



Large Group

Experience-Rated Underwriting



## Underwriting Guidelines

*These guidelines apply to EmblemHealth-branded large group products underwritten by Group Health Incorporated (GHI) and HIP Insurance Company of New York (HIP). They do not apply to HMO products, small group products or Government Sponsored and/or state subsidized programs that EmblemHealth may offer for sale (e.g., Medicare, Healthy New York, etc.) The product sponsor should be consulted for policies and procedures that are applicable to their products. Additionally, these guidelines do not apply to legacy GHI or HIP products, as defined by EmblemHealth. The respective legacy product organization's guidelines apply.*

*EmblemHealth provides health benefit coverage and services through its subsidiary companies in New York State: Group Health Incorporated, HIP Health Plan of New York, HIP Insurance Company of New York and GHI HMO Select Inc.*

# Table of Contents

## SECTION 1

Group Eligibility	1
Employee Eligibility	1
Employer Contribution Level	2
Census Data	3
COBRA and Retirees	4
Domestic Partners	5
Unions	5
Product Availability	6
Out-of-Area Enrollment	6
Participation Requirements	6
Plan Offerings	8
Plan Combinations	9
Tier Structure	10

## SECTION 2

Experience Rating	11
Credibility Rating	11
Rating Methodology	12
High Claims Pooling	12
Funding Arrangements	13

## SECTION 3

New Business	
Requirements for Quotes	14
Brokers and Commissions	14
Turnaround Time	15

## SECTION 4

Existing Business	
Renewal Requirements	16
Renewal Components	16
Benefit Changes	17

## SECTION 5

Option Product	18
Requirements for Quotes	18
Renewals	19

## Group Eligibility

*When is a group eligible for a large group EmblemHealth product?*

**E**mblemHealth large group products are available for sale to all qualifying large groups in New York State.

Specifically, a business must have its principal location within an EmblemHealth service area, it must have more than 50 eligible employees at time of initial quote and renewal, and it must be actively operating its business at all times that EmblemHealth coverage will be in effect.

We require that there is an employer-employee relationship in effect at the group and that the employer contributes at least 50% of overall premium. We may request confirmation that the group has a Federal Employee Identification Number (EIN) and evidence of authority to conduct business in New York State. We may confirm the size of the group by requesting and evaluating a census of the group, which must list all W-2 employees who are eligible for health benefits. See *Census data, page 3 for a description of a census*.

If a group has been terminated within the past 12 months due to non-payment of premium, EmblemHealth reserves the right to not issue a contract.

## Employee Eligibility

*How does EmblemHealth define “eligible employee”?*

**E**mblemHealth evaluates eligibility based on the United States Internal Revenue Service’s definition of an employee. Full-time, active-at-work employees are considered eligible

employees for EmblemHealth large group products. Full-time (or permanent part-time) employees must work 20 or more hours per week, each week. If an employer requires a longer number of hours worked in order to meet eligibility, then EmblemHealth will use the employer’s criteria to define full-time eligible employees.

Employees must complete their employer's benefit waiting period before being considered eligible for coverage. Employees who have not completed their employer's benefit waiting period *will not be included* in the determination of large group size or participation requirements (see *Participation Requirements, page 6*).

The following categories of employees are **not eligible** for coverage:

- + Temporary employees
- + Leased employees (i.e., PEO, etc.)
- + Statutory employees
- + Individuals who receive 1099 forms.
- + Seasonal employees

We request a census of all W-2 employees who are eligible for health benefits, and the census must specify which employees are currently enrolled in a health plan and which employees have waived coverage. Upon sale, we require the completion of spousal waiver forms to confirm that coverage has been waived due to coverage on another plan.

If we require further information to determine employee eligibility, we will request the group's most recent NYS-45-X form on file with the State of New York (or other applicable forms for other states).

Quoting is contingent upon Underwriting receiving the data it requests, which can vary according to the complexity of the case under review.

