UBCM

Union of BC Municipalities

UBCM Group Benefits Plan

TIME TO RENEW

UNDERSTANDING GROUP BENEFIT RENEWALS

Presented in partnership with

George&Bell CONSULTING

PACIFIC BLUE CROSS™

UBCM and Group Benefits

UBCM has managed and administered a group benefits plan on behalf of BC local governments and affiliated provincial associations since 1983. Our mandate is to represent and serve all local governments by being the recognized advocate for their common interests and meeting the members' common needs. UBCM is committed to ensuring that all of our members stay informed on current trends in benefit administration, market factors affecting benefit premium rates, plan design saving opportunities and the different plan types. This article will focus on explaining the benefit renewal process and provides some additional information on Plan Funding options.

1. **Benefit Usage** – Extended health and dental plans are most influenced by the "expected usage" of the plan by your members. How much have the benefits been used? How much dental, extended health (including prescriptions, massage, physio, etc.) have been claimed by individuals in the plan? The past claiming patterns influence future expectations.

2. **Delivery Model** – If we consider the financial performance of a policy being equal, the principles of group benefits state: *the larger the group, the more advantageous financial terms they can obtain*. There are multiple reasons for this, but the main reason is because there are some fixed costs associated with group benefits plans, and when a group is larger the insurance carrier is able to spread out these fixed costs over a larger population base. The UBCM Benefit Plan, for example, allows small and mid-sized local governments to purchase group benefit coverage as a collective, therefore reducing their costs by working together as compared to what they would achieve by themselves.

   The renewal assumption where this is best observed is the Target Loss Ratio ("TLR"). For example, if a TLR is 85% that means for every dollar in premium paid to the insurer, the insurer expects to pay out $0.85 in claims to the employees. The remaining $0.15 is retained by the insurance company for the cost of administering the plan or paid out to the Plan Sponsor's broker in commission. The larger the group the more efficient and higher the TLR which means larger groups pay much lower administrative fees to an insurer.

3. **Demographic Profile** – Income-based benefits such as life and disability insurance rely on a plan sponsor's demographic profile. Characteristics such as the age distribution, gender mix, occupational and industry risk, and insured coverage amounts will determine their likelihood of incurring a claim for one of these benefits *(i.e., mortality and morbidity).*

Underwriters review how a plan sponsor's demographics will evolve since plan inception and incorporate adjustments in their renewal rating to reflect their current risk. In general, this review often means that two organizations of similar size and plan design will have very different premium rates due to the different demographic mixes. Demographics influence extended health and dental benefits as well but they are generally captured in the claims as described above as opposed to explicitly during the renewal analysis.

4. **Trend Factors** – Group benefit costs are expected to increase over time due to general inflation, cost shifting between provincial health coverage and private health coverage, plan usage and fee guides that document the maximum amount an insurer will pay (e.g. dental fee guide). While some of these factors are outside of a plan sponsor's control, you can manage some aspects of cost escalation through your plan design. *For example,* by implementing a managed drug formulary you may be capping your risk of high-cost prescription drugs.
5. **Reserves** – There is an implicit lag associated with group benefit claims. For instance, a member may incur a claim at the end of the experience period but has not yet had the opportunity to submit this claim into the insurance company. To account for these types of claims, the insurance carrier will hold an Incurred-But-Not-Reported reserve that is adjusted each year. Group benefit plans operating on their own can be greatly impacted by the establishment of this reserve when they join a new insurance company. Long term disability plans also provide payment to claimants over many years so the insurer will set up a reserve for those future payments which can be significant depending on the age and benefit level of the claimant.
6. **Large Amount Pooling** – Plans typically have protection for large claims incurred both in and out of Canada. This protection includes a threshold *(e.g.$10,000, $25,000, etc.)* that ensures if an employee claims for an amount in excess of the threshold *(e.g. out-of-country accident, expensive drug claims)* the excess amount goes into a pool and doesn't affect the renewal calculation. This protection can ensure your plan does not experience a significant rate increase as a result of one or two claims. However, premiums are paid for this coverage so a plan sponsor must assess the value of the level of protection they select versus the cost.
7. **Credibility** – The larger your plan is, the more weighting will be placed on your claims experience when setting your rates. For shorter-term benefits such as extended health, or dental, it can be easier to obtain full credibility given the budget able nature of these benefits. For longer term

benefits such as basic life or long-term disability, a plan can require nearly 300 to 500 lives before an insurance carrier will place any credibility on your claims experience.

