

# Excellus

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## **Commercial Underwriting Guidelines**

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### **Applied on a Group Level**

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Policies Effective: November 1, 2011

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## Introduction

Commercial health insurance coverage is available to employer, trust and association groups, subscribers and dependents that meet the qualifications specified in 4235 (c) (1) of the New York State Insurance Law and the Underwriting Guidelines of Excellus Health Plan, Inc, doing business as Excellus BlueCross Blue Shield and Univera Healthcare (“Health Plan”). Outlined below are the basic criteria that the Health Plan will follow to qualify employer, trust and association groups, employees and dependents for commercial coverage.

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## Disclaimer

Excellus reserves the right to make exceptions to these guidelines, for circumstances where the group/subscriber/dependent does meet all of the criteria in these guidelines and when the exception will not violate any laws/regulations or harm the community pool.

These guidelines are effective 11/01/2011 and replace all previous group commercial guidelines in use.

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## **I. Group Eligibility**

### **A. Eligible Groups:**

A group, or if the group is a trust or association, a member firm participating in the group is eligible for commercial group coverage if it meets the following criteria:

#### Employer group/trust:

The group/trust:

1. is headquartered in the Health Plan's service area. In the event the Health Plan is insuring only the local employees of a multi-location group, must have an office in the Health Plan's service area;
2. is engaged in a legal business or is a government entity with the legal authority to contract;
3. regularly employs persons on an active basis for salaries or wages throughout the year;
4. maintains a non-seasonal business in that the group employs at least one employee for 50% of the working days in the previous year;
5. maintains an employer-employee relationship with its subscribers;
6. files state and federal income taxes as an ongoing commercial enterprise, non-profit entity, is validly exempted from filing taxes or is a government entity; and
7. meets and maintains applicable participation and contribution requirements as required by the Health Plan's Underwriting Guidelines.

#### Association groups:

The association:

1. must meet criteria #1 above for employer groups/trusts, as well as other criteria specified in 4235(c)1 related specifically to associations.
2. member firms must comply with the same underwriting guidelines as groups/trusts enrolled by the Health Plans on a direct basis.

### **B. Ineligible Groups:**

The following groups are ineligible for commercial group coverage:

1. groups previously terminated for fraud.
2. groups in bankruptcy proceedings.
3. groups terminated for non-payment of premium by any insurance carrier are ineligible as follows:
  - a. small groups (see section "C" below) for 12 months following the termination for non-pay.
  - b. large groups (see section "C" below) for 24 months following the termination for non-pay.

### **C. Group Size:**

The definition of sole proprietors is per 4317(f) (3) of the insurance laws of New York State. The definition of small groups, including association groups, is in accordance with Regulation 145.

To determine a group's classification as "small" or "large", the Health Plan calculates eligible employees based on the following general guidelines:

1. groups with common ownership/control count as being part of one group.
2. groups with membership both inside and outside the Health Plan service area will be counted together, even if membership within the service area is minimal.

**D. Group Effective Date:**

New groups or groups making changes to existing coverage must provide all required enrollment information to the Health Plan by the 15<sup>th</sup> of the current month in order to be effective the 1<sup>st</sup> of the following month. New small groups must include payment of the first month's premium along with all other enrollment materials.

**E. Group Renewal Date:**

Groups renew annually as follows:

1. community rated groups renew on January 1, unless the product has rolling rates or level premium.
2. a group with rolling rates renews on the 1<sup>st</sup> of the month of the anniversary of its effective date
3. level premium or experience rated groups renew throughout the year, based upon on a date the group specifies at the time the rate is quoted.

**F. Guaranteed Renewal:**

A covered small group or, if the group is a trust or association, a member firm will be renewed unless terminated due to any of the following occurrences:

1. non-payment of premium;
2. fraud or misrepresentation of material facts;
3. violation of the Health Plan's contribution or participation requirements;
4. violation of the Health Plan's service area requirements;
5. lapsed membership or membership is downgraded from "full" to "associate" in the trust or association (including a chamber of commerce) through which the coverage is offered;
6. inability to meet the definition of a permissible group under 4235(c) (1); or
7. the Health Plan discontinues participation in the market or discontinues the class of coverage.

**G. Open Enrollment Period:**

The Health Plan's standard policy is one (1) open enrollment (re-opening) period per year, at the time of the group's renewal. The open enrollment period is the time when eligible group members who have previously declined coverage through the group may enroll. Subscribers may select from among the various offerings available through the group during the open enrollment period.

**H. Special Open Enrollment Periods:**

A group may request a special open enrollment period when significant change in business conditions occur such as a purchase of a new division or the group expands coverage to a new class of employees.

