Purpose

The purpose of the PRISMHealth Underwriting Guidelines is to provide process and guidance pertaining to the general criteria applicable to the approval of new program members. The PRISMHealth Committee oversees the provisions of the Guidelines and may recommend changes from time to time.

Underwriting Approval Process. The PRISMHealth Committee has established a policy on the approval of new members. This policy outlines the member evaluation review that is followed prior to being presented to the Committee for consideration. Member evaluation is conducted by Alliant Underwriting Services (AUS) based on the established underwriting guidelines. Based on the initial review, AUS makes a recommendation for assignment of the new member into the large or small member segments of the PRISMHealth Program. The exception to this process is when a prospective member specifically requests to be considered for a member segment in which they may not meet the basic guidelines. Recommendations into the large member segment are reviewed by the Committee as a new member application, with the Committee having final decision for approval or declination of member program participation, based on preliminary analysis. The Committee has delegated authority to staff and AUS to approve all new members in the small member program segment.

Approval of New Members in Consecutive Years of Application
Prospective members often apply to join the PRISMHealth Program, are approved by the PRISMHealth Committee, but do not join the Program for the approved participation year. In subsequent years, the prospective member may submit another application to join the PRISMHealth Program. Provided the members' enrollment does not change by more than 15%, their risk profile remains the same and they still meet the Underwriting Guidelines as outlined below, PRISM staff and AUS are delegated the authority to approve the members upon review of the AUS analysis. This delegated authority is applicable for two (2) years following the most recent approval from the PRISMHealth Committee and reportable to the PRISMHealth Committee, under the Consent agenda item, at the Committee meeting following the approval. PRISM staff and AUS reserve the right to present any prospective member to the Committee for approval regardless of last approval date.

1. Eligibility & Underwriting Guidelines

The following PRISMHealth Program Eligibility and Underwriting Guidelines address the detailed criteria that is considered for the PRISMHealth Program membership. While most items pertain to both large member and small member program segments, there are a few areas in which the criteria differs and those are clearly noted.

The PRISMHealth Program is comprised of large and small member segments. These segments have been established to reflect the general number of employee/retiree lives taken into consideration when evaluating the risk. The member

size segments, as outlined in the table below, ***are meant to be a guideline for segment placement***, but are not the only consideration when evaluating a member. All aspects of the program underwriting guidelines are reviewed by AUS and can differ when a prospective member makes a specific request.

Eligibility (Large and Small member segments)

Active Employees	Full-time salaried or hourly employees who are actively at work at least 30 hours per week.
Part-Time Employees	Part-time employees who are actively at work at least 20 hours per week.
Dependent Eligibility	Eligible dependents are covered to age 26 and will terminate coverage first of the month following 26th Birthday. Disabled dependents are covered regardless of age but must be approved by the plan administrator (claim fiduciary medical management) prior to annual enrollment.

COBRA Participants	Eligible to elect coverage through COBRA.
Board Members, Trustees, Council Members, or Other Elected Officials	Directors, board members, and other elected/appointed officials can only elect plan if they are eligible on the current plan and are subject to the same requirements as Active employees. Exceptions can be made at the recommendation of AUS and disclosure to PRISM staff and PRISMHealth Committee.
Retirees	To qualify for Medicare plans and rates, retiree must be enrolled in Medicare Parts A&B.
	Retired employees who are currently eligible and participating on the plan will be eligible to continue coverage under the Program, if the coverage permits. Retirees who declined coverage may not enroll in any coverage at a subsequent enrollment date.
	Medicare eligible retirees must enroll in Medicare parts A&B.

Underwriting Guidelines

Total Eligible Population	**Small Member Segment** Minimum: 2 Maximum: 200 **Large Member Segment** Minimum: 100* Maximum: None *Member specific size and plan requirements will be evaluated when assessing program member applications and determining the most appropriate PRISMHealth participant segment.
Participation Guidelines	

Total Eligible Population	Minimum participation of 75% of all eligible population Non-Medicare Retirees should be thoroughly reviewed by AUS if they exceed 20% of the total covered population. Exceptions can be made at the recommendation of AUS and with the approval of the PRISMHealth Committee.
Employer Contributions	
Contributions should be structured to allocate cost for tiers with dependent coverage. Cash-Back or "Cash-in-lieu-of" employer contributions are not permitted. • Exceptions for Small Member Segment can be made with approval from AUS. • Exceptions for Large Member Segment can be made at the recommendation of AUS and with the approval of the PRISMHealth Committee.	
Active Employees	Minimum 75% of single-only cost, 50% suggested contribution for dependents.
Retirees	No minimum employer contribution.

