



Midwest Small Group Underwriting Guide

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<i>The Underwriting Department at Anthem Blue Cross and Blue Shield is committed to providing excellent service to our customers, the brokers that partner with us. We will provide our brokers with the tools necessary to write the quality products Anthem offers to small employers. This Underwriting Guide is intended to be a tool to help you understand our underwriting rules and guidelines as you enroll new groups with Anthem.</i>	I. Who is Eligible? 2
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I. Who is Eligible?

Eligible groups

An employer group with at least two, but not more than 50 full-time, eligible employees.

Classing out of employees (e.g., management only groups) is not allowed except in the case of union negotiated benefits. However, all eligible employees, including both union and non-union employees, are used to determine if the group is small or large.

The Health Insurance Portability and Accountability Act states that all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code shall be considered one employer.

Eligible employees

- *Full-time employees working at least 30 hours (25 in Ohio) per week and paid by W-2.*
- *Full-time working owners or partners.*
- *1099 employees are eligible if they work 30 or more hours (25 in Ohio) per week, work exclusively for the company with which they are applying and at least 50 percent of the group is paid by W-2.*

Industry groups

There are industries that present higher than average and lower than average risks for future health expenses. Anthem establishes rates for differences in industry risk. Respective lower and higher industry factors apply to the rates. The examples below are industries with lower and higher than average risks. This list is not all-inclusive.

Lower Risk Industries

Accounting
Architect
Advertising
Banking & Financial Institutions
Business Services
Certificated Air Transport
Commodity Traders
Communication
Computer Programming Services

Lower Risk Industries (continued)

Credit Agencies other than Banks
Dairy Products
Electric Lighting, Wiring Equipment/Radios/TVs
Engineering
Engines and Turbines, Farm/Garden Machinery
Equipment Rental
Holding, other Investment Companies
Instruments and Related Products
News Syndicates
Office and Computer Machines
Paper and Paper Products
Printing and Publishing
Public Relations
Refrigeration and Service Machinery
Research
Surveying Services

Higher Risk Industries

Agriculture
Amusement and Recreation
Asbestos Products
Drinking Places
Eating Places
Explosives
Fishing, Hunting
Health Services
Hospitals
Hotels/Other Lodging
Leather Tanning
Liquor Stores
Local Passenger Transportation
Mining and Quarrying
Oil and Gas Extraction
Physical Fitness Facility
Primary Metal Industries
Public Administration
Railroad Transportation
Sanitary Services
Scrap and Waste
Taxicabs
Trucking
Water Transportation

II. Underwriting Requirements for New Groups

Employer application

The employer application must be completed, signed and dated by the broker who sells the new group and the authorized group representative. The employer application provides the underwriter with information to assess the risk, including the nature of business, eligibility, employer contribution levels, prior carrier information, requested effective date and other data necessary to process the group.

Enrollment applications

Enrollment applications must be completed and signed by all eligible employees, including those waiving coverage, those on COBRA or in their COBRA election period, employees not actively at work, and those in their waiting period.

Full medical information is required for applicants applying for health coverage.

We do not require medical information for waivers.

We do not require medical information for life only applicants as long as they are applying for the guaranteed issue amount.

Wage and tax statement

The most recent Quarterly Wage and Tax Statement must denote “full-time,” “part-time,” “termed,” plus dates, etc., by all names and include any new hire names, plus dates of hire to clarify status. The Wage and Tax Statement is used to verify eligibility and participation requirements are being met.

Anthem’s benefit/rate proposal

Anthem’s benefit/rate proposal must be signed and dated by the group’s representative. The proposal verifies the benefits and requested effective date being applied for by the group.

Most recent prior carrier billing

Verifies participation requirements and is used to substantiate evidence of creditable prior coverage.

Initial premium check

First month’s premium check is required to submit a group.

Other requirements

Other requirements may be necessary as the needs of the business change. Anthem’s Underwriting Department may require an Attending Physician’s Statement (APS) to make a rating decision. Underwriting may also request a Medicare/Secondary Payer Form.

III. Underwriting Rules for Health Coverage

Employer contribution

The minimum employer contribution is at least 25 percent of the total cost for health coverage(s) chosen in the event the employee has dependent coverage, and at least 50 percent of the total cost for health coverage(s) in the event the employee has single coverage. If the employer contributes 100 percent of the premium, 100 percent of the net eligible employees must enroll.