## II. Subscriber/Dependent Eligibility

### A. Eligible Subscriber:

An eligible subscriber must be a citizen of the United States or must be in the United States validly working on at least a semi-permanent basis (e.g., "H" visa). If the product covering the subscriber has a limited network or requires election of a primary care physician (PCP), the subscriber must live, work or reside in the appropriate Health Plan service area.

Additionally, under various group situations, an eligible subscriber must meet the following criteria.

For coverage through an employer group (including member firms within a trust or association), an eligible subscriber must be:

1. a permanent full or part-time employee working at least 20 hours per week;
2. an officer or director if engaged in the operation of the business at least 20 hours per week and receiving compensation. An owner of a business is eligible regardless of whether he or she actively works at the business, unless the owner is determined to be a silent partner (i.e., exerting no influence on the management or operation of the business).
3. an elected or appointed official, if the employer group is a public entity (e.g. city, school district);
4. if a retiree, covered by the Health Plan immediately prior to retirement and with continuous coverage through the Health Plan;
5. an employee disabled or on FMLA;
6. a former employee on COBRA/NYS extension of benefits, until the maximum period ends;
7. a reservist; or
8. a "1099 employee" who is considered an employee per DOL regulations (e.g., realtors, contractors).

Note: Large groups may insure employees that work 17.5 hours or more

For coverage through a professional society (e.g. medical, bar, realtors), an eligible subscriber must:

1. qualify for full membership in the professional society under the organization's by-laws; and
2. be a licensed professional.

### B. Employer Probationary Periods:

Employers may select probationary periods from zero (0) to one (1) year in monthly increments.

### C. Eligible Dependent:

The eligible dependents are dictated by the subscriber contract/certificate. In general, the eligible dependents are as follows:

1. Spouses
  - a. Spouse, unless the marriage is dissolved through divorce or annulment. A same-sex marriage will be recognized when the marriage is performed in a state where full legal status is conferred
2. Dependent Children
  - a. children of a subscriber are covered until age 26 regardless of financial dependence, residency, student status, employment, marital status, or eligibility for other coverage (unless, until January 1, 2014, the subscriber is covered under a grandfathered group health plan in which case the dependent must not be eligible for coverage through his/her own employer);

b. in addition to the coverage listed in subparagraph a. above, coverage for the children of a subscriber is available, if elected by the subscriber or eligible young adult, for unmarried young adults under 30 years of age who are not insured or eligible for insurance through their own employer, who live, work or reside in New York State or Excellus Health Plan, Inc.'s service area and who are not covered under Medicare;

c. in addition to the coverage listed in subparagraph a. above, coverage may be available through a "make available" rider, if elected by a group, for the children of a subscriber who are unmarried, under 30 years of age, who are not insured or eligible for insurance through their own employer, who live, work or reside in New York State or Excellus Health Plan, Inc.'s service area, and who are not covered by Medicare

d. for purposes of subparagraphs b. and c. above, the term "children" includes natural children, stepchildren, legally adopted children and children for whom a court of law has made the subscriber or spouse legally responsible to support.

#### **D. Subscriber/Dependent Initial Enrollment and Retroactivity**

Excellus will enroll a subscriber and/or dependent for the requested date, provided that:

1. the application is received within the retroactive period specified in the subscriber contract/certificate from the date of the qualifying event or,
2. if unspecified, 30 days.

If not enrolled when initially eligible, the subscriber/dependent must wait until the next open enrollment period, unless the subscriber/dependent qualifies for a special enrollment period (see following Section E).

#### **E. Special Enrollment Periods:**

The Health Plan recognizes the special enrollment rights available to covered persons under federal and state law and/or regulation. These special enrollment rights allow an employee, spouse or dependent who did not enroll in the group plan when originally eligible due to coverage under the spouse's employer group plan to enroll for coverage at a time other than the group's open enrollment period, if the other coverage is lost for one or more of the following reasons:

1. termination of the spouse's employment;
2. termination of the spouse's other plan or benefit contract;
3. death of the spouse;
4. legal separation, divorce or annulment;
5. reduction in the number of hours worked by the spouse; or
6. employer ceased its contribution toward the premium for the spouse's plan or benefit contract.

If the employee, spouse or dependent applies within 30 days of the loss of coverage or within such longer period specified in the subscriber contract or certificate, he or she may enroll effective the date of the loss of coverage.

**F. Pre-existing Conditions:**

The definition of waiting periods for pre-existing conditions (pre-ex) is in the subscriber contract/certificate. Pre-ex applies for the period specified in the subscriber contract/certificate, for services in connection with any disease, illness, ailment or other condition where medical advice, diagnosis, care or treatment was actually recommended by or received from a licensed health care provider within 6 months before the coverage began. Pregnancy or conditions in newborns or adopted children enrolled within 31 days of birth are not subject to pre-ex.