## Employer Contribution Level

*What do we mean when we say the employer must contribute at least 50% of overall premium?*

**E**mployers need to contribute a fair and reasonable percentage of group premium rates so that a majority of employees are able to afford participation in the plan. Our minimum required employer contribution level is 50% of total premium for the group. The following chart illustrates how we would determine whether a group is meeting this minimum level. We would not quote the cases in the last two scenarios.

<i>Minimum Overall Employer Contribution Level Determination</i>						
<i>Example</i>	<u>Monthly Rate</u>	Possible Employer Contribution Scenarios				
Employee Only	\$400.00	100%	100%	50%	75%	60%
Employee + Family	\$1,000.00	100%	50%	50%	25%	40%
	\$1,400.00					
Overall Employer Contribution (\$)		\$1,400	\$900	\$700	\$550	\$640
Overall Employer Contribution (%)		100%	64%	50%	39%	46%
		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Census Data

*What is a census and why does a group have to supply a census?*

The first action that Underwriting must perform on any new business quote or renewing group is to determine whether a group is a large group or a small group. In New York, an insurer has a legal obligation to ascertain that a group qualifies for large group rating and that the group is not circumventing community rating requirements. Furthermore, an insurer who fails to investigate the credentials of a group is also subject to discipline by the Insurance Department.

In order to fulfill this basic legal requirement, Underwriting needs to examine a listing, or **census**, of all employees in a group as well as all other persons who may be eligible to receive health insurance coverage, such as Retirees and COBRA members.

Standard data elements of a census are:

- + Name
- + Date of birth
- + Gender
- + Employment status (Active: Full-time/Part-time; Retired, COBRA)
- + Class (Union, Salaried)
- + Enrollment status (Enrolled/Waived: Spousal coverage, declined coverage; Not eligible for coverage)
- + Residence Zip Code
- + Enrollment category (Employee only, Employee/Spouse, Employee/Child(ren), Employee/Family)

A sample census follows:

Name	Date of Birth	Gender	Employment	Class	Enrollment Status	Residence Zip Code	Enrollment Category
			Status				
P. Parker	11/1/1952	M	Active	Union	Enrolled	11375	EE
C. Kent	6/18/1960	M	Active	Union	Waived	60611	--
R. Smith	4/20/1982	M	Active	Non-Union	Enrolled	10021	Family
A. Jones	10/29/1948	F	Retiree	Non-Union	Waived/spousal	10354	--
J. Lewis	3/18/1988	M	COBRA	Union	Enrolled	11101	EE/Child

**All new business quotes** require the provision of a census.

**All renewing groups** will be asked to supply a census in order to evaluate their continuing qualification for an experience-rated product and to ensure that the most aggressive rate possible is issued. If a renewing group with fewer than 51 enrolled contracts does not supply a census, it must be assumed that the group is no longer eligible for a large group product and a renewal will not be issued.

## COBRA and Retirees

*Does EmblemHealth cover COBRA participants? Do we cover Retirees?*

**E**mblemHealth covers COBRA participants and their eligible dependents as long as the total number of COBRA participants does not exceed 10% of the total eligibles of the group. *Note: EmblemHealth does not administer COBRA billing for groups--this is the plan sponsor's responsibility.*

If a fully-insured group covers Retirees, they must be identified at initial underwriting and the total number of Retirees cannot comprise more than 10% of the total eligibles of the group (An exception is when the retirees enroll in an EmblemHealth Medicare Advantage plan). If a fully-insured group covers Retirees, it must contribute at least 50% of their total premium.

If COBRA employees or Retirees exceed 10% of the total eligibles of the group, the group may not be quoted. These categories of members no longer have an employer-employee relationship, which is an underlying requirement for a group insurance policy.

Since COBRA participants or Retirees (including Early Retirees and Medicare beneficiaries) are not active employees, they *will not be included* in the determination of large group size or participation requirements.

EmblemHealth also offers a Medicare Risk product that can be obtained from Sales, Government Programs.

