California Small Group Medical Underwriting Guidelines

Standard Guidelines

Standard Guidelines

1
Eligibility Requirements

1.1
Small Employer

1.1.1
Definition

In order for an employer to qualify as a small employer under the legislation, the group must:

- Maintain a primary presence in the state of California (HSC §1357.500).
- Have a majority of its employees working within the state. Thus, any group with more than 49% of its eligible employees working outside the state of California will not be considered for coverage under the legislation (HSC §1357.500).
- Be a person, proprietary or nonprofit firm, corporation, partnership, public agency, or association that is actively engaged in business or service (HSC §1357.500).
- On at least 50 percent of its working days during the preceding calendar quarter, or preceding calendar year, employ at least one, but not more than 100 employees, when adding full-time employees together with full-time equivalents (quarters do not need to be consecutive). Note: In determining whether to apply the calendar quarter or calendar year test, the test that ensures eligibility must be used, if only one test would establish eligibility (HSC §1357.500, 26 USC 4980H(c)(2)).
- Not be comprised of owners only, or owners and spouses only, regardless of the type of business entity. Once it has been established that there is at least one eligible W-2 employee that is not the owner or spouse of the owner, a group may then enroll any owner and/or spouse that otherwise meet the requirements of an eligible employee (HSC §1357.500).
- Not have formed primarily for the purposes of buying health insurance (HSC §1357.500).
- Show that a bona fide employer-employee relationship exists. This is established through the collection of paperwork including but not limited to: the Group Service Agreement (GSA), DE-9C, Company Payroll, Workers' Compensation, and binder payment (HSC §1357.500).

Note: Affiliated companies that are eligible to file a combined tax return for state taxation; companies that are part of a controlled group of corporations; trades or businesses, whether incorporated or unincorporated, that are under common control; or, affiliated service groups may enroll under the same policyholder as long as they still meet the definition of a small employer as a combined entity.

1.1.2
Calculation of Group Size

Beginning with 1/1/2016 effective business, the definition of a small employer requires the size of the group to be determined by adding together the number of full-time employees (i.e., those working a minimum of 30 hours per week on average) and full-time equivalent employees, the majority of whom were working in California, for 50% of the prior calendar quarter or 50% of the prior calendar year. Seasonal workers, temporary workers, leased employees, contractors, and those on COBRA are not counted. However, any group with 100 or fewer employees on their DE-9C cannot be Large Group, so this calculation does not need to be performed unless a group has 101 employees or more on its DE-9C. Health Net will not perform this calculation on behalf of the employer, but will require the employer to fill out the Group Size Attestation form attesting to the fact that they have performed the group-size calculation using one of the methods below. Please see Section 7.8 for more details.

1.1.2.1
50% of the Prior Calendar Quarter Test

To determine the number of full-time equivalents using the 50% of the prior calendar quarter test, add up the total number of hours worked by all non-full-time employees (i.e., those working less than 30 hours per week on average) over the course of 6 weeks during the calendar quarter prior to the quarter for which coverage is being requested, and divided that number by 180. If your calculation does not come out to a whole number, round down.

Formula:
Total # of Full-time Employees + (Total # Non-full-time Employees' hours worked / 180)

Example 1:
An employer has applied for coverage effective 3/1/2016 and has submitted the Q4 2015 DE-9C and 6 weeks of payroll from the same time period. There are 90 full-time employees and the non-full-time employees worked 900 hours over the course of 6 weeks. Group size is calculated as follows:

90 + (900 / 180) = 90+5=95.

In this example, there are fewer than 101 employees, so the group is eligible for small employer coverage.

Example 2:
An employer has applied for coverage effective 2/1/2016 and has submitted the Q4 2015 DE-9C and 6 weeks of payroll from the same time period. There are 95 full-time employees and the non-full-time employees worked a total of 1200 hours over the course of 6 weeks. Group size is calculated as follows:

95 + (1200 / 180) = 95+6.67=101.67 = 101

In this example, there are 101 employees, so the group is not eligible for small employer coverage.

