Mid-Market Underwriting Guidelines for Brokers (Groups of 51-99)

Independence Blue Cross Underwriting Department

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

This document is for informational purposes only and is not intended to be all inclusive. Independence Blue Cross (IBC) reserves the right to change these underwriting guidelines without notice as IBC, within its sole discretion, believes necessary to comply with federal and/or state law or as required by federal and/ or state regulatory agencies. IBC has the sole discretion and final authority to interpret the scope and application of the underwriting guidelines. These guidelines supersede any previously released guidelines.

Independence

Contents

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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 apply rate adjustments for new business customers not in compliance with the Underwriting Guidelines. Renewing customers not in compliance with the Underwriting Guidelines may be subject to rating adjustments or possible termination of the group contract. This applies to pre or post sale and renewal business.

Eligibility and enrollment requirements

IBC/Keystone Health Plan East (KHPE) 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.
Group location requirements	▪ The group must be located within the Greater Philadelphia five-county area, as defined above. ▪ 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. ▪ Group members enrolling in HMO/POS coverage must reside within the IBC service area.
Group participation requirements (eligible employees)	▪ Minimum 75 percent participation ▪ 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 the group must consist of a minimum of 75 percent active employees. Retiree-only groups will not be accepted. ▪ Participation audits: IBC reserves the right to perform periodic audits to assure continued compliance with the above requirements.
Employer contribution requirement	▪ For contributory plan offerings, employers must contribute a minimum of 25 percent of the calculated gross monthly premium or 75 percent of the single-tier rate for each plan offered.
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 within a group from coverage is **not** permitted. ▪ Existing groups may not split into multiple groups to obtain multiple benefit levels. ▪ Qualifier: Subject to the above conditions, IBC will comply with the coverage classifications requested by the employer, **but approval of such request is not a representation by IBC to the employer that the requested classifications comply with applicable laws/regulations**. The employer 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; and – meet all requirements as defined in the carrier's plan documents and fulfilled any authorized waiting period requirements; and – work at least 25 hours per week; and – reside or work in the applicable service area. – In accordance with the PPACA laws, employee probationary periods cannot exceed 90 calendar days. ▪ **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).
Dependent eligibility	▪ Employee's spouse (if both husband and wife work for the same company, they may enroll together or separately.) ▪ 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.
Changes in employee or dependent eligibility criteria	▪ Definition: Employer-initiated requests to change group's eligibility criteria: For example, changing minimum hours worked requirement for eligibility (must meet guidelines listed for minimum hours worked requirement); changing dependent eligibility from age 26 to age 30, etc. ▪ Changes in eligibility criteria may only be made on group's anniversary date and with at least 120 days prior notification to Underwriting. (Please note that changes to eligibility may affect premiums.) ▪ Requests for off-anniversary changes will require Underwriting review and approval. ▪ Changes may not be made on a retroactive basis.

COBRA	▪ COBRA coverage will be extended in accordance with the federal law. ▪ Employers with 20 or more employees (full- or part-time) are eligible to offer COBRA coverage. ▪ The number of COBRA enrollees is limited to 10% of the group enrollment. ▪ COBRA members are not to be included for purpose of counting employees to determine the size of the group. Once the group size has been established, and it is confirmed that the law is applicable to the group, COBRA members can be included for coverage subject to the normal underwriting guidelines.
Employer eligibility	▪ An employer must employ on average at least 51 **full-time employees, including 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. ▪ Group applicants not meeting this definition of an employer are not eligible for coverage under the Mid-Market Employer programs, but may be eligible for coverage under the Small Employer program— refer to the Small Group Underwriting Guidelines manual. ▪ Organizations must not be formed solely for the purpose of obtaining health 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 all of the following criteria are met (combined arrangements will not be quoted until sufficient proof of ownership is provided, as outlined below): – One owner has controlling interest of all business to be included; and, – Provides proof of ownership (acceptable proof includes copies of IRS Forms 851, 1065 - Schedule K-1, SS4 – Application for Employer ID, or latest federal tax return – all businesses filed under one combined tax return must be enrolled as one group); and, – Provides UC2A Employer's Quarterly Report of Wages for each entity and combined census with all eligible employees from all entities; and, – Must have common policymaker legally authorized to make benefits decisions for the combined business; and, – Provides letter from employer indicating desire to combine the commonly owned entities ▪ Subject to underwriting review and approval on a case-specific basis. ▪ Once common ownership is established, and premium rates have been provided, the groups are required to be rated as an affiliation and must accept the premium rates as presented. ▪ Common ownership groups may later be separated for group coverage only when based on verifiable legitimate business reasons.