# Domestic Partners

*Does EmblemHealth cover Domestic Partners?*

**Y**es, a rider is available to cover Domestic Partners. A domestic partner will be treated as a dependent, and eligible dependents of the domestic partner can also be covered. Domestic partners are not recognized by the IRS as dependents and therefore may not receive tax benefits afforded to non-domestic partners (e.g., Health Savings Accounts). To qualify, cohabitation and financial interdependence criteria must be met. The group is responsible for the administration of this criteria and EmblemHealth may from time to time request verification of domestic partnerships.

# Unions

*Are Unions eligible for large group products?*

**Y**es, Unions are eligible for large group products. At Underwriting's discretion, the following documents may be requested to ensure that the Union is not a Multiple Employer Welfare Arrangement (MEWA). MEWAs are not eligible for EmblemHealth experience rated products.

- + Union Charter (*signed and dated*)
- + Trust Agreement/Bylaws (*signed and dated*)
- + Copy of current Collective Bargaining Agreement that indicates the Union is negotiating wages and benefits (*signed by the Union president*)
- + DOL Filing #
- + current LM-2 or LM-3 annual filing (*signed and dated*)
- + current Form M-1 annual report (*signed and dated*)
- + Two (2) years of audited financial statements (*signed and dated*)
- + Current Form 5500 inclusive of all 5500 schedules (*signed and dated*)
- + And other documents that may be subsequently requested based on a review of all the information available to EmblemHealth.

## Product Availability

*Where are EmblemHealth products available? Do any products have geographic restrictions?*

**E**mblemHealth's service area for its CompreHealth EPO product is an eight-county NY Metro Network that includes the counties of New York, Kings, Queens, Bronx, Richmond, Westchester, Nassau and Suffolk. Members must access care within these counties.

All other products are available throughout New York State, and members can access care throughout New York State on an in-network or out-of-network basis as defined by the plan their employer purchases.

## Out-of-Area Enrollment

*Can EmblemHealth cover employees who reside outside the State of New York?*

**Y**es, according to the following guidelines:

+ At least 80% of the enrolled employees must work in New York State Legal

Department written approval is required for any other situations.

## Participation Requirements

*Does EmblemHealth have minimum participation requirements?*

**Y**es. EmblemHealth requires an overall participation rate of at least 50% of total eligibles and 75% of net eligibles calculated as follows:

+  $\frac{\text{Total Enrolled}}{\text{All Eligibles}}$  must equal at least 50% participation, and

+  $\frac{\text{Total Enrolled}}{\text{All Eligibles, Excluding Spousal Waivers}}$  must equal at least 75% participation. \*note:

Medicare Advantage enrollees are excluded from participation calculations.

The following chart illustrates two scenarios of how participation rates are determined.

<i>Minimum Participation Guidelines Example</i>		
	<b>Example</b>	<b>Example</b>
	<b>#1</b>	<b>#2</b>
Enrolled	100	60
Waived due to spousal coverage	20	30
Waived coverage, other reason	10	35
Not Eligible*	20	25
<b>Total Employees in Group</b>	<b>150</b>	<b>150</b>
<i>Participation of total eligibles must be 50%</i>		
Total Enrolled	100	60
Total Employees Eligible for Coverage <b>(a)</b>	130	125
	76.9%	48.0%
	;	:
<i>Participation of net eligibles must be 75%</i>		
Total Enrolled	100	60
All eligibles, Excluding Spousal Waivers <b>(b)</b>	110	95
	90.9%	63.2%
<i>(a) Line 1. Enrolled plus Line 2. Waived due spousal coverage plus Line 3. Waived, other reason = Total Employees Eligible for Coverage</i>		
<i>(b) Line 1. Enrolled plus Line 3. Waived, other reason = All Eligibles, Excluding Spousal Waivers</i>		

Spousal waivers must be identified and verified through completion of a spousal waiver form at initial enrollment.

