provides the second tier of information dependent healthcare cost controls. So a good fact finding interview to gather more information for the underwriter is conducted with the executive decision makers, during the interview it may be discovered that one or all of the following risk management techniques may be viable cost saving strategies for the group. During the interview it is discovered that the previous plan design was not working well to keep employees economically involved in their healthcare decisions throughout the plan year resulting in over prescribing by the providers, so the employer expressed a willingness to entertain a lower monthly deductible instead of his calendar year deductible which was quickly met by the sickest members of the group, leaving them with no economic involvement for the rest of the year. This plan design results in a 10% discount from the underwriter. Next, it is discovered that the group is willing to change to a smaller network which offers better overall discounts but less coverage than the national network the group is currently with resulting in an 8% credit from the underwriter. It is also discovered that the group is not happy with the claims payment efficiency of the current insurance company. The group expresses a willingness to change to the underwriters preferred TPA resulting in a 5% discount. It is also discovered that the group is willing to outsource their mental health and pharmaceutical benefits to an outside vendor who charges a capitated fee which annually is lower than what the group is currently spending, this results in another 4% credit. Finally it is discovered that the group has not made a quality effort to actively communicate and enroll employees in the plan, as a result many healthy employees have dropped coverage and a new communication effort should attract them back into the plan. The total overall savings that comes from the wise and diligent collection of information places the plan with over 50% savings off the manual quote.



Once the case is moved to a responsive custom plan administrator and information about the groups medical plan utilization is being discovered, other risk management techniques may begin to surface. Again, these risk management techniques are totally dependent on information. The group may decide that a employee wellness initiative is in order and may implement “glove and fist” incentives for healthy lifestyles. Also, the employer may decide that he doesn’t want the cost for brand name drugs to be shared by healthy employees who don’t subscribe to the idea that pills solve life’s problems so he may choose to implement “RX Pick and Choose”. It also may be discovered that new hires and the hourly class of employees are responsible for more than their fair share of the costs. Therefore, the employer may decide to limit plan payouts for new hires or the hourly class. The group may also discover that an expanded diagnosis list triggering a hard line disease management program may be a viable approach. The employer may also want to pay a fixed rate to set up an on-site clinic offering free healthcare to employees and dependents cutting back on absenteeism and ultimately costing less than the services would on the open market. The employer may want to implement smoker/non-smoker rates to collect more money from those who are responsible for more of the costs as a result of their chosen lifestyle. Also the employer may decide to set internal payout limits on large conditions triggering the governmental safety net.

Again, all of these opportunities to save are wasted if the information related to the case is not properly managed.