Waiting Period	
Date of hire is not allowed unless date of hire is on the first of the month. All plan changes resulting from Qualifying Events will be effective on the first of the month following the event. Births and deaths are exceptions and coverage may be added/dropped outside of the first of the month following.	
Waivers	
Coverage can only be waived with proof of coverage through spouse, other group coverage, Medicare/Medical or COBRA. Waivers should be reviewed by AUS if they exceed 25% of the total covered population. Exceptions for the large member segment can be made at the recommendation of AUS and with the approval of the PRISMHealth Committee or PRISM staff. Non-Program participants are excluded from this waiver definition (i.e., union carve-out).	
Plan Selections, Combinations, and Other Programs	
Plan Selection	**Subject to underwriting review and approval:** • 2-100 enrolled lives: 2 plans + 1 Kaiser plan • 101+enrolled lives: standard is 3 plans + 1 Kaiser plan; Current plan structure will be reviewed and approved via the Underwriting process and disclosed to the PRISMHealth Committee
Plan Combinations	• 2-100 Only one HMO or HDHP plan may be offered (excludes Kaiser) • 101+ Two or more HMO or HDHP plans require underwriting approval (excludes Kaiser) • Current plan structure will be reviewed and approved via the underwriting and renewal process
Other Programs	• The PRISMHealth Program will be offered to all agency represented and non-represented employees in most situations. • The PRISMHealth Program will consider approving a member to enter the program with its entire employee/retiree population OR with one or more segments of the represented or non-represented employee population. • All carve-out proposals must be approved by Alliant Underwriting Services and presented to the PRISMHealth Committee for consideration during the New Member Application approval process.

	• Alliant Underwriting Services must be able to evaluate the entire member population, including any proposed carve-out population, for compliance with all other Underwriting Guidelines (i.e., employer contribution, participation, retiree enrollment, etc.). • If a member enters the program with less than their entire population, additional segments of the employee population may be added in future years assuming underwriting guidelines are met. • A member may only exit the program as a total population. No population carve-outs of existing employee groups will be allowed once a member has entered the program. • The PRISMHealth Program will consider the option for employers to offer a Medicare Advantage plan(s) alongside other options offered to Medicare-eligible retirees and dependents. The in-force Medicare Advantage plans and enrollment will be reviewed and approved via the Underwriting process and disclosed to the PRISMHealth Committee.

Lock-out and Lock-in period
As outlined in the PRISM JPA Agreement, large group members that withdraw from the Program are not allowed to return (re-apply) to the Program for a period of three (3) years. Additionally, once a member joins the PRISMHealth Program, they must remain in the Program for a period of three (3) years. Small segment members will comply with the withdrawal and termination rules of the JPA in which they contract for coverage.

2. Rating Methodology

As a fully-pooled risk arrangement, PRISMHealth is underwritten and renewed as a single pool. The pool is self-funded internally for non-Kaiser plans, but member groups receive a fixed rate. Kaiser remains fully insured. This means the pool takes all the risk and over time, each individual member group is shielded from higher-than-average rate increases.

For new members entering the pool, they are guaranteed to receive the 'pool' renewal for a specified period of time. This means that regardless of the members actual losses they are guaranteed to get the pool renewal for a specified period. Given the pool's historical renewal performance this often works in the members favor. Below is a breakdown of how members are rated.

Experience Rated Members: (All products HMO/PPO - were experience rated)

- 1st PRISMHealth Renewal: Pool average increase
- 2nd PRISMHealth Renewal: Pool average increase
- 3rd PRISMHealth Renewal and beyond: Pool average increase + Eligible for up or down CPRA Adjustment every other renewal year
- Members will be experience rated if the experience data is complete as requested in the program's RFP forms and if it is deemed credible / sufficient

to base PRISMHealth rates on. This means that a prospective member can still end up being manually rated even when experience data is available.

Manually Rated Members: (All products (HMO/PPO) were manually rated)

- 1st PRISMHealth Renewal: Pool average increase
- 2nd PRISMHealth Renewal and beyond: Pool average increase + Eligible for up or down CPRA Adjustment every other year

Combination Rated Members: (One of the products is experience rated and the other product is manually rated)

- Based on where the majority of enrollment lies (i.e., majority experience rated or majority manually rated)
- Above methodology applies

After the guarantee period, the member receives the pool renewal but they are also eligible for an adjustment based on their own performance every other year, this methodology is called the Claims Performance Risk Adjustment (CPRA).

The CPRA is an algorithm developed to adjust an individual member's renewal when their loss ratio may be consistently better than, or worse than, the pool average. Once a member becomes eligible for a CPRA adjustment, the model calculates whether or not an adjustment from the pool average renewal is actually warranted and, if so, what that adjustment should be. The final results are then reviewed by underwriting and actuarial to ensure the CPRA intent is being properly executed.

The CPRA looks at the following metrics for each member:

- **Loss Ratio:** the CPRA uses up to three years of loss ratio data for each member and uses a weighted average
- **Loss Ratio Variance:** The CPRA looks at the member's weighted average loss ratio and compares it to the pool's weighted average loss ratio and generates a variance value.
- **Member Size:** The member size is used to determine a Safe Harbor Corridor for each member. Smaller members have a larger Safe Harbor Corridor while large members have a smaller corridor. This supports the underwriting philosophy that large members are more stable and require a smaller Safe Harbor Corridor while smaller members are less stable and require a larger corridor.

Triggering an adjustment: If the Variance Value is within the Safe Harbor Corridor, no adjustment is triggered. If the variance value is greater than the Safe Harbor Corridor an adjustment is triggered. The amount of the adjustment is the difference between the

variance and the Safe Harbor Corridor, up to 7.5%. The PRISMHealth Pool Renewal and Member Specific Renewals are approved annually, adjustments or changes cannot be made without the majority approval of the PRISMHealth Committee.