# Plan Offerings

*What product choices does EmblemHealth offer to large groups?*

**E**mblemHealth has developed a product suite of seven plan types that we offer on a full-takeover basis only. Within the plan types, copays for Hospital, Medical and Rx benefits can be customized for an employer. The seven plan types include the following products, listed in order of their average overall program cost :

- + PPO: EmblemHealth's highest level of coverage, offering employees the choice of seeing physicians in- or out-of-network.
- + InBalance PPO: Deductibles and coinsurance for out-of-network and select in-network services.
- + EPO: Network-only plan
- + InBalance EPO: Deductibles and coinsurance for certain in-network services.
- + ConsumerDirect PPO: High deductible plans with Health Savings Accounts.
- + CompreHealth EPO: Network-only plan with multi-specialty physician practices and individual practitioners.
- + ConsumerDirect EPO: Network-only high deductible plans with Health Savings Accounts.

A wide range of copays, deductibles and coinsurance levels are available within each product type so that numerous ranges of premium levels are available within each type of plan.

**Option Products:** *EmblemHealth has a selection of EPO plans that are available for sale in an option, or multiple carrier, offering. Please see Section 5, Option Product for Underwriting requirements for those plans.*

# Plan Combinations

*How many plans can a group have, and are there any rules about product combinations?*

**E**mployer groups can offer up to 3 plans to each of the following classes of employees, if they are classified according to:

- + Management/Union + Hourly/Salaried
- + Executive/Non-Executive
- + Worksite Location
- + Date of Hire

Any other definable class is subject to underwriting review and legal approval.

Employer groups can customize their plan offerings to members as follows:

- + Single Plan Offering: A member has a choice of 1 plan. Single plan offerings are available to groups of 51 or more eligible employees.
- + Dual Plan Offering: A member has a choice of 2 plans. Dual plan offerings are available to groups of 51 or more eligible employees.
- + Triple Plan Offering: A member has a choice of 3 plans. Triple plan offerings are available to groups of 100 or more eligible employees.

In order to minimize risk selection under Dual and Triple Plan offerings, EmblemHealth requires a minimum of 10% of enrolled contracts in each offering. Dual and Triple Plan offerings are also priced higher than single plan offerings because they carry a higher underwriting risk and plan administration cost.

All product combinations are allowed under Dual or Triple Plan offerings *with the exception* of combining a community-rated product with an experience-rated product.

EmblemHealth recommends establishing the CompreHealth EPO as a base plan in all Triple Plan offerings.

All plans must have the same riders—for example, each plan must have a pharmacy benefit—and each plan must have the same dependent age limits.

# Tier Structure

*What is available for quoting and what do we need to quote?*

**E**mblemHealth's premium rates can be provided on either a two-tier basis

(Employee/Family) basis or a four-tier basis (Employee, Employee/Child(ren), Employee/Spouse,Family).

If a group wants to change tier structure at renewal, the request must come in writing from the group. If the group wants to change to a four-tier rate from a two-tier rate, the group must identify who will be moving from the Family category into the Parent/Child(ren) category and the Husband/Wife category.

Premium rate tier structure must be the same for both plans in a Dual Plan offering and for all three plans in a Triple Plan offering. The Option Product must match the tier structure of the group's other carriers.

## Experience Rating

*Then what is experience rating? Does EmblemHealth use retrospective experience rating?*

**E**xperience rating is the general term referring to the use of a group's own claims in the calculation of its premium rates. When a group reaches the level of 750 contracts, the group is 100% credible, or fully credible. At that point, EmblemHealth will only use the group's own experience to determine its initial or renewal rate.

There are two types of experience rating: *prospective* experience rating, where premium rates are set for a year and EmblemHealth is at risk if actual claims and administrative costs vary from required premium, and *retrospective* experience rating, where a year-end accounting is done and the group shares in the gains or losses for the contract year based on the actual experience for the period.

EmblemHealth uses *prospective* experience rating for all large groups. Underwriting will, at its discretion, consider *retrospective* experience rating for groups with more than 1,000 enrolled contracts.

