Policy: Minimally acceptable underwriting requirements for Proposals	Policy No: 02-01-03
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I. Policy: Minimally acceptable Underwriting Requirements for issuing a Proposal

II. Purpose and Scope:

a. This policy standardizes the production of a proposal for medical stop loss, outlining the required data elements needed to generate a bindable rate and factor expressed within the proposal. Data typically originates from the employer's benefits consultant. A proposal is considered bindable for both parties and reflects our offer to bind an insurance policy between the client's captive and the client.
b. The Underwriting department is responsible for preparing proposals. All cases must undergo a Clinical review before Proposal issuance.
c. Clinical Review Protocol, in summary
    1) For Renewals (current client): A clinical review must be conducted before a **proposal** is released to the insured or their designee.
        1. Whether that clinical review occurs before or after starting underwriting work on the renewal offer is irrelevant.
    2) For Opportunities (not a current client): It shall be underwriter discretion regarding whether a proposal should start before or after a clinical review.
        1. An example of when a clinical review may be warranted before a proposal is started:
            a. High frequency of severity claims
                i. **The underwriter shall reference the acceptable Frequency of Severity Limits Policy**
            b. Trigger disease state known for high cost
                i. **The underwriter shall reference the Trigger Diagnosis schedule set forth within the TPA Admin guide.**
            c. When an underwriter's judgment is triggered, a cursory clinical review is warranted.
d. An underwritten rate presented in a Proposal is our offer to bind an insurance policy between the client's captive and the client.
e. The underwriter should invest most of his/her time in preparing a proposal.
f. The primary objective is to assess and manage risk as set forth by the Underwriting Committee.

g. The Underwriters' secondary objective is to produce an output, such as quotation proposals (bindable contracts), build models to predict the future cost of risk, and report to Underwriting Committee Members on past KPI's and opine on the future cost of risk.

h. Data required to start work on a proposal

1) Employee census, to include

Employee name: expressed as full name or first name & last name, or
Some unique identifiers in place of the employee's name
Employee gender: expressed as "M" for male or "F" for female. When gender is not identified by either acceptable label, it shall be assumed to be female "F" for all ages
Employee date of birth: expressed as xx/xx/xxxx or any feasible combination allowing for calculation of the age of the employee on the first day of the policy effective date • If average age of the employee segment of the population is greater than or equal to 50.0 on the first day of the policy effective date, a proposal cannot be issued.
Employee tier election: expressed as any of the following common labels – Single or employee only, employee + spouse or Employee + one, Employee + children, family
Employee plan election: if the employer currently offers 2 or more plans, the plan the employee elects, plus the election tier is required.
Underwriter discretion for items below
Total eligible employees
Dependents of the employee: – (if available) • Gender expressed as M for Male and F for Female. When no gender is provided, the default is Female for all non-labeled genders. • Zip code of covered lives, including dependents (when available) • TAKE NOTE: Dependent participation is an important part of the generation of rates. Our assumptions on dependent population are generally conservative, which translates into an inaccurate or overstated premium and/or agg factor value. The insured should want to get the most accurate valuation possible and, therefore, should want to remit dependents to underwriting.

2) Rating Review, currently self-funded

Aggregate report (current), through the first 9 months
Aggregate report (completed) from the prior period, if self-funded
To show both medical and Rx, a combined report is acceptable, but not desired

3) Rating Review, currently not self-funded

Current: Some indication of premium to claims, month over month
Prior Period: Some indication of premium to claims, month over month
To show both medical and Rx, a combined report is acceptable, but not desired

4) Clinical Review, currently self-funded

Detailed prescription claims, including NDC, drug label, quantity, day supply & plan cost
Pended claims report and/or denied yet payable
Large claim report, 50% of specific claims report
Clinical notes on triggered members. A Triggered member as defined within the TPA Admin Guide
Discretionary items below
Clinical case notes on triggered members
Clinical case notes on members meeting additional clinical questions

5) Clinical review, currently fully insured

Discretionary items below, which may not be available from fully insured
Detailed prescription claims, including NDC, drug label & plan cost at a minimum
Pended claims report and/or denied yet payable
Large claim report, 50% of specific claims report
Clinical notes on triggered members
Clinical case notes on triggered members
Clinical case notes on members meeting additional clinical questions

6) Current, enforce carrier premium (stop loss policy attributes)

Current, enforce Stop Loss policy, or	
	Current specific deductible and lasers
	Current Aggregating specific deductible, if applicable
	Current premiums for specific deductible
	Current aggregate factors and rate(s)

7) Current, enforce carrier premium (fully insured policy)

Current, enforce group insurance policy	
	Current premiums for each tier and each plan