1.1.2.2
50% of the Prior Calendar Year Test

To determine the number of full-time equivalents using the 50% of the prior calendar year test, add up the number of hours worked by all non-full-time employees (i.e., those working less than 30 hours per week on average) over the course of a month and divide that number by 120. That is your FTE calculation for one month. Perform that calculation for 6 months during the prior calendar year and divide that number by 6. If your calculation does not come out to a whole number, round down. That is your FTE calculation for 50% of the prior calendar year.

Formulas:
Total # of Full-time Employees + (Total # Non-full-time Employees' hours worked / 120)
(Employee count for Month 1 + Month 2 + Month 3 + Month 4 + Month 5 + Month 6) / 6

Example 1:
An employer has applied for coverage effective 1/1/2016 and has submitted the Q2 and Q3 2015 DE-9Cs and 26 weeks of payroll from the same time period. It is determined there were 87 full-time employees in April, 94 in May and June, 92 in July, and 93 in August and September. It was also determined that the non-full-time employees worked 1000 hours in April, 900 hours in May, 950 hours in June, 1100 hours in July, 1050 hours in August, and 1200 hours in September. Group size is calculated as follows:

April 2015: 87 + (1000/120) = 87 + 8.33 = 95.33
May 2015: 94 + (900/120) = 94 + 7.50 = 101.50
June 2015: 94 + (950/120) = 94 + 7.92 = 101.92
July 2015: 92 + (1100/120) = 92 + 9.17 = 101.17
August 2015: 93 + (1050/120) = 93 + 8.75 = 101.75
September 2015: 93 + (1200/120) = 93 + 10 = 103

(95.33 + 101.5 + 101.92 + 101.17 + 101.75 + 103) / 6 = 604.65/6 = 100.78 = 100

In this example, there are fewer than 101 employees, so the group is eligible for small employer coverage.

1.2 Employee

1.2.1 Eligible Employees

As required by HSC 1357.500(c)(1), in order to be eligible, the following criteria must be met:

Any permanent employee who:

- Is actively engaged on a full-time basis in the conduct of the business of the small employer.
- Has a normal workweek of an average of 30 hours per week over the course of a month.
- Is located in the small employer's regular place of business.
- Has met any statutorily authorized applicable waiting period requirements.
- Is included as employees under a health benefit plan of a small employer.
- A permanent employee who works at least 20 hours but not more than 29 hours is deemed to be an eligible employee if all five of the following apply:

    1) The employee otherwise meets the definition of an eligible employee except for the number of hours worked.

    2) The employer offers the employee health coverage under a health benefit plan.

    3) All similarly situated individuals are offered coverage under the health benefit plan.

    4) The employee must have worked at least 20 hours per normal workweek for at least 50 percent of the weeks in the previous calendar quarter.

    5) Necessary information has been provided to document the hours and time period in question, including, but not limited to, payroll records and employee wage and tax filings.

1.2.1.1 Commissioned Employees/Statutory Employees

A commissioned employee for purposes of this section is an employee who derives a majority of their income from commissions. This also includes statutory employees who derive the majority of their income from commissions. Employees who do not derive a majority of their income from commission shall be treated as regular employees.

The nature of commissioned work presents a risk of high turnover. In an effort to reduce this dynamic, the commissioned employee must:

- Be on a draw, get a wage, or earn a level of commission consistent with the earnings of an eligible non-commissioned employee.
- Be covered by the employer's Workers' Compensation.
- Be employed on a full-time basis meeting the hours-per-week requirement and probationary period indicated on the GSA.
- Be reported on the most recent DE-9C (or 2 weeks of payroll, documenting a base salary or a consistent level of commission, if employee is new and does not appear on last quarter's DE-9C).
- Submit a letter from group explaining the situation and defining the relationship between the employer and each commissioned employee. The letter must elaborate upon any low wages, identify who is commissioned, and describe any agreement involved.