The Health Plan will count all sources of creditable coverage, as defined by law, towards the subscriber or dependent's waiting period(s). Employer probationary periods, if any, are included as credit towards the waiting period.

Pre-existing waiting periods, for dependents and subscribers 19 years of age and older, apply to the Health Plan's commercial group coverage as follows:

1. groups with 50 or fewer eligible employees must have pre-existing waiting period provisions
2. groups with 51 to 299 eligible employees may select not to have pre-existing waiting period provisions
3. groups with 300 or more eligible employees must not have pre-existing waiting period provisions

Members under 19 may not be subject to pre-existing condition limitations.

**III. Product Offering Requirements**

**A. Participation Percents:**

HMO products are not subject to participation percents, but enrollment in the Health Plan's HMO products may contribute to the total participation percentages. The group size and participation percents are based upon eligible employees. To obtain or maintain group coverage, 50% of the eligible employees must be enrolled in our health plan.

**B. Maximum Number of Products or Options:**

Groups meeting standard participation requirements may select the following number of products/options:

<u>Enrolled Employees</u>	<u>Number of Products/Options</u>
1 - 5	1
6 - 20	2
21 - 50	3
51 - 499	4
500+	Negotiated among Sales, Rating and Underwriting

Groups with multiple product/option selections may choose the same or different type of products, but may not cause adverse selection by violating the Health Plan's multiple product offering guidelines. See Section C below.

### **C. Multiple Offerings:**

To reduce the potential for adverse selection, the following rules govern which products are available in multiple product offering situations:

1. when offered next to a competitor, the benefit level of the Health Plan's products must be less than the competitor's benefit offering.
2. when multi-option offerings are offered next to a competitor's plan our lowest option has to be the lowest option offered and we must have enrollment in this option.
3. all offerings must either include or exclude drug. High/low offerings may have different drug benefits, but the high base/high drug benefit and the low base/low drug benefits must be paired together.
4. the eligibility criteria for subscriber and dependents must be the same for all products (e.g. domestic partner, student age).
5. the underlying benefits must be essentially the same, except for benefits like vision, which have a low risk of adverse selection.
6. rating tiers must be identical.
7. renewal/open enrollment periods must be the same.
8. the rate differential among Health Plan product offerings must be at least 5% and no more than 30%. If an HSA product is offered, special consideration may be given.
9. if an HSA is offered in conjunction with another product in groups of 1 to 5, two products/offerings, rather than one product/offering may be allowed.

### **D. Employer Contribution:**

The employer must contribute a minimum of 50% of the single premium for each product offering.

If an employer contributes 100% of the premium, all eligible subscribers must be enrolled in the group plan.

### **E. Group-Initiated Changes in Coverage:**

If a group wishes to change its coverage, the following rules are generally in effect:

1. riders may be added or eliminated only at the renewal.
2. groups that eliminate riders may not add the rider to coverage for a period of 2 years. This includes prescription drug and eligibility riders.
3. for experience rated groups benefit changes should occur at the renewal date. One (1) off-cycle change may occur per calendar year.

For community rated groups,

1. upgrades may occur once per year at the time of renewal.
2. downgrades may occur at any time, but not more than once during the year.

### **F. Rating:**

Sole proprietors and groups with 2-50 eligible employees are community rated. Sole proprietors receive a surcharged rate. Rates are based upon the group's location and product selection, in accordance with rates filed with the New York State Insurance Department (NYSID).

Groups with 51 or more eligible employees will be experience rated for Article 43 products.

### **G. Rate Changes:**

For community rated plans, The Health Plan must provide notice to the group policyholder or contract holder, as well as certificate holders, on or before the date the Health Plan files its initial rate change filing with the New York State Insurance Department. The Health Plan may provide the group policyholder or contract holder with a sufficient supply of rate change notices for distribution to certificate holders. The rate contained in the notice to group policyholders or contract holders and certificate holders must be no more than 5% from the actual rate. Upon receipt of approval of its rate change application, the Health Plan must provide the group policyholder or contract holder, as well as certificate holders, with 60 days prior written notice of the approved rate change before it may be implemented.

Rates for experience rated groups are prepared in accordance with a formula filed with the NYSID. The experience rated groups receive notice of the rate change at least 60 days in advance of the effective date of the rate change.

## **IV. Other Requirements**

### **Eligibility Verification:**

New group and subscriber/dependent eligibility and guideline compliance will be verified using information from tax forms, other filings with government agencies and appropriate company records as determined by the Underwriting Department. Recertification of a group will occur annually through a direct request for information from the Health Plan. The annual cycle will repeat as long as the group purchases health coverage from the Health Plan.