8) Opportunity details,

Business name, full address of corporate office, Industry
Current renewal offer from the incumbent carrier
Desired third-party administrator (“TPA”)
Desired pharmacy benefit manager (“PBM”) and other vendor programs
Desired managed care network or reference based repricer
To whom indications will be delivered to, ie, consultant or insured

9) Coverage details

Specific deductible level requests, up to 3
Desired renewal date
Policy terms, such as 12/12, 12/15, 12/18 (default)
Policy coverage duration, such as 5 months, 9 months, 12 months (default)

Any special requests of the consultant and/or insured
Number of desired tiers (EE, EE+Sp, EE+Ch, EE+Ch(ren), Fam)

III. Procedure

a. All requests for proposals should submitted using the RFP Questionnaire and be sent or forwarded to rfp@completecaptive.com
    1) If a proposal request is sent directly to any other e-mail or other delivery, it should be forwarded/packaged and sent to rfp@completecaptive.com as well as a completed RFP Questionnaire.

b. The underwriter shall perform a high-level review of the data sent to ensure that the necessary information has been submitted.

c. If a cursory review concludes that not enough data was sent to assemble indications, the underwriter shall reach out to the sender and request additional information to satisfy the Minimum Acceptable data points.
    1) Attempts should always be made to obtain enough data to proceed with an underwritten proposal.
        a. Once enough data is obtained, the underwriting team will start work on the requested proposal.
    2) Notification can take form as folder color coordination, file labeling nomenclature, and/or a direct e-mail communication.
        a. It shall not be acceptable to simply verbally communicate to the underwriting team that a request for proposal has enough data elements to warrant either Indications or Proposal
        b. Unless extenuating circumstances occur at the time the RFP was received, it shall be understood that a request for proposal, which satisfies all data elements for Indications, should be delivered to the appropriate sales team within five business days not during busy season. During busy season a proposal/renewal should be delivered within 10 business days.
    3) Conservative assumptions are permitted when data is incomplete, but this situation must be documented.
    4) Underwriting discretion to deny a quote will undergo review and a potential conference with the designated sales representative and an additional leader/executive to address concerns

d. Turnaround Timeline
    1) If all data for a proposal is met, the proposal should be delivered to the Director of Captive Strategies ideally within 5 Business Days during non-busy season and up to 10 business days during busy season.
        1. It shall be the role of the Captive Strategies personnel to stay on top of the Underwriting Department regarding aging incomplete proposals.

e. Busy Season
    1) Let it be known that “busy season” for medTRANS Insurance is generally understood to be the increased workload for the underwriting department

for January 1 renewals. This period starts typically from mid-September through early December.

f. Quote Denial Protocol
    1) Underwriter discretion alone shall not justify a decline to quote.
    2) Quote denials must undergo review with leadership for reasons outside of automatic denials, such as:
        1. Average age greater than 50
        2. Ineligible class of trades

g. Escalation Process
    1) In the event of a dispute or denial:
        1. Escalate to Underwriting Leadership
        2. Coordinate with the Vice President of Captive Strategies
        3. Resolution requires a joint decision with one executive leadership team

h. Compliance and Data Security
    1) All data submissions containing PHI/PII must comply with HIPAA and internal data security guidelines. Secure transmission protocols must be used.

IV. Definitions

a. **Proposal:** A binding offer of coverage terms.
b. **Indication:** A non-binding rate estimate.
c. **Triggered Members:** Individuals whose claims or medications require review due to thresholds.
d. **Clinical Review:** Medical analysis conducted by clinical staff.
e. **Underwriter Discretion:** Judgment applied to non-mandatory data elements.
f. **Conservative Assumptions:** Default estimates used when data is missing (e.g., female gender, high risk tier).

V. Related links and resources

a. Proposal Intake Form
b. Census Submission Template
c. Sample Completed Proposal

VI. FAQ

a. **Q: What if we receive only partial census data?**
   A: Apply conservative assumptions. If insufficient for even an indication, request missing data.
b. Q: Can we quote with assumed PBM pricing?
c. A: Yes, but must be documented clearly in the proposal.
d. Q: What if the average age is unknown?
e. A: Cannot proceed with a proposal unless age can be determined.
f. Q: Can we accept claims reports without member names?
g. A: Yes, as long as enough detail exists to identify high-cost triggers

VII. Responsibilities Matrix

Role	Responsibility
Underwriter	Prepare proposal; apply discretion; escalate when needed
Clinical Team	Perform clinical review; flag potential high-cost members
Client Success Manager	Validate submission, ensure completeness, notify UW team
Captive Strategies	Coordinate with client/consultant receive proposal feedback
Director of Underwriting	Coordinate and participate in escalations as needed

VIII. Exhibits

a. Exhibit A: Trigger Diagnosis list.

Exhibit A: Trigger diagnosis List
medTRANS_Appendix_A_High_Cost_ICD10_Trigger_List.xlsx