Small Group Underwriting Guidelines for Brokers

(Groups of 2-50)

Independence Blue Cross Underwriting Department

Applies to groups effective or renewing on or after 1/1/2014

Independence

Contents

Eligibility and enrollment requirements

Please note: *The guidelines listed in this document are internal policies and are not intended to be a description or summary of applicable laws. These guidelines are applicable to new and renewing customers. IBC reserves the right to decline to quote new business groups or to terminate a group at renewal that is not in compliance with the underwriting guidelines. Any termination will be in compliance with the federal Patient Protection and Affordable Care Act (PPACA).*

IBC/Keystone Health Plan East service area	• Greater Philadelphia Five County Area: Philadelphia, Bucks, Montgomery, Chester, and Delaware • Contiguous Counties (counties that border the five counties): Warren, Northampton, Lehigh, Berks, Hunterdon, Lancaster, Mercer, Burlington, Camden, Gloucester, Salem, New Castle, and Cecil. • 5 county rating area for PA is rating area 8, per new federal geographical requirements.
Group location requirements	• The employer must be located within the Greater Philadelphia five-county area, as defined above. • No more than 50% of the enrolled employees can be located out of the service area (applies to renewal business only; exceptions must be reviewed by Underwriting and Marketing management). • Group members enrolling in HMO/POS coverage must reside within the IBC service area. • Group members who live in non-contiguous counties and have HMO/POS coverage must be covered under and issued booklets by an affiliate of IBC.

Participation requirements (eligible employees)	• Groups of 2-50 must have a minimum of 70 percent participation.
	• IBC and affiliates must be sole carrier
	Valid waivers:
	  • Employees with group coverage through IBC subsidiaries (coverage through an individual "direct pay" plan is not a valid waiver) , Medicare or Medicaid, Veteran or other government issued coverage;
	  • Employees covered through their spouse;
	  • Employees covered as an eligible dependent to age 26, in accordance with federal Patient Protection and Affordable Care Act;
	• For groups covering retirees, 100 percent participation is required for retired employees and at least 70 percent of the active employees must participate.
	• Early retirees (under age 65 retirees not eligible for Medicare) cannot represent more than 10 percent of the total group enrollment. Retiree-only groups will not be accepted.

Employer contribution requirement	• For contributory plan offerings, the employer must contribute a minimum of 25 percent of the calculated gross monthly premium.
Coverage classes	• Definition: Distinct categories (classes) within the group, where these classes will receive different levels of health care coverage. • Classes must be determined by conditions relating to employment; must be clearly identifiable; and must exist for purposes other than insurance risk (for example, union/non-union, salaried/hourly, full time/part time). • Excluding a class from coverage within a group is **not** permitted. • Existing accounts may not split into multiple accounts to obtain multiple benefit levels.

	Qualifier: Subject to the above conditions, IBC will comply with the coverage classifications requested by the customer, **but approval of such request is not a representation by IBC to the customer that the requested classifications comply with applicable laws/regulations.** The customer should consult with its own legal counsel or tax advisor to determine if the coverage classification is permissible under applicable laws/regulations.

Employee eligibility	• Eligible employees include all active employees and owners or partners actively engaged in the business who:
	  • Are deemed benefit-eligible according to the employer;
	  • Meet all requirements as defined in the carriers' plan documents and fulfilled any authorized waiting period requirements; and
	  • Reside or work in the applicable service area.
	  • To minimize adverse risk selection it is recommended that employees work at least 25 hours per week.
	• **Off-cycle adds:** Employees who initially waive coverage because they are covered under a spouse's medical plan may be added off-cycle to the group's benefit plan upon the occurrence of a life event (for example, spouse's employment is terminated).
	• **Probationary Period:** In accordance with PPACA laws, employee probationary periods cannot exceed 90 calendar days from the hire date.

Dependent eligibility	• Employee's spouse
	• Dependent children of the employee (natural, adopted, under legal guardianship or court-ordered custody), as defined in plan documents and in accordance with state and federal laws, are eligible for coverage up to age 26.
	• At employer's request, medical coverage for dependent children may be extended to age 30, if the dependent child meets the following criteria: (*Pennsylvania State Law*)
	  • Is not married and has no dependents (need not be a full-time student);
	  • Is a resident of the Commonwealth of PA or enrolled as a full-time student in an institution of higher education;
	  • Is not provided coverage under any other group or individual health plan, including eligibility for any government health care benefits program.
	• Overage handicapped dependent children who, in the judgment of IBC, are incapable of self-support due to mental or physical incapacitation (coverage will terminate upon marriage of the dependent).
	• Individuals cannot be covered as an employee and dependent under the same plan, nor may children be eligible for coverage through both parents and be covered by both under the same plan.
	• Domestic partners, only if the employer elects this designation at contract effective or renewal date (See Domestic Partner Coverage criteria below).
	• Dependents must enroll in the same benefit option as the employee.