1.2.1.2
Union Employees

A labor union is an organization of employees who have united in order to improve their working conditions. The leaders of a union negotiate a collective bargaining agreement with the management of the company that the employees work for, agreeing to various conditions and benefits such as work hours, wages, promotions, hiring and firing, workplace safety, and health benefits. Not all collective bargaining agreements are alike. Some require the employer to provide coverage for its union employees directly. Others establish a labor fund that provides coverage for the union employees.

When employers are required to provide coverage directly for their union employees, all employees meeting the definition of an eligible employee—whether union or non-union—will be eligible for coverage.

When employers have union employees that are obtaining coverage through a labor fund, those employees will also be considered eligible if they meet the definition of an eligible employee. However, recognizing that union employees in this scenario will remain on the union coverage, Health Net will consider those employees to be valid waivers in an effort to help employers meet Health Net's participation requirements.

In either scenario, only those employers with a total group size that conforms to small group legislative requirements will be eligible for small employer coverage. This means that the group cannot have had more than 100 total employees in both the union and non-union populations for at least 50% of the prior calendar quarter or 50% of the prior calendar year. Please see Section 7.11 for information on the additional paperwork required for groups with union employees.

1.2.1.3
Employees on Leave of Absence (LOA)

Depending on the circumstances, employees out on a leave of absence may be considered for coverage under Small Group. Please refer to the below listing for specific guidelines:

- Sabbatical—Employees on Sabbatical will not be allowed under any circumstances on the active plan. However, any employee on Sabbatical at the time of sale who is currently offered coverage through the group may be extended COBRA.

- Non Workers' Compensation Related Disability—Employees not actively at work, due to a non-work related injury, for less than 6 months, will be allowed to enroll under the active plan as long as the employee is currently covered under the group's plan as active. Those employees out on a leave of absence who are not currently covered under the group's active plan may not be considered for coverage. Once an employee has been on LOA under this circumstance for a period of six months, they must be transferred off the active plan onto COBRA. Those employees who are not expected to return within 6 months or who have been out for a period of more than 6 months will be extended COBRA if currently covered under the active plan.

- Family Medical Leave—An employer may elect to cover employees out for FMLA under the active plan as long as the leave is no longer than a period of 12 weeks and the employee is currently covered under the active plan. Those employees who are not currently covered under the group's active plan will not be considered for coverage. An employee that has been out longer than a period of 12 weeks, who is currently covered on the active plan, may be extended COBRA/Cal-COBRA.

- Military Duty/Training—Employees not actively at work due to active military service or training may remain on the group policy or may be removed from coverage during this time. Employees who are removed from coverage will be reinstated to active coverage without waiting periods upon return from leave. In either case, an official government document establishing active military status must be provided.

- Workers' Compensation Leave—An employee that is on leave due to a Workers' Compensation injury/illness, will be permitted to remain on active coverage provided the employer submits a letter on company letterhead specifying that the employee is on Workers' Compensation leave.

Any employee enrolling must establish the employer-employee relationship in addition to specific requirements mentioned above, by way of a DE-9C and/or payroll information. Those employees, who as a result of the above are offered COBRA or are not covered, must complete the probationary period for the group and submit necessary paperwork to prove eligibility before they will be allowed to enroll.

1.2.2
Ineligible Employee

1.2.2.1
Retirees

Both Early Retirees and Retirees are by nature no longer actively at work and as such are not eligible for coverage under the legislation. No exceptions will be considered.

1.2.2.2
Part Time

Those employees who do not meet the hours-per-week requirement shall be considered part time and therefore ineligible for coverage. Any individuals listed on the DE-9C who show high wages relative to the enrolling population will have their status questioned and will be required to submit payroll showing hours worked. There is no alternative to this requirement.

1.2.2.3
Seasonal/Temporary/Substitute

In order to be considered eligible, an employee must be permanent and actively engaged on a full-time basis. As such, seasonal and temporary employees are not covered by the legislation and may not be considered for coverage.

