



Small Group (2-50) Underwriting Guidelines NEW BUSINESS

In order to obtain a small group rate quote, an employer must have 50 or fewer total employees. Total employees are defined as full-time and part-time employees, even if such classes of employees are not eligible for insurance. Groups must also meet guidelines for small business as defined by the Health Insurance Portability and Accountability Act.

HealthAmerica and HealthAssurance reserve the right to revise these guidelines at any time.

Retiree Coverage

- No coverage is available for groups with 2 - 50 eligible employees.

Total Replacement

- HealthAmerica and HealthAssurance are available as total replacement, for groups with 2- 50 eligible employees, to all competitive insurance plans including managed care and traditional indemnity plans.
- Small market groups are not permitted to carve out the prescription drug benefit.

Groups Previously Insured by HealthAmerica and HealthAssurance

- Employer groups previously insured by HealthAmerica or HealthAssurance will be reviewed by Accounts Receivable to ensure that they have not been under intention to term for non-payment of premium and must pay any outstanding premium due to HealthAmerica or HealthAssurance.
- Groups previously termed for non-payment must pay two months' premium in advance of coverage.
- HealthAmerica and HealthAssurance reserve the right to validate the financial status of a company at any time and may use Dunn & Bradstreet (D & B) reports to accomplish this.

Employer Eligibility

- Groups will be rated appropriately for medical conditions, but cannot be denied coverage.
- Employer groups must be in business for a minimum of six months.
- Organizations must not be formed solely for the purpose of obtaining health insurance coverage.
- No management carve outs are allowed; coverage must be offered to all employees meeting probationary and weekly work hour criteria.
- Union or non-union groups may be quoted separately in the Small Business model as long as the total group size does not exceed 50 lives.
- Eligible groups must have Worker's Compensation insurance in-force, as required by state law.
- Absentee owners, seasonal workers, directors, 1099/contract employees, and trustees of the company are not eligible for coverage.
- Eligible dependents include an employee's spouse under a legally recognized common law arrangement. An affidavit of common law marriage is required. Domestic partners are not eligible for coverage in the Small Market segment.

(Employer Eligibility cont'd)

- Husband/wife coverage is subject to the collection of a UC-2 or Schedule C with both names appearing on the documents. Additionally a copy of the current group insurance premium invoice must be obtained, listing both the husband and wife as independent subscribers/policyholders.
- Applications must be submitted for all employees, including any enrolling, waiving, and COBRA eligible employees.

Participation

- At least 50 percent of the total eligible employees (full-time employees offered benefits) must enroll in the HealthAmerica or HealthAssurance plan(s) offered. 75 percent of all employees must have coverage either through the group or their spouse. Any exceptions are at the discretion of Underwriting.
- Waiving employees must complete the coverage declination section of the enrollment/medical application.
- Employees covered by a spouse's plan must complete waiver information and provide sponsor plan number.
- Non-contributory plans should have 100 percent participation, excluding spousal waivers.
- Dependent participation is not required.
- Cobra Eligibles cannot exceed 10 percent of total members.
- Cobra can only be offered to groups having 20 or more total employees, either full- or part-time.

Employee Eligibility

- Eligible employees are those employees who are permanent and work on a full-time basis a work-week of at least 25 hours and have met the set probationary period.
- Part-time employees working fewer than 25 hours per week are not eligible for coverage.
- 1099 employees (contracted employees), directors, stockholders, partners, or other outside consultants who are not active, permanent full-time employees are not eligible for coverage.

Probationary Period

- Probationary periods are determined by the employer group and must be applied consistently to all employees.
- PA employer groups are not permitted to have more than a 12-month waiting period for new hires, and Ohio restricts the waiting period to no more than 90 days.
- HealthAmerica and HealthAssurance Group Administration will enforce given probationary periods.

Contributions

- The employer must contribute a minimum of 50 percent of the premium rates for each coverage tier (employee, couple, employee/children, family) or a minimum of 75 percent of the single premium toward the cost of each tier.

Tax Information

- For employer groups requesting a January 1, 2005 or later effective date, and having between 2 – 50 eligible employees, a copy of the most recent PA UC-2/Quarterly Wage and Tax Statement (Unemployment Compensation Tax Form) must be submitted. This must contain the names, salaries and weeks worked of all employees of the employer group.
- Employees that have been terminated or work part-time must be noted accordingly on the UC-2.
- Recently hired employees not listed on the UC-2 should have a W4 or payroll stub submitted with the UC-2.

If a UC-2 is not available, submit one document from Category A and one document from Category B.

Category A	Category B
➤ IRS 1040 - Schedule C or F	➤ Articles of Incorporation
➤ IRS 1065 - Partnership Income	➤ Partnership Agreement
➤ IRS 1120 - Corporate Income	➤ Current Business license
➤ IRS 941 - Not for profit use only	➤ Leases and other contracts
➤ IRS 990- Return of organization Exempt from Tax	

Dual Option Coverage

- In order to offer more than one HealthAmerica or HealthAssurance plan design within the same employer group (i.e., a dual option offering), a minimum of 20 subscribers must enroll across both plan options. Dual option may be quoted down to 10 subscribers for groups being quoted by Presidents Council or Key brokers.
- Plan combinations must be approved in advance by underwriting for groups with more than 20, but fewer than 50 employees. Dual option must be a true "buy up" situation and not used to carve out a management offering of a higher benefit.