Participation requirements

Minimum participation requires at least 75 percent of net eligible employees (net out those waiving coverage due to having other group health insurance through their spouse) and 50 percent of the total eligible employees. A minimum of two employees must be enrolled.

For example, a group has 14 total eligible employees:

- *four employees have spousal group coverage and waive coverage, leaving 10 people “net eligible”*
- *75 percent (10) = 7.5 or (eight) required*
- *eight employees are greater than 50 percent of the total employees eligible (.50(14)) = seven employees required*
- *a minimum of “eight employees” must enroll to meet minimum participation*

As a result, the group meets participation requirements by having at least 75 percent of the net employees enrolling and at least 50 percent of the total employees enrolling.

Participation requirements and eligibility may be checked periodically to ensure compliance.

If a group does not meet minimum participation or contribution requirements, the group coverage will be terminated.

Multiple product offerings

With a changing economy, Anthem has recognized a need for employers to provide different levels of coverage to their employees. Anthem offers a variety of multiple product offerings to their small employers including Dual Choice (HMO/PPO), Anthem ByDesign[®], and Anthem ByDesign[®] for Health Savings Accounts.

For these products, an employer must have a minimum of 10 employees enrolled between the two plans with at least two covered in the plan with the lowest enrollment. In addition, there must be a 10-35 percent spread in the cost of benefits between the two plans. Movement between the plans is only allowed during the plan’s open enrollment period.

Waiting period(s)

A waiting period is the time a new employee must wait before coverage is effective. Waiting period options are:

For Indiana and Kentucky - 0, 30, 60, 90 or 180 days or the first of the month following any of these periods.

For Ohio - 0, 30, 60, 90 days. Ohio law does not allow more than a 90-day waiting period. Coverage will be effective on the 91st day, if enrollment forms are received within 120 days of hire date.

A group may change their waiting period one time per year upon written request. The earliest date is the date the request is received by Anthem.

The waiting period change will not be for existing employees, only a new employee hired after the request is received.

III. Underwriting Rules for Health Coverage (cont.)

Late enrollees

A late enrollee is one who applies for coverage more than 30 days after they are eligible for coverage, or more than 30 days after the end of the waiting period. An enrollee is not late, if, at the time of enrollment, the enrollee had other health insurance coverage, signed a waiver to that effect and later lost that coverage for one of the following reasons:

- *termination of the health insurance plan*
- *death of a spouse*
- *divorce*
- *termination of employment*

If coverage is applied for within 31 days of this event, the person is not a late enrollee, but a “special enrollee.”

Late enrollees may only enroll during the group’s open enrollment period. The open enrollment period begins 30 days before and ends 30 days after the anniversary date.

Pre-existing conditions and creditable coverage

The pre-existing condition exclusion will apply when medical advice or diagnosis, care or treatment was recommended or received for a condition during the 6 months prior to an individual’s enrollment date.

The pre-existing condition exclusion will not last for more than 12 months (nine months in Indiana) after an individual’s enrollment date, if timely enrollment has been made. The pre-existing condition exclusion is 18 months (15 months in Indiana) if late enrollment has been made.

The exclusion period will be reduced by the number of days the individual had prior creditable coverage, excluding coverage before any break in coverage of 63 days or more.

Certificates of Creditable Coverage are not required for new groups. The employee application will provide the Underwriting department with information required to determine prior coverage,

effective and termination date, reason for termination, and the name of the prior carrier. This information must be completed to ensure appropriate pre-existing credit is given.

Or instead, any of the documents listed below can be substituted for the Certificate of Creditable Coverage to support evidence of prior coverage:

- *a copy of prior carrier’s bill, provided effective date of coverage is listed*
- *a health insurance identification card*
- *a certificate of coverage under a group health policy*
- *records from medical care providers indicating health coverage, or*
- *an explanation of benefits claim (EOB)*

Effective dates

The earliest possible effective date is the date all new case requirements are received by Anthem’s Underwriting department. A future effective date cannot exceed 90 days from the date the applications are signed or 60 days from the date the group is submitted.

For Kentucky, effective dates can be the 1st or 15th of the month.