To establish ineligibility, any group with seasonal employees must submit enough evidence to establish "seasonal" status. Acceptable evidence includes multiple DE-9Cs or payroll showing a truly seasonal relationship with the employer. Those seasonal or temporary employees who appear on consecutive DE-9C's for six months, or more, with similar wages, will be considered eligible and therefore must enroll or decline coverage.

1.2.2.4
1099 Employees/Statutory Non-Employees

1099 employees and statutory non-employees are not contemplated under the definition of an eligible employee and therefore are not eligible for coverage.

2
Rate Considerations

2.1
Rate Guarantee

Health Net provides for a 12-month rate guarantee for new and existing business. The only exception to this offering is at the request of the employer. Employers that would like to waive their right to a 12-month contract must submit a request in writing clearly outlining their desires.

2.2
Rating Methodology

The only factors that may be used for premium rating for an employee are age, geographic region, and family composition. No other factors, including medical history, health risk, or tobacco use, may be used.

2.2.1
Age Bands

- 0-14
- 15-20, in one-year increments
- 21-63, in one-year increments
- 64+
- Note: The rate of a 64-year-old may not be more than three times the rate of a 21-year-old.

2.2.2
Geographic Regions

California is divided into 19 different rating regions:

- Region 1: the Counties of Alpine, Del Norte, Siskiyou, Modoc, Lassen, Shasta, Trinity, Humboldt, Tehama, Plumas, Nevada, Sierra, Mendocino, Lake, Butte, Glenn, Sutter, Yuba, Colusa, Amador, Calaveras, and Tuolumne
- Region 2: the Counties of Napa, Sonoma, Solano, and Marin
- Region 3: the Counties of Sacramento, Placer, El Dorado, and Yolo
- Region 4: the County of San Francisco
- Region 5: the County of Contra Costa
- Region 6: the County of Alameda
- Region 7: the County of Santa Clara
- Region 8: the County of San Mateo
- Region 9: the Counties of Santa Cruz, Monterey, and San Benito
- Region 10: the Counties of San Joaquin, Stanislaus, Merced, Mariposa, and Tulare
- Region 11: the Counties of Madera, Fresno, and Kings
- Region 12: the Counties of San Luis Obispo, Santa Barbara, and Ventura
- Region 13: the Counties of Mono, Inyo, and Imperial
- Region 14: the County of Kern
- Region 15: the ZIP Codes in Los Angeles County starting with 906 to 912, inclusive, 915, 917, 918, and 935
- Region 16: the ZIP Codes in Los Angeles County other than those identified in Region 15
- Region 17: the Counties of San Bernardino and Riverside
- Region 18: the County of Orange
- Region 19: the County of San Diego
- Note: Rating for all employees, whether residing in California or out of state, will be based on the employer's principal business address in California. Please see §2.2.3 for additional information.

2.2.3
Principal Business Address

45 CFR 147.102(a)(1)(ii)(B) requires an employer's principal business address to be used for rating purposes. Principal business address is defined as the worksite registered with the State, or if the business is not registered with the State, or is registered but is not a substantial worksite for the employer's business, the principal business address is the worksite within the State where the greatest number of employees works.

Health Net will deem the registered address for all corporations, LLCs, and registered partnerships, as the address filed with the Secretary of State. Any employer group not required to file with the Secretary of State may use the address listed on the DE-9C.

The rating region will be based on the business address where the greatest number of eligible employees work. In the event none of the employer's addresses are within the rating region for a plan or network being offered, the rating region where the most eligible employees reside may be used instead.

Under no circumstances may an employer have more than one rating region assigned and all rating regions must be approved by Underwriting.

2.2.4
Family Composition

The family premium is determined by summing the rates of the employee, the spouse, all dependent children ages 21-26, and the three oldest covered children under age 21. Additional child dependents under the age of 21 will be able to enroll with no additional premium charged to the employee.