Product offerings – groups of 51-99

(New Business: eligible enrollees; Existing Business: enrolled contracts)

Benefit plans available:

- **Blue Solutions for Mid-Market Employers portfolio (**with or without a Drug Rider and Vision plan/rider)
  - Flexibility to choose from several Select Drug and Basic Drug plan options.
  - Employers may not offer same medical plan with different drug, dental and/or vision options.
  - If Drug plans are offered, they must be offered with all medical plans. Exception: If one option is HSA-qualified HDHP with integrated drug, other *non-HSA qualified plans not required to include drug.*
- **HSA-qualified high-deductible plans** - **with integrated drug**
  Note: Existing customers without drug benefit may retain their current plan.
- **Keystone Health Plan East Dental and Vision Riders (available only with an IBC or** *Keystone medical plan)*
- **Freestanding Dental Plan (UCCI)**
- **Freestanding IBC Vision Plan**
  - Must be offered alongside a medical plan
  - Biennial/ annual benefit options (standard: biennial)
  - Note: Voluntary Davis Vision plan is not available to groups of 2 to 99.
- **Quoting Policy:**
  - Maximum 3 total packages to include three medical options with two drug riders and one vision.
- **Group size:**
  - Existing groups with non-Blue Solutions PPO, HMO or POS plans may retain existing PPO, HMO, or POS plans but any benefit change will be Blue Solutions Products.

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 implemented for IBC health benefit plans: – Autism benefit – Pennsylvania State mandate effective July 1, 2009: Applied to existing groups with 51 or more enrolled contracts and is required for new and existing groups with 51+ total commercial employees. – Mental Health and Substance Abuse Parity benefit – federal mandate effective October 15, 2009: Applied to existing groups with 51 or more enrolled contracts and is required for new/existing groups with 51+ total commercial employees. – Notes: A commercial employee includes any non-Medicare employee, including seasonal and/or part-time employees.
Downgrading benefit plans off anniversary date	▪ Off-anniversary downgrades are permitted using the following guidelines: – All changes must be completed 180 days prior to anniversary. – Limit of one off-anniversary and one on-anniversary downgrade per contract year. – Off anniversary benefit changes must be submitted to Underwriting 75days (or more) in advance of the benefit change effective date. – All requests subject to underwriting approval.
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 – Employers are not allowed to: – Fund more than 50% of the employee/family deductible costs to an HRA or HSA; – provide a supplemental benefits plan that augments the core health insurance plan; – pay more than 50 percent of employee/family deductible costs through an allowance or claims payment; or, – provide any combination of the above that causes the total amount funded to be greater than 50 percent of the employee/family deductible. • When the HSA-qualified HDHP is offered off-cycle, the full annual deductible will apply to the shortened period—there is no deductible carryover to the next contract year. • 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. If the employer group has a prescription drug program through another carrier, the group may request IBC to combine the Rx claims with the IBC medical plan claims. Such requests are subject to underwriting review, and if approved, an additional administrative fee will apply for this service. ▪ If an HDHP product is offered off cycle, the full annual deductible will apply to

	the shortened period — there is no deductible carryover to the next contract year. • An HDHP or HSA-qualified HDHP may be offered along with other products, as long as the maximum number of product offerings is not exceeded.

Health Reimbursement Account (HRA)	• Available to groups of 51-99 enrollees (existing business) or eligible employees (new business). • 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 funding to the HRA cannot exceed 50 percent of the annual employee/family deductible. • Only one HRA option per customer • Debit card option not available
Health Spending Account (HSA)	• Available to groups of 51-99 enrollees (existing business) or eligible employees (new business). • Available only with a federally qualified high deductible health plan (HDHP) with integrated prescription drug benefit. • Employers adding or changing to an HSA-qualified plan with a contract year benefit period may change anniversary date, which would apply to all products.
Blue Solutions Choice Defined Contribution Products	• **Defined Contribution – Overview:** – 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. • **Maximum Product Offerings:** – Maximum of 5 defined contribution products • **Defined Contribution Product Guidelines:** – Employers may choose from several Select Drug and Basic Drug plan options. – 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 option's gross monthly premium or 75 percent of the single tier rate of the lowest cost option offered. • **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 Mid-Market Group Underwriting Guidelines generally apply to defined contribution products.*

Rating information

Prospective rating

Definition	▪ Fully-insured, experience rating program ▪ Employer pays a fixed premium rate to IBC, and IBC assumes the entire claim risk for the covered services. ▪ No surplus/deficit determination
Eligibility for Prospective Rating Methodology	▪ An employer must employ on average at least 51 **full-time employees, including full-time equivalents (FTEs)** on business days during the preceding calendar year. ▪ Standard rating method for groups 51 or more based on total number of employees for new business, groups of 51 or more renewing coverage will retain the rating method

Affiliation groups (multi-employer affiliations)

Definition and requirements

- Groups of 51 or more that meet specific requirements, may be eligible to join an affiliation.
- See Large Group underwriting guidelines for affiliation requirements.