Dual Option Small Market Groups 10 – 50

Who is eligible?	Groups with a minimum of 20 enrolled employees in our service area. Presidents' Council and Key Producers have the ability to write cases with as few as ten enrolled subscribers for dual option. Consult UW for additional information.						
What plan designs would be available for Dual Option?	Any plan would be available as long as there is a clear benefit differential between the programs. Plans that are not eligible include similar plans but different products (i.e., a 100/80 \$10 OV copay under a PPO and the same plan under a POS). Because our PPO and POS products operate similarly, this does not create a dual option. We are essentially offering the group the same plan.						
If the group has OOA individuals, what plan is offered?	The high option plan should be matched, but the group does have the flexibility to match it to the low plan if desired. (Refer to OOA guidelines on how rates are to be presented.) We will only present one out of area plan. A dual option OOA plan approach is not available for Small Group plans.						
How will these groups be priced?	The entire group will be rated together to produce the rate for both plan designs. If the benefit value is within 15 percent, then no loads will apply. If the spread exceeds 15 percent, please use the following table and the corporate training to determine the appropriate load on both, or one of the plans. <table border="1"> <thead> <tr> <th>Spread</th> <th>Load</th> </tr> </thead> <tbody> <tr> <td>15-25%</td> <td>2.0%</td> </tr> <tr> <td>25-35%</td> <td>3.5%</td> </tr> </tbody> </table>	Spread	Load	15-25%	2.0%	25-35%	3.5%
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Is there a range for a differential between the rates of each plan?	We are removing the standard 5-15 percent range; however, you should expect to have a minimum of 5 percent and no more than a 35 percent differential because of the addition of the QHDHP options. This range plays a key role depending on your circumstances.						

How do contributions affect our strategy?	<p>Contributions play a key role in the design of a dual option program. For instance, if the employer is contributing 90 percent of the single rate for both options, this may not incent the employee to select the low option plan (i.e., if the HMO costs \$210 and the PPO is \$232, the employee only pays an extra \$2.20 per month to buy the PPO).</p> <p>If the employer pays 90 percent of the low option and the employee must pay 100 percent of the buy up, then the employee needs to pay an extra \$22 per month and then may be more influenced to stay with the HMO if their doctors are in the network.</p>
Is there a minimum requirement of number of employees in each plan?	Our guideline here will be to have at least one subscriber of the total enrolled in the plan.
How does offering an HMO affect my dual option strategy?	<p>While it is perfectly acceptable to offer an HMO as one of your plan options, you need to be cautious.</p> <p>In some instances an HMO offering may not be the best risk alternative. CRC pieces may not be conducive. Additionally, if you offer the HMO with an 80/60 POS, you most likely will attract the poorer risk in the HMO because they want the 100 percent benefits...so you have created a selection issue. Each case will be unique, so you must evaluate them on their own merits.</p>
How does offering an HSA affect the loads?	<p>You will treat the HSA plan just as any other dual option offering with the following exceptions:</p> <ul style="list-style-type: none"> • When evaluating the dual option, it will now be medical plus all riders (including Rx) for all the options you are evaluating. This is due to the fact that the Rx on paper is incorporated into the total price for the HSA program. If there is no information known about the employer funding or if they will even fund, then you will just need to use the actual value of the plan they are selecting.

Census Data

- Premium rates for qualified groups will be determined from census data and other underwriting information, including medical questionnaires.
- Premium rates quoted are based upon original census information and are subject to a re-rate if demographics have changed once enrollment materials are received.
- All applications for coverage are subject to review and approval by the home office Underwriting department. Prospective employer groups are advised not to cancel coverage until approval from HealthAmerica is received.
- Final enrollment forms must be delivered to HealthAmerica by the date communicated by broker relations, for coverage to be effective the first of the following month.
- Census data must be provided on all eligible (and COBRA eligible, if applicable) employees including name, date of birth, date of hire, gender, home zip code, and tier status.
- Enrollment completed by brokers should indicate the names of the employees as well as dates of birth, gender, zip code, and tier category.

Out of Area Coverage

- Out-of-area, PHCS enrollment is offered to groups with 10 or more enrolled subscribers and is limited to no more than 15 percent of in-area enrollment for groups under 20 lives; no more than 20 percent of in-area enrollment for groups over 20 lives.

Late Applicants

- Late applicants, those initially waiving group coverage, will not be allowed to enroll until the next open enrollment period, unless there is a qualifying event. All new hires must meet the probationary period outlined by employer.

HRA/FSA/HSA Arrangements

- HRA/FSA/HSA vendor must be identified prior to submission to underwriting, using either the HealthAmerica and HealthAssurance vendor or an outside vendor.
- Funding arrangements must be non-discriminatory.
- Amount of HRA/FSA/HSA must be disclosed prior to submission to underwriting if using our internal vendor.

Renewals

- Renewals will be generated on the anniversary date of the original effective date and will be valid for a period of twelve months.
- Renewals will be generated with the census that is valid 120 days prior to the renewal.
- Prescription drug may not be “carved out,” but is a component of the plan package.