2.2.5
Composite Rates

Composite rates are not available for any product or plan.

3
Plan Portfolio Specific Guidelines

3.1
Enhanced Choice

Enhanced Choice is a prepackaged set of plans from which a group chooses outside of any plan combination rules. Enrollees may select from any and all plans offered within the package. The following rules apply:

- Age banded rates only.
- Health Net is not required to be sole carrier as long as minimum participation requirements are met.
- For groups of 1-4 enrolling employees, a minimum of 70% participation is required. For groups of 5-100 enrolling employees, a minimum of 25% participation is required.
- A minimum of 1 enrolled active subscriber is required.
- A minimum contribution by the employer of 50% of the lowest cost plan, or $100 per employee to the employee rate, is required.
- If selected, the chiropractic rider will be applied to all plans within the package.
- If selected, the infertility rider will be applied to all plans within the package.
- Groups of 2 or more may mix and match any plans within the following networks:
    - Full Network HMO
    - WholeCare HMO
    - SmartCare HMO
    - Salud HMO y Mas
    - CommunityCare HMO
    - PPO

Service area restrictions apply to all networks with the exception of PPO.

4
Carrier Specific Guidelines

4.1
Effective/Case Completion Dates

4.1.1
Standard Effective Date

Health Net provides for a standard effective date of the first of the month. All cases requesting a first of the month effective date must be received by the 5th of the month for which coverage is to be effective. If the 5th of the month falls on a weekend or holiday, the cut-off date for submission will fall to the following business day.

4.1.2
Odd Effective Date

For cases in which group coverage from the prior carrier terminates on the 14th, Health Net will provide for a 15th of the month effective date. All cases requesting a 15th of the month effective date must be submitted by the 20th of the month for which coverage is to be effective. When requesting a 15th of the month effective date, please include a check for six weeks premium, and a prior carrier bill or other documentation showing termination on the 14th. Note: Groups applying for a 15th of the month effective date will be given a 12.5-month contract to facilitate a 1st of the month renewal.

4.1.3
Case Completion Dates

All standard effective date cases must be complete by the 20th of the month for which coverage is to be effective. All odd effective date cases must be complete by the 25th of the month for which coverage is to be effective. Those cases, which are not complete by their respective completion dates, will be moved to the next available effective date.

Cases not meeting minimum participation and/or contribution requirements that are submitted between November 15th and December 15th during the special enrollment period for a January 1st effective date are required to be complete by January 20th. Cases not complete by January 20th will be required to withdraw and resubmit their application during the next special enrollment period. Please see Section 5.7 for more information on the special enrollment period.

4.2
Turnaround Time

Under normal conditions Health Net will process complete new business requests for coverage within 3 business days. The 3 days are comprised of the following steps:

- Case Review—Health Net will make every effort to review all new business case submissions within 2 business days after receipt. Those cases that are complete will move to the next step, while those cases with missing information or incomplete information will be required to submit said information before proceeding. Any missing information not received by the 20th of the month for which coverage is being sought shall be moved to the effective date of the following month.

- Case Approval—Once the case is complete and accepted, Health Net will complete all necessary information related to the approval of the case within 1 business day. Completion of this step includes sending the case to membership for installation.

The above constitutes Health Net's standards with respect to case submission and approval. While it is desirable to underwrite all cases within these standards, Health Net reserves the right to modify the above timeframes as needed.

5
Group Specific Guidelines

5.1
Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008

When employers subject to MHPAEA offer mental health coverage, the terms and conditions of the mental health benefits cannot be any more restrictive than the medical. This legislation affects any employer who had an average of 51 or more total employees during the previous calendar year, even if they had between 1 and 50 eligible employees. However, all Small Group products and plans are MHPAEA compliant, so determining the average number of employees during the prior calendar year is not necessary.