For Indiana and Ohio, effective dates can be the 1st, 5th, 10th, 15th, 20th or 25th day of the month.

It is recommended that the group maintain current coverage until underwriting approval is finalized.

Medical underwriting

Enrollment applications must be completed and signed by all eligible employees, including those waiving coverage, those on COBRA or in their COBRA election period, employees not actively at work, and those in their waiting period.

Full medical information is required for applicants applying for health coverage.

We do not require medical information for waivers.

III. Underwriting Rules for Health Coverage (cont.)

We do not require medical information for life only applicants as long as they are applying for the guaranteed issue amount.

Completion of the medical information section provides answers to health questions about employees and their dependents. This information is used to rate the group based on the risk of future health expenses. More individual risk is assumed as the size of the group increases.

Below is a list of health impairments that have potentially high claims dollars. It is probable that a small group with these conditions may require a sizable rating factor. This list is not intended to be all-inclusive.

Acquired Immune Disorder Syndrome
Aneurysm
Aortic Valve Replacement
Arteriosclerotic Heart Disease
Bone Marrow Transplant
Cancer
Chronic Pancreatitis
Chronic Renal Disease
Coronary Artery Disease
Cystic Fibrosis
Heart Attack
Heart Surgery
Hemophilia
Hepatitis B or C or Chronic
Kidney Diseases
Kidney Transplant
Liver Transplant
Muscular Dystrophy
Peripheral Vascular Disease
Quadriplegia
Stroke

Each health condition has varying degrees of associated risk. Anthem's underwriter assesses the exact diagnosis, dates, treatments, medications and prognosis to assign an appropriate rate for the risk. It is important that the applicant disclose this information with full details to ensure there is no delay in the process and that the appropriate rating is assigned. Misstatements or failures to report medical information prior to the effective date may result in a material change to coverage or premium.

Below are common health conditions. The questions regarding these conditions are a guideline/tool to help you provide details for pricing the group submission.

Arrhythmia's (Heart)

1. Type/Diagnosis?
2. Date of onset?
3. Treatment including medications?
4. Any evidence of underlying heart disease or systemic disease?
5. Has surgery been advised or discussed?

Arthritis

1. Type – Rheumatoid, Osteoarthritis, Psoriatic, Juvenile?
2. Date of onset?
3. Joints affected?
4. Joint deformities?
5. Treatment including medications/surgery?
6. Any activity restrictions?
7. Has surgery been advised or discussed?

Asthma

1. Date of onset?
2. Number of episodes per year?
3. If hospitalized or treated in the ER, provide dates.
4. Treatment including medication?
5. Currently smoking?

Back Conditions

1. Date of onset?
2. Exact diagnosis?
3. Any disk disorders?
4. If surgery performed or anticipated, provide dates.
5. Treatment including medication?

Cancer

1. Date of diagnosis?
2. Exact diagnosis/type?
3. Location of cancer?
4. If surgery performed or anticipated, provide dates.
5. Radiation/Chemotherapy and dates?
6. Any lymph node involvement?
7. Any evidence of metastasis?
8. Any other treatment recommended, but not yet performed?

III. Underwriting Rules for Health Coverage (cont.)

Cataract

1. If surgery performed or anticipated, provide dates.
2. Unilateral or bilateral?
3. Further treatment anticipated?

Chest Pain

1. Dates of episodes?
2. Cause/diagnosis?
3. Treatment including medications?

Cholesterol

1. Treatment including medication?

Colitis

1. Type – irritable bowel, spastic, ulcerative, Crohn’s disease?
2. Number of episodes and dates?
3. Treatment including surgery, medication and/or steroids?
4. Future surgery advised or discussed?

Diabetes

1. Date of diagnosis?
2. Treatment including medications/insulin?
3. Last Hemoglobin A1C, date and results?
4. Any complications due to diabetes?
5. Currently smoking?

Emphysema (Chronic Obstructive Pulmonary Disease)

1. Date of onset?
2. Treatment including medications?
3. If hospitalized or treated in the emergency room, provide dates.
4. Currently smoking?
5. Any history of smoking and date of last use?
6. What activities cause shortness of breath?

Epilepsy/Seizures

1. Type of seizures – Petit mal, Grand mal, other?
2. Number and dates of seizures?
3. If hospitalized or treated in the emergency room, provide dates.
4. Treatment including medication?