8. **Prospective Analysis** – A group benefit renewal is a prospective analysis, meaning that premium rates are set to fund your program for future periods. While past claims experience, adjusted for benefit inflation, is generally the best indicator of what is expected to occur in the future, it is not always the case. *As an example*, COVID-19 created service disruptions for dental offices in Spring 2020 and incurred dental claims over this period dropped dramatically. When rates are reviewed for 2021, the claims incurred during this period will need to be adjusted to reflect a more typical claiming pattern or this period will need to be removed from plan consideration entirely.
9. **External Market Factors** – Other factors such as interest rates, changes in government programs (e.g., EI, CPP), changes in claim patterns, and changes in cultural norms (e.g. mental health, chronic health conditions, etc.) also have an impact on the renewal process.

NEXT:
The Renewal Process

The Renewal Process

To ensure strong financial management and governance over their plan and the renewal, organizations should develop a sound renewal process. This process will guide the renewal and establishes the objectives, scope, purpose, risks and timeline. Organizations generally engage an actuarial consultant or will have a broker that represents their interests in the renewal process if they do not have the internal skillsets required.

As an example, UBCM manages this process on behalf of the groups in our program in partnership with our actuary. The actuary will negotiate with the insurance provider to ensure that costs/premiums are distributed in a consistent, unbiased, transparent and accountable manner and will also provide an allocation of benefit premium costs (where required).

Renewals are completed on an annual basis and generally take anywhere from one to three months. The effective date of the renewal depends on the agreement between the insurer and policy holder. Negotiated premium rates for a renewal are based on the renewal factors noted above and include any changes (amendments) that have occurred during the renewal period.

A typical renewal generally includes:

1. **Planning & Preparation**
    a. Actuary requests information from the insurer *(e.g. experience reports for health and dental, etc.)*
    b. Insurer provides the renewal information, reports, etc.
2. **Negotiations**
    a. Insurer provides renewal documents and proposed rates.
    b. Actuary reports to client and begins negotiations as required
3. **Client Review and Approval**
    a. If required, actuary provides cost updates following additional negotiations
    b. Actuary provides rate adjustments as required.
    c. Client reviews rates, seeks clarification if required.

Under the UBCM Benefit Plan, the group business of 130+ municipalities is combined when negotiating with our insurance company to obtain the most advantageous financial terms possible. From there, the aggregate proposal is allocated amongst individual plans in a fair and equitable manner.

Types of Plan Funding

Another factor that plays a significant role in the cost of benefits is your underwriting arrangement *(i.e., your "funding model").* Different types of plans have different funding models, and which type you are in should depend on your own individual factors such as organizational size and risk tolerance.

The main plan funding models are:

1. **Fully Insured Plans (Non-Refund)**
    a. A fully insured (i.e., Non-Refund) arrangement is a "classic insurance" arrangement *(similar to home insurance in principle)* and provides the plan sponsor with the most financial protection. The premium rates are set at the beginning of the plan year and the plan sponsor pays the premium throughout the year. No surpluses or deficits will be reconciled and refunded/charged to the plan sponsor.
    Note: *The UBCM Group Benefits Plan works under this model.*

2. **Self-Insured (Administrative Services Only)**
    a. These plans are uninsured with an arrangement between the plan sponsor and the insurance carrier. In this plan the insurance carrier is not financially responsible for claims and only provides administrative services (receive and pay claims, adjudication, etc.). The organization assumes all liability for the financial results of the plan (if premiums collected exceed actual claims the organization keeps the surplus or if the reverse occurs the organization is responsible for any deficiencies). Larger organizations tend to use this model and are able to manage the large reserve requirements and bear the risk/rewards. Health and dental claims are typically more predictable and therefore many large organizations use this model for their health and dental.

3. **Refunding Accounting**
    a. These plans are a hybrid between the two models above whereby the plan is insured but there is an annual reconciliation at the end of each year. If the premiums were insufficient to fund the cost of claims, expenses, and reserves a deficit is declared which is generally paid off by the plan sponsor over time.

b. If the premiums were in excess of the cost of claims, expenses, and to fund reserves, that surplus may be returned to the plan sponsor. This arrangement is not overly common, but it does allow for plan sponsors to share in the risk with fully accepting the risk.

Additionally, there are some hybrid funding models available in the market.

These arrangements can provide value to plan sponsors at times, but many are used as sales strategies for advisors which can result in negative outcomes for plan sponsors if not well understood at the onset.

In Summary

Salaries and benefits represent a significant cost to an organization. Understanding how your benefit premium rates are calculated each year and the type of plan you participate in will ensure that you make informed decisions at renewal time.

With 30+ years in benefit administration, UBCM is here to answer your questions, offer assistance and advocate on behalf of all of our members.

Please Contact **UBCM Group Benefits** at: groupbenefitsplan@ubcm.ca.

UBCM Group Benefits Plan

SCAN ME

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