5.2
Gender Nondiscrimination in Health Insurance

An applicant's gender, gender identity, or gender expression cannot be used as risk selection criteria to determine the insurability of an applicant or of an employer group for any of Health Net's Small Group products. Specifically, during the underwriting evaluation of an employer group, Health Net:

- Cannot deny, cancel, limit, or refuse to issue or renew an insurance policy based on gender, gender identity, or gender expression.
- Cannot demand or require a payment or premium that is based on gender, gender identity, or gender expression.
- Cannot designate gender, gender identity, or gender expression, including that an individual is a transgender person, as a preexisting condition for which coverage would be denied or limited.

5.3 Workers' Compensation Coverage

All employees, except those not required by law, must be covered by workers' compensation. This requirement is imperative to the establishment of an employer-employee relationship and allows Health Net to avoid the cost associated with work-related injuries.

Business owners such as sole proprietors, partners of partnerships, officers of corporations, and members of Limited Liability Companies, are often excluded from this requirement; however, in some instances, they may be required to be covered. Owners who are uncertain if they or any other individuals should be excluded from workers' compensation coverage should consult their legal counsel.

Workers' compensation that is "pending" at the time of sale is not acceptable. Coverage must be in effect on or before the first day of medical coverage through Health Net.

If a group cannot provide documentation to justify the absence of workers' compensation coverage, health insurance coverage will be declined.

5.4 Probationary Period

Also known as a waiting period, a probationary period is a defined period of time an employee must wait prior to becoming eligible for benefits. All new hires are subject to a probationary period prior to being eligible. As such, employees in their probationary period shall not be counted towards the number of eligible employees when defining a group as a small employer. There are 2 exceptions to this policy:

- At the time of sale the employer may waive the probationary period as long as the waiver applies to all similarly situated employees.

- An employee not actively at work due to active military service or training who is removed from coverage while on leave may be reinstated to active coverage without waiting periods upon return from leave.

Employers may choose from probationary periods of date of hire, 1 month, 30 days, and 60 days. However, coverage must begin on the first day of the month following the date the probationary period is met. Under no circumstances will Health Net allow a probationary period that would result in the enrollment of a subscriber on any other day than the first of the month. Note: ACA guidelines require coverage to begin no later than the 91st day from the date the employee becomes eligible. As a result, employees subject to a 60 day probationary period who meet it on the first day of a given month will be enrolled the same day.

A group may select no more than 1 probationary period in order to comply with ACA non-discrimination requirements.

5.5 Participation

Health Net's participation varies by group size. For groups of 1-4 enrolling employees, a minimum of 70% participation is required. For groups of 5-100 enrolling employees, a minimum of 25% participation is required. HSC §1357.503(d) requires carriers to have "reasonable" participation requirements for small employers applying for coverage. Requirements must be applied uniformly among all small employers, except that a carrier may vary participation requirements by the size of the small employer. Groups not meeting minimum participation requirements will be able to apply during the special enrollment period. Please see Section 5.7 for more details. The following information is taken into consideration when determining a group's level of participation.

5.5.1 Valid Waivers

Per HSC §1357.503(d), Health Net may not "reject an otherwise eligible small employer because of the number of persons that waive coverage due to coverage through another employer." Therefore, it becomes important to determine which waivers would not count against participation.

Additionally, valid waivers do not reduce the size of the group when determining whether the group is a small employer. As a result, a group of more than 100 employees that has valid waivers would not be considered a small group because of its size. Valid waivers only impact a group's participation.

The following is a partial list of valid waivers:

Valid
Group coverage through a spouse/domestic partner on or off the Exchange
Spousal/domestic partner coverage through the same employer*
Union employees covered through a labor fund
Individual coverage on or off the Exchange**
TRICARE**
VA**
Other group coverage through another group/employer
COBRA
Medicare**
Medi-cal**
Medicaid**
Active Military Duty

*An eligible employee enrolling as the spouse of another eligible employee will be considered a valid waiver, but will not be required to complete a waiver.

**While the above is not supported by the legislation as a "valid" waiver, Health Net does allow it to be considered as such.