Domestic partner (DP) coverage	• DP coverage may only be added or removed on group's anniversary date. • Must be offered by all in-force carriers in order to add to the IBC/KHPE coverage. • Must be added to all groups within an affiliation. • Must be added to all lines of business – separate group numbers not permitted. • Domestic partners cannot be covered retroactively.

COBRA and Pennsylvania State continuation coverage (referred to as mini-COBRA)	• COBRA coverage will be extended in accordance with the federal law. • Employers with 20 or more employees (full/part time) are eligible to offer COBRA coverage. • Employers with less than 20 employees (full/part time) are eligible to offer mini-COBRA coverage. • The number of enrollees in COBRA and/or Pennsylvania mini-COBRA coverage is limited to 10 percent of the group enrollment. • Note: COBRA/Mini-COBRA members are not to be included for purpose of counting employees to determine the size of the group. Once the size of the group has been determined, and it is determined that the law is applicable to the group, COBRA/Mini-COBRA members can be included for coverage subject to the normal underwriting guidelines.

Employer eligibility	• An employer must employ on average at least one **but not more than 50 employees, including full-time and full-time equivalents (FTEs)** on business days during the preceding calendar year.
	• All persons treated as a single employer under specified sections of Section 414 of the Internal Revenue Service Code shall be treated as one employer.
	• New group applicants not meeting this definition of a small employer are not eligible for group coverage under the Small Employer plans. The following groups do not meet the definition of small employer:
	  • As of January 1, 2014 employee and spouse (including same sex marriage, civil union and domestic partners) only businesses are no longer eligible for small group coverage, unless the business is organized as a C Corporation (Please note: Spouse is excluded from the federal definition of employee).
	  • Owner only groups, where there is not at least one common law employee; this includes partner only groups.
	  • Groups comprised of immediate family members only (e.g. father and son groups), where there is not at least one common law employee.
	• Organizations must not be formed solely for the purpose of obtaining health coverage.
	• A group of one is permitted, provided that the group consists of *one* owner and *one* employee but only the employee is being offered coverage.

Common ownership affiliation (two or more companies affiliated or associated)	• Employers who have more than one business with different tax identification numbers (TINs) may be eligible to enroll as one group if the following criteria are met (combined arrangements will not be quoted until sufficient proof of ownership is provided, as outlined below):
	  • One owner, either a single person or business entity, has controlling interest (greater than 50 percent interest) of all businesses to be included.
	  • Provides proof of ownership (acceptable proof includes copies of IRS Forms 851, 1065 - Schedule K-1, or SS4 – Application for Employer ID, and/or a copy of latest federal tax return -- all businesses filed under one combined tax return must be enrolled as one group).
	  • Provides UC2A Employer's Quarterly Report of Wages for each entity and combined census with all eligible from all entities.
	  • Must have common policymaker legally authorized to make benefits decisions for the combined business.
	  • Letter from the employer indicating desire to combine the commonly owned entities
	  • Subject to underwriting review and approval on case-specific basis.
	  • Also applies to existing groups wishing to add new businesses under common ownership arrangement (i.e. acquisitions, mergers).
	  • Once common ownership is established and premium rates are provided, the rates must

be accepted as presented.

- Common ownership groups may later be separated for group coverage only when based on verifiable legitimate business reasons.
- If employer later elects to cover one or more of its businesses through another carrier, the remainder of the group will be subject to cancellation (applies to renewal business).

Product regulations and requirements

Benefit plans available

- Blue Solutions for small employers portfolio (Medical product integrated with Drug and Vision benefits)
- HSA- qualified high-deductible products – with integrated drug
- Adult dental product

Quoting Policy

- Maximum Product Offerings:
  - Small groups are allowed a maximum of three complete packages (medical with drug, pediatric and adult vision, and pediatric dental benefits).
  - If a second package is offered, *we recommend* it be within the same metallic level or one level above or below the first package offered.
  - Medicare products are not counted toward maximum number of products.
- For groups with out-of-area (OOA) employees:
  - If a group is offering a PPO plan for out of area enrollment, the PPO benefit level must be equivalent to the benefit plans offered to the in area employees. Group offerings may not exceed three plans, including an out-of-area PPO coverage.