Gerd/Acid Reflux

1. Treatment including medications?

Heart Disease

1. Exact diagnosis?
2. Heart attack and dates?
3. Heart surgery (and type) and dates?
4. Number of heart vessels involved?
5. Other treatment including medication?
6. Currently smoking?

Hepatitis C

1. Current treatment including medications?
2. Any symptoms?
3. Liver function tests normal or abnormal?
4. Transplant advised or anticipated?

Hypertension (High Blood Pressure)

1. Treatment including medications?

Lupus

1. Type – Discoid or Systemic?
2. Date of onset?
3. Symptoms and organs involved?
4. Treatment including medications?

Mental or Nervous Disorders

1. Exact diagnosis?
2. Dates of episodes?
3. Treatment including medications?
4. Hospitalizations and dates?
5. Is counseling required?

Multiple Sclerosis

1. Date of onset?
2. Treatment?
3. Current functional limitations or mobility problems?

Pregnancy

1. Due date?
2. Any history of complications?
3. Is a Caesarian Section or multiple birth anticipated?

Stroke

1. Dates?
2. Operated and dates?
3. Treatment including medication?
4. Residual Effects?
5. Currently smoking?

IV. Underwriting Rules for Ancillary Coverage

Dental

Dental contributions should match the medical; however, when it does not, it must be at least 25 percent of the total, but not less than 50 percent of the single rate.

Dental participation should match the medical; however, when it does not it must be at least 50 percent of the total eligible employees, or 75 percent of the “net eligible employees,” whichever is greater. “Net eligible employees” are the total eligible employees less those with other group dental coverage not sponsored by the same employer.

Eligibility waiting periods and effective dates must match the medical. In addition, it is preferred that the enrollment category (i.e., single/family status) be the same for medical and dental, but this is not required. However, regardless of the enrollment category, the employee must always take the coverage.

Retiree dental coverage is not available for small groups.

For groups taking dental coverage only (i.e. stand-alone dental), at least 10 employees must enroll.

Dual choice of dental products is not available for small groups.

Orthodontia coverage is available to small groups with at least 15 enrollees. If the group had prior orthodontia coverage, the minimum is 10 enrolled.

Vision

Vision contributions should match the medical; however, when it does not, it must be 25 percent of the total but not less than 50 percent of the single rate.

Eligibility waiting periods and effective dates must match the medical. The enrollment category (i.e., single/family status) must be the same for medical (or dental if sold only with dental) and vision.

Retiree vision coverage is not available to small groups.

Stand-alone vision coverage is not available to small groups.

Dual choice of vision products is not available for small groups.

A minimum of 10 enrollees is required for dental and vision only coverage (i.e., no medical).

Life and disability

Minimum employer contribution for all coverages (except dependent life) is 25 percent. Employee may pay 100 percent of dependent life premiums, as there is no minimum employer contribution.

Employee participation requirements are 100 percent if the plan is non-contributory (entirely employer paid) and 75 percent of eligible participation if the employee contributes.

Evidence of insurability may be required for late enrollees and individuals that apply for amounts over the guaranteed issue limit.

V. Other Underwriting Rules

Renewals

Renewals are projected based on the experience of the pooled small group block. A portion of the renewal is based on the experience of each group. Small group rating restrictions are applied. Rating restrictions limit the degree of price variation in two ways:

1. The premium rates charged during a rating period to employers having similar case characteristics and similar benefits may not vary from the midpoint by more than +/- 35 percent (+/- 50 percent in Kentucky).
2. The maximum rate increase for any group may not exceed the sum of:
 - The percentage change in base rates (new business rates),
 - 15 percent (20 percent in Kentucky) annual increase based on claims experience, health status or coverage duration, and
 - Any adjustments due to changes in benefit design, demographics, census, age or changes in the case characteristics of the small employer group.

Requests for Benefits Changes

A group may request a reduction in benefits at any time throughout the year except within 100 days prior to their renewal date. A signed and dated quote must be submitted.

An increase in benefits may be requested at the group's renewal date and underwriting approval is required.

For Kentucky, a written statement may be required from the group for off-cycle benefit reductions acknowledging that the new rate is less than 12 months.



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