## Credibility Rating

*What is credibility rating and when do we use it?*

**W**hile all products in the EmblemHealth suite are experience-rated products, the degree to which a group's experience is factored into its rate depends on its size.

Simply put, very large groups have more accumulated experience data that can be reliably analyzed, and they have a larger premium base to absorb year-to-year claims fluctuations. Smaller groups have less data to evaluate and the premium base can appear to be too high or too low based on only a few claims.

## Rating Methodology

*How does EmblemHealth rate large groups? Does it vary by product?*

All products in the EmblemHealth product suite are experience-rated products. That means that a group's own claims experience is factored into both its initial premium rates and its renewal premium rates. And it means that a group's premium rates can fluctuate from year to year by more or less than general medical trends based on its own pattern of utilization.

## High Claims Pooling

*What if there are one or more catastrophic claims during a year— do they affect premium rates?*

Yes, but only up to a limit, which is called the pooling limit. EmblemHealth utilizes high claims pooling to minimize rate swings that might result—especially on smaller groups—if a catastrophic claim occurs and its payment exceeds a predetermined level. The levels are set by group size, and there is a charge applied to a group's initial and renewal premium to fund this pool. Smaller groups have a lower limit than larger groups because they are less able to absorb high claims in their premium base.

Only groups with *more than 1,000 contracts* can request opting out of the high claims pool, and Underwriting must approve the arrangement. A group which exempts itself from high claims pooling cannot return to a high claims pooling arrangement for 5 years.

All other groups are required to have high claims pooling. If a group wants to increase or decrease its pooling level, it can only be done once every three years. This maintains the stability of the pool for all groups. Pooling charges are calculated on a Per Member/Per Month basis and include a trend to account for medical inflation based on an actuarial memorandum on file with the Insurance Department.

## Funding Arrangements

*Can I get a self-funded, or Administrative Services Only quote?*

**G**roups with more than 250 contracts can be considered for self-funded quotes. An ASO group is charged a fee--either on a Per Contract/Per Month (PCPM) basis or on a percentage of claims basis--for the processing of its claims by EmblemHealth. A sample ASO contract is available from EmblemHealth's Compliance Department

*Can I get a Minimum Premium or Deferred Premium funding arrangement?*

**I**f Underwriting has approved a group with more than 1,000 contracts for retrospective experience rating, then *upon request*, Underwriting will also consider structuring an alternate funding arrangement, such as Minimum Premium or Deferred Premium arrangement for the group. Please contact Underwriting for details of these arrangements.

## New Business

### Requirements for Quotes

*What does Underwriting need in order to prepare a rate quote?*

**S**ales must provide all of the following data elements to evaluate a group:

- + Census data in Excel format
- + Current benefit summary
- + Current rates and renewal rate history
- + Three year carrier history
- + Paid claims by line of business (*required* on groups with more than 100 contracts)
- + Other documents available or requested by Underwriting, such as premium invoices and high claims reports.

## Brokers and Commission

*How do we factor commission into the rate proposal?*

**E**mblemHealth will include broker commission in rate proposals. Sales must indicate the broker commission level and the commission level must fall within EmblemHealth's filed commission ranges.

If there are multiple brokers requesting a quote for a prospect, the first quoted commission level for the first broker who submitted the prospect is the only level that will be quoted for the group.

If one broker provides data that is material to the quote process and significantly different than data provided by another broker, e.g., a different census, different claim data or different high claims data, EmblemHealth *reserves the right to retract* all quotes that were provided without this information and EmblemHealth will re-evaluate the proposal.

# Turnaround Time

*When can I get my rate quotes?*

**U**nderwriting turnaround time averages five business days if a submission is complete.

Formal RFPs are released according to the RFP's specified timeframes.

## Existing Business

**E**mblemHealth thoroughly analyzes the program costs of all of its enrolled accounts and prepares an annual renewal proposal tailored to each group's utilization patterns and benefit design. We estimate future claim levels and formulate alternative plan options that can provide opportunities for savings.