Rating Structure

- All small group medical, prescription drug, vision and dental plans will be calculated on a member-level build-up rating structure.

Existing Groups with non Blue Solution PPO, HMO, or POS plans

- Small Group offerings are limited to the Blue Solutions product suite. Existing groups of 51 or more that qualify and transfer to the small group segment must select from the small group Blue Solutions product suite.

Mandated benefits	• Definition: Benefits that are required to cover the treatment of specific health conditions, certain types of healthcare providers, and some categories of dependents, such as children to a certain age. Health care benefits may be mandated by state and/or federal law.
	• Examples of mandated benefits and how they are implemented for IBC health benefit plans:
	  • Autism benefit:
	  • Components of the Autism benefit are included in all Essential Health Benefit products for small group.
	  • Mental Health and Substance Abuse (MHSA) Parity benefit:
	  • As a part of the ACA requirement, Mental Health and Substance Abuse Parity benefit will be included in all small group Essential Health Benefit products.

Benefit Plan Changes	• Small groups will not be permitted to change benefits until their anniversary date.
Collective bargaining/ union agreements	• Collective bargaining/union agreements will not be honored due to the Patient Protection Affordable Care Act federal guidelines.

High deductible health plans (HDHPs), including HSA-qualified HDHPs	• Definition:
	  • HDHP – Any plan with an in-network deductible of $500 Single/$1,000 Family or higher.
	  • HSA-Qualified HDHP – Plans must follow prescribed federal guidelines and requirements, which are updated annually by the IRS.
	• Guidelines for funding deductibles:
	  • Per the Affordable Care Act regulations, employers should not fund more or less than the federally mandated standards for funding employee deductibles.
	  • The high deductible plan design selected will specify the funding requirement; please refer to each plan design for specific funding requirements.
	• An HSA-qualified HDHP may be offered along with other products, up to the maximum plan offerings (dual plan options) for the size of group.
	• HSA-qualified HDHPs: Health Savings Account (HSA) regulations have distinct requirements for prescription drug coverage. Federal requirements for HSA-qualified HDHPs do not allow a separate prescription drug program (or rider) to provide benefits before the HDHP annual deductible is satisfied; therefore, if a plan provides any prescription drug benefit before the annual deductible is met (except in the case of preventive drugs), it is not a qualifying HDHP for a Health Savings Account.

Health Reimbursement Account (HRA)	• An employer funded account used to reimburse employees for qualified medical expenses.
	• May be offered only:
	  • On group's anniversary date;
	  • With a Flex Deductible medical plan option (prescription drug plan selection will follow high-deductible plan rules.)
	• Employer should not fund more or less than the federally mandated standards for funding employee deductibles.
	• Only one HRA option per customer.

Health Spending Account (HSA)	• A tax-exempt trust or custodial account created to pay for qualified medical expenses of the employee and their dependents. • Available only with a federally qualified high deductible health plan (HDHP) with integrated prescription drug benefit. • Groups adding or changing to an HSA-qualified plan with a contract year benefit period may change anniversary date, which would apply to all products.
Consumer-driven health care tool kit	• For more information on HRAs and HSAs, connect to the consumer-driven health care tool kit on the IBC website at http://www.ibx.com/broker_group

Blue Solutions Choice Defined Contribution Products	• **Defined Contribution**
	  • For defined contribution products employers contribute a defined amount towards the employees' premium. The employee is responsible to pay the remainder of the premium after the employer contribution.
	  • The employer can offer multiple defined contribution products from the defined contribution product portfolio to its employees.
	  • The defined contribution products are available to groups of 2-50 enrolled (new and existing business).
	• **Maximum Product Offerings:**
	  • Five defined contribution products
	• **Defined Contribution Product Guidelines:**
	  • The Blue Solutions Choice product for groups of 2-50 is packaged with prescription drug, pediatric and adult vision and pediatric dental.
	  • If the employer decides to offer Vision, Drug, or Dental coverage with defined contribution products, Vision, Drug, or Dental must be offered with all defined contribution products offered by the employer.
	  • Employers may not offer the same defined contribution product with different drug, dental and/or vision products.
	  • Defined contribution products cannot be combined with coverage options from non-defined contribution products.
	• **Employer Contribution Requirement:**
	  • For contributory plan offerings, employers must contribute a minimum of 25 percent of the lowest cost options gross monthly premium.
	• **Off-Cycle Benefit Changes:**
	  • Upgrades and downgrades to defined contribution products will be allowed only on anniversary.
	