5.5.2
Non-valid Waivers

Non-valid waivers are not supported by the legislation and therefore, do count against participation. The following is a partial list of non-valid waivers:

Non-valid
Coverage with another health insurer through the same employer on or off the Exchange*
Religious reasons
Can't afford it
Don't want it
Don't care
Coverage through an association

*An eligible employee who enrolls as the spouse of another eligible employee will be considered a valid waiver. See above.

5.5.3
Calculation of Participation

The calculation of participation is a process of comparing the enrolling population to the eligible population. In doing so, it is important to note, valid waivers are first subtracted from the eligible population while non-valid waivers are not subtracted from the eligible population and therefore count against participation.

Formula:
Enrolling / (total eligible – valid waivers)
Let A = # of enrolling employees
Let B = # total eligible employees
Let C = # valid waivers

[A / (B – C)] = % participation

Example 1:
10 eligible employees with 2 enrolling: Of the 8 choosing not to enroll, 7 employees are covered under their spouse's group plan and 1 has a non-valid waiver. Participation is calculated as follows:

[2 / (10 - 7)] = 66.7%

This group DOES NOT meet participation because a group enrolling less than 5 employees is subject to 70% participation, and this group has 66.7% participation.

Example 2:
15 eligible employees with 4 enrolling: Of the 11 choosing not to enroll, 10 employees are covered under the plan of another employer and 1 has a non-valid waiver. Participation is calculated as follows:

[4 / (15 - 10)] = 80%

This group DOES meet participation because a group enrolling less than 5 employees is subject to 70% participation, and this group has 80% participation.

Example 3:
20 eligible employees with 5 enrolling: Of the 15 choosing not to enroll, all of the waivers are non-valid. Participation is calculated as follows:

[5 / (20 - 0)] = 25%

This group DOES meet participation because a group enrolling at least 5 employees is subject to 25% participation, and this group is enrolling 5 and has 25% participation.

5.6 Contribution

Health Net requires a minimum contribution by the employer of 50% of the lowest cost plan or $100 per employee to the employee rate. HSC 1357.503(d) requires carriers to have "reasonable" contribution requirements for small employers applying for coverage. Requirements must be applied uniformly among all small employers. Carriers cannot vary contribution requirements by the size of the small employer. Groups not meeting minimum contribution requirements will be able to apply during the special enrollment period. Please see Section 5.7 for more details.

5.7 Special Enrollment Period for Low Participation/Contribution Groups

Carriers establish participation and contribution guidelines to ensure that there is a good mix of health risk, but 45 CFR 147.104(b)(1)(i)(b) requires carriers to accept all groups that meet the definition of a small employer, whether or not they meet these requirements. However, the ACA section also allows carriers to limit the time to a one-month special enrollment period, during which they are required to provide coverage for low participation and/or low contribution groups for a January 1st effective date.

These groups must be in Health Net's Underwriting department no earlier than November 15th and no later than December 15th. Groups that are submitted at any other time will be required to withdraw their application and resubmit during the appropriate time period. Groups that qualify for this special enrollment period based on failure to meet minimum participation or contribution requirements must still meet other legislative requirements and other Health Net guidelines.

Group applications that are incomplete must be completed no later than January 20th. A group application that is still pending after that date will be withdrawn. Such a group will not be able to reapply until the next special enrollment period.

6 Member-Specific Guidelines

6.1 Pre-Existing Condition Exclusions

Health Net will not impose any pre-existing condition exclusions with respect to plan or coverage on any member regardless of medical history.

6.2 Prior Deductible Credit Allowance

All Small Group PPO plans that have deductibles allow for prior carrier deductible credit, as long as this policy is replacing a similar policy that has been issued to the Group Policyholder. This means that members electing a Health Net PPO plan must be replacing a PPO plan with their prior carrier.