## Renewal Requirements

*How does EmblemHealth renew experience-rated groups?*

**A**ll groups enrolled with an experience-rated product will be provided with a renewal rate notification no later than 30 days before their anniversary with EmblemHealth *as long as* at the time of renewal, all *Group Eligibility* and *Employee Eligibility* requirements listed in *Section 1* are met.

If a group's total contract size falls below 51 at time of renewal, EmblemHealth will request a current census of the group to determine whether the group still meets *Group Eligibility* requirements. Failure to provide documentation of large group status will result in cancellation. *See Census data, Section 1 for more detail.*

## Renewal Components

<b>Account Size at Renewal:</b>	<b>Renewal Components:</b>
Less than 100 contracts	Renewal rates
100-250 contracts	As above, <i>plus</i> : Rate Rationale
	<u>Renewal period monthly claims and enrollment <i>upon request</i></u>
More than 250 contracts	As above, <i>plus</i> : Monthly claims reports provided four times per year <i>upon request</i> .

# Benefit Changes

*Can I see plan alternatives? When can I make changes?*

**E**mblemHealth can accommodate benefit change requests according to the following guidelines:

<b>Benefit change</b>	<b>Implementation period</b>
Benefit upgrades	At renewal for insured groups, anytime for ASO groups
Benefit downgrades	Anytime during the contract period

Benefit changes can be implemented up until the 20<sup>th</sup> day of the month preceding the effective date. This is to allow sufficient time to make changes in time to issue new identification cards, adjust bills and change product platforms.

## Option Product

**E**mblemHealth has a product line for opportunities where plan sponsors offer their employees more than one carrier's health plan and would like to include EmblemHealth among their offerings. Our *Option* product line has several EPO and ConsumerDirect EPO plan combinations that Sales can present to prospects.

The Option product is offered on a 4-tier basis to full-time active employees only. Retirees and COBRA participants are not eligible for the product. Rates are pooled rates and the rate development is proprietary to EmblemHealth. Renewal experience data is not provided to individual groups.

## Submitting a Quote Request

*How do I get an Option quote?*

**T**o request a quote, your account executive must complete a *New Business Submission Form*, an Option Product *Benefit Checkoff Sheet*, and obtain and submit the following data to Underwriting:

- + Current rates and plan designs for all of the plan sponsor's health plan offerings; Renewal rates and plan designs for all of the plan sponsor's health plan offerings; Full census of eligible employees

## Requirements for Quotes

*Are there any guidelines about benefits design or participation?*

**Y**es. We evaluate all rates and plan designs to ensure that our offering will be on a level playing field with the offerings of the other carriers. EmblemHealth *must be the lowest option* offered to the group or the product will not be quoted.

We also have guidelines for participation and employer contribution guidelines for the Option product:

- + Minimum Participation: Initial enrollment of 5% of total group eligibles and a minimum of 10% enrollment of total group eligibles by the 32<sup>nd</sup> month of coverage.
- + Maximum Participation: If the EmblemHealth offering gains more than 75% of total group eligibles, the group will be rated on its own at its next renewal with a total takeover product.
- + Employer contributions: At least 50% across all premium rate tiers, or at least 100% of the employee-only rate.

## Renewals

### *How do you renew Option products?*

We renew groups with the Option product in a similar way to the evaluation performed at initial underwriting. We will request the following information from Account Management: + Current rates and plan designs for all of the plan sponsor's health plan offerings.

- + Renewal rates and plan designs for all of the plan sponsor's health plan offerings. + Full census of eligible employees.

We will also check to see if the group has met or exceeded the product's participation guidelines. As long as the group also still meets overall guidelines for *Group Eligibility* and *Employee Eligibility* in *Section 1* and the specific guidelines in this section, Underwriting will release a renewal rate sheet to Account Management. Rates are pooled rates and the rate development is proprietary to EmblemHealth. Renewal experience data is not provided to individual groups.