Rate quote submission

Documentation required when submitting a rate quote request

Incomplete submissions may impact our ability to evaluate the group application and provide a competitive proposal. Subject to applicable state and federal laws, IBC reserves the right to pend quote requests. Such a decision will not be based in any way on the medical condition of the group's members. This section is not inclusive of all underwriting requirements, additional requirements may apply.

Existing business – employers with 51-99 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 51 to 99 employees:

- Marketing strategy and group/broker expectations (if applicable)
- Is prospect a previous IBC customer (if so, provide details)
- Name of existing insurance carrier
- Broker and/or consultant information
- Five-year carrier history
- Length of time with current carrier
- Summary of current plan design (source documentation)
- Current renewal, including premium rates (source documentation)
- Three-year rate history (if available)
- Employee contribution by plan design and rating tier (percentage or dollar value)
- ***Claims information:***
  - Twelve to 24 months of prior claims data (minimum of 12 months mature experience)
  - Experience period should be defined (specify incurred and paid periods)
  - Specify any benefit changes made within each experience period provided
  - Medical claims broken out by inpatient, outpatient, and professional claim categories
  - Medical claims broken out by facility and zip code
  - Enrollment for each month of the experience period
  - Shock claims information (individual claims in excess of $50,000)
  - Diagnosis and prognosis for excess claims
  - Prescription drug claims data to include:
    - Script count
    - Break-out by generic, brand and non-formulary, as well as retail and mail order
- ***Rate information:***
  - Current and renewal rates (source documents)
  - Historical rate increases for last three-year period
  - Current financial arrangement
  - Broker commissions (if applicable)

- ***Detailed census – in spreadsheet format – must include the following:***
  - Employee name

- Date of birth (MM/DD/YYYY)
- Current plan design indicator(for example, employee John Doe is enrolled in HMO high option plan)
- Zip code of current residence
- Employee gender
- Coverage status (enrollment by coverage tier)
- Waivers (eligible employees 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)
- New hire information: date hired or date eligible for coverage if employees are in a probationary period
- COBRA subscribers and expiration date

- Additional required information (where applicable):
  - Request for proposal (RFP) with all attachments
  - Competing carrier information (if available)
  - Union agreement (if applicable)

Proof of Business Documentation*(applicable when additional information is needed to prove that a group is an eligible business)*

The following documentation must be provided for consideration:

- Most recent UC2-A or
- Business license (not a professional license). If not available, a copy of the partnership agreement, articles of organization, or articles of incorporation; and,
- Employer identification number/federal tax ID number; and,
- Quarterly Wage and Tax Statement. If not available, when will one be filed; and,
- Letter from Certified Public Accountant (on CPA's letterhead) listing the names of all employees (full- and part-time), number of hours worked each week, dates of hire, weekly salary, and confirmation of establishment of payroll records.

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
- Non-standard requests not viewable as alternatives to renewals on ROAM

New business: All requests for employers with 51-99 employees

Post-sale submission requirements

Post-sale enrollment requirements	▪ Rates quoted are conditional pending receipt, review and acceptance of the standard submission requirements. ▪ Post-Sale enrollment requirements should be sent to underwriting management for review. ▪ Rates are based on final enrollment – IBC reserves the right to re-evaluate rates quoted if final enrolled contracts vary by ten percent, plus or minus.
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) ▪ 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. ▪ Group 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 group is responsible for all due but unpaid premiums and any accrued deficits. ▪ When active group is terminated, all COBRA groups, retiree groups, and Medicare groups (including Medicare Advantage groups) must also be terminated – COBRA-only, retiree-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 of the group coverage. ▪ Groups cancelling traditional Blue Cross Hospitalization or Blue Shield Medical/Surgical coverage must also cancel the Major Medical program.
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) the group makes payment of six months of premium in advance of issuance of health benefits plan. Prior IBC Medical claims information (medical loss ratio) subject to review along with information provided on the employee application and included in the overall assessment of the group. ▪ For former IBC groups reapplying for coverage, determination of group status will be based on the following criteria: o Groups returning within 12 months of termination will be deemed "renewal" business; o Groups returning more than 12 months following termination will be deemed "new business." ▪ IBC reserves the right to assess a reinstatement fee for administrative services. ▪ 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. ▪ Limit of one reinstatement per year.