	Note: *Other than the specific guidelines for defined contribution products described in this section, the Small Group Underwriting Guidelines generally apply to defined contribution products.*

Rating information

Rating programs	• For new and existing groups, applicable rating methodology will be as defined by the federal Affordable Care Act guidelines.
Underwriting for small groups	• Definition of Small Group New business and Renewal rating: As allowed under the Affordable Care Act, groups will be given community-based member level rates adjusted for the following factors: age, tobacco status, family size and employer geography.
Changes in group size – effect on rating	• The employer is responsible for notifying IBC if the employee count has changed from small employer to mid-market, or vice versa. • If an employer group was previously rated as mid-market and drops below 51 total employees at renewal, the employer group will continue to be rated as mid-market and retain the Mental Health Parity and Autism mandated benefits until proof is submitted confirming they no longer have 51+ total commercial employees. • Retroactive changes in rating methodology will not be permitted. If an employer group was renewed as a small employer and subsequently informs us that their employee count was 51+, the renewal rates would stand until the next anniversary date. • Employer groups can only change from small employer to mid-market or vice versa on anniversary date.
Change in Anniversary	• Request to change a group anniversary will be allowed only for valid business reasons such as: – Consolidating Businesses – Merger – To align with an anniversary for other lines of business • Proof of valid business reason is required. • Requests must be received at least 90 days in advance of the group's current anniversary. • Underwriting approval is required for request to change a group's anniversary date.
Rate quote submission	Most rate quote requests can be submitted through the ROAM system, but there are situations requiring submission through the IBC account executive.
Situations requiring rate quote submission through IBC account executive	**Existing business:** • A change in anniversary date – Documentation Required: Letter from employer (on customer letterhead) • A material change in the census (for example, purchasing a new entity) – Documentation Required: Proof of common ownership (see "Common Ownership" rules under *Eligibility Requirements* section of this document – Requires approval by Underwriting • A change in location of the group or employees.

	• Non-standard requests not viewable as alternatives to renewals on ROAM.
Documentation required when submitting a rate quote request	**Existing business – employers with 2-50 employees:** • Requested plan design • If adding new contracts totaling more than 10 percent of existing population, refer to "new business group" requirements outlined below. **New business - employers with 2 to 50 employees** • ***Step 1:*** Broker will submit the following group census information through ROAM to receive an initial sample rate based on group characteristics. **Group census for all eligible employees, dependents and COBRA participants, to include:** • Employee name (surname required) • Date of birth (MM/DD/YYYY) • Gender • Relationship to employee • Waivers (eligible members not electing coverage because they are covered under another plan) • Opt-outs (eligible employees not electing coverage and who are not covered under another plan) • Zip code (if available) • Tobacco status
Open Enrollment 2014	• As mandated by the PPACA, the open enrollment period for small group will begin October 1, 2013 through March 31, 2014. • Participation requirements will be waived for group applications and renewals received during the period of November 15, 2013 to December 15, 2013 (only applies to 1/1 effective dates). • A quote request must be submitted at least fifteen days prior to the quote effective date (i.e. for coverage effective 1/1/2014, the group application must be submitted on or before 12/15/2014). ***Note:*** All other small group guidelines listed in this document will apply.
Right to decline to quote	• Subject to applicable federal and state laws, IBC reserves the right to decline to quote any group deemed to be in violation of our underwriting guidelines. Such a decision will not be based in any way on the medical condition of the group's members. • IBC reserves the right to perform periodic audits to assure continued compliance with the Underwriting Guidelines.

Post-sale submission requirements

Post-sale enrollment requirements	• Rates quoted are conditional pending receipt, review and acceptance of the standard submission requirements. *All offerings are subject to final underwriting review and acceptance. Additional guidelines and policies may apply*

Documents required with group submission	The following documentation must be provided for consideration:
	• Application for New Employer Health Benefits (front and back)
	• Universal Enrollment Forms (one for each employee enrolling)
	• Rate Quote
	• First month's premium check(s)
	• Most recent PA UC2A Form (Unemployment Compensation Tax Form)
	• Small Employer Certification (front and back) – required for newly-formed or family-owned business when a PA UC2A form is not available.
	
	Employers that do not have/file a UC2A because they are a newly formed company, family-owned business, or a non-profit entity, must provide **one proof of business *and* one proof of employment** from the list below. Documentation should confirm that the business is active and the location of the business:
	
	• **Proof of business: (provide one)**
	  • Current business license (not a professional license)
	  • Corporate Tax Form (Form 1120)
	  • Partnership agreement, articles of organization or articles of incorporation
	  • Official document with Employer Identification Number/federal tax ID number
	  • Federal Form 990 or IRS Exemption letter (for non-profit entities)
	AND:
	• **Proof of employment: (provide one)**
	  • Payroll record (Paychex, ADP, etc.)
	  • W-2 for all employees
	  • IBC Eligibility Form for Owners/Partners completed and signed by each owner/partner (requires tax documentation)
	  • Letter from Certified Public Accountant listing the names of all employees (full and part time), number of hours worked each week, dates of hire and weekly salary.

Group terminations and reinstatements

Termination process	• Any terminations will be in compliance with the federal Patient Protection and Affordable Care Act. • Employer may terminate coverage on contract anniversary date, with at least 30 days' advance written notice to IBC. • IBC may terminate the group's coverage for nonpayment of premium, upon written notice, effective the last day of the 30-day grace period. • IBC reserves the right to terminate a group's coverage off-anniversary if the group fails to meet IBC's underwriting guidelines, including but not limited to minimum participation requirements.
Terms and conditions upon termination of coverage	• The employer is responsible for all due but unpaid premiums. • When active group is terminated, all COBRA groups and Medicare groups (including Medicare Advantage) must also be terminated – COBRA-only or Medicare-only groups are not allowed. • Groups terminating to purchase individual coverage will not be eligible for group coverage for 12 months from the date of termination. • Any terminations will be in compliance with Patient Protection Affordable Care Act regulations.
Reinstatement of coverage	• Applies to groups terminated from coverage due to nonpayment of premium. • Reinstatement must occur within 60 days of the effective date of cancellation. • Must be retroactive to the cancellation date. • Groups that have been terminated for non-payment by IBC will not be eligible to reapply until: (1) All outstanding financial balances are paid in full; and (2) payment of six months of premium in advance of issuance of health benefits plan. • Upon satisfaction of the above conditions, IBC Underwriting will review the case and make a final determination whether or not to approve reinstatement and applicable rate level. • Limited to one reinstatement per year. • Reinstatements will be in compliance with Patient Protection Affordable Care Act regulations.
Former IBC coverage	• Groups returning within 12 months of termination date will be deemed as "renewal" business and therefore subject to participation and contribution requirements. • Returning groups must be in compliance with the underwriting guidelines prior to coverage being issued.

Guidelines for Small Business Health Option Program (SHOP) Groups

This section applies to groups that elect to purchase IBC SHOP products. Other than the specific guidelines for SHOP products described in this section, the Small Group Underwriting Guidelines generally apply to these groups.

Product Offerings:

Groups are allowed ***one*** pre-packaged plan which includes medical, prescription drug, and pediatric and adult vision benefits.

Off-Cycle Benefit Changes:

- Benefit changes and employee contributions may only be changed at the time of your annual open enrollment period as defined by the federal Patient Protection Affordable Care Act (PPACA).

Small Business Tax Credits:

- Small Business Tax Credits may be available to small groups who qualify.
- Small groups who plan to claim the Small Business Tax Credits must complete a SHOP health coverage application and submit it to the Health Insurance Marketplace. An official eligibility determination from the SHOP Marketplace is required in order to claim the Small Business Health Care Tax Credit.

Submissions Deadlines:

- For customers purchasing SHOP plans, all paperwork required for group implementation must be received by IBC a minimum of 30 calendar days prior to the effective date. Please see grid below:

Deadline for Paperwork	Earliest Effective Date of Coverage
April 1, 2014	May 1, 2014
May 2, 2014	June 1, 2014
June 1, 2014	July 1, 2014
July 2, 2014	August 1, 2014
August 2, 2014	September 1, 2014
September 1, 2014	October 1, 2014
October 2, 2014	November 1, 2014
November 1, 2014	December 1, 2014

Note: *Customers should allow sufficient time for mailing in order to meet the deadline for required paperwork. Coverage for groups enrolling in SHOP plans may only be effective on the first of the month.*

Audits:

Groups that purchase SHOP products will be subject to a concurrent or post-enrollment audit to ensure all underwriting and federal compliance guidelines are met.

Benefits underwritten or administered by QCC Insurance Company, a subsidiary of
Independence Blue Cross — independent licensees of the Blue Cross and Blue Shield Association.

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