If a covered person has satisfied any portion of the deductible under the prior carrier plan, the credit will apply to the satisfaction of the covered person's initial calendar year deductible under the policy. The credit will also apply to the satisfaction of the out of pocket maximum if the deductible is included in the out of pocket maximum. The maximum credit from the prior carrier cannot exceed the current deductible dollar amount. Proof in the form of an Explanation of Benefits (EOB) will be required at initial enrollment. Please see Section 7.9 for more information.

6.3 COBRA/Cal COBRA

6.3.1 Qualifying Event

Both COBRA and Cal COBRA are tied to a qualifying event, or the day in which the employee's continuation coverage is effective.

Enrollment forms for both COBRA and Cal COBRA enrollees must list the qualifying event, the date of the qualifying event, and the effective date of coverage. If the qualifying event date is the same as the group's effective date, the employee must be on the current DE-9C. Proof of prior coverage must be submitted in the form of a prior carrier bill.

6.3.2 COBRA

Federal COBRA is an employer law and is tied to any employer who, on a typical business day during at least 50% of the preceding calendar year had more than 20 employees regardless of hours worked.

Federal COBRA enrollees are not considered actively at work and as such are not tied to eligibility for a group health plan.

At the time of sale, a COBRA enrollee may only select from a plan offered to the entire group even if there is no active participation on the plan. Those COBRA participants who are out of the California Service area, but are within the OOS PPO service area, will be assigned PPO.

Those COBRA participants who, during the course of the year, move out of the California service area, but are within the OOS PPO service area, will be offered PPO.

6.3.3 Cal COBRA

Cal COBRA is a state insurance law and is tied to any employer who, on a typical business day during at least 50% of the preceding calendar year had between 2 and 19 employees regardless of hours worked.

Cal COBRA enrollees are not considered actively at work and as such are not tied to eligibility for a group health plan.

At the time of sale, a Cal COBRA enrollee may only select from a plan offered to the entire group even if there is no active participation on the plan. Those Cal COBRA participants who are out of the California Service area, but are within the OOS PPO service area, will be assigned PPO. However, if during the course of the year the Cal COBRA enrollee moves out of the California service area or OOS PPO service area, they will no longer be eligible for coverage.

6.4 Out of Area (OOA)

In order for a small employer to qualify for coverage on a guaranteed issue basis, the majority of the group must be employed within the California service area. As such, the following guidelines are for those employees who are out of area.

6.4.1 OOS PPO

Health Net's OOS PPO product is available to those employees out of the California service area, who are within the OOS PPO area. No other products may be offered in this area. A maximum of 49% of the group's eligible population may be written on the OOS PPO product. NOTE: Health Net does not offer out-of-state coverage to employees and/or dependents residing in Hawaii.

6.4.2
OOA/OOS Dependents

When an employee elects to cover eligible dependents (or is required to enroll eligible dependents), and one or more dependents are located outside of the California service area, the employee must elect one of the plans made available by the employer (i.e., HMO or PPO). The plan selection must apply to both the subscriber and dependent, as split enrollment is not allowed. Based on plan selection, the following coverage will be available:

- HMO—The dependent has the option of coordinating PCP visits when in the California service area. Otherwise emergency services only will be covered while the dependent is out of area.

- PPO—Dependents who permanently or temporarily (i.e., while in school) live outside of the California service area have the option of utilizing the In-network benefit through the PPO Travel Access Program, if they live in the OOS PPO service area, or utilizing the OON benefit if not in the OOS service area or access a non-network provider.

6.5
Spouses

Under 45 CFR 147.104(e), health insurance carriers cannot discriminate on the basis of certain specified factors, including sexual orientation. Carriers that offer coverage to opposite-sex spouses must also offer coverage to same-sex spouses. Health Net provides coverage to all spouses, whether in a same-sex or opposite-sex marriage. However, this regulation does not interfere with an employer's ability to define a dependent spouse for purposes of eligibility for coverage.

6.6
Domestic Partners

Employers are required to cover both same sex and opposite sex domestic partnerships, and to provide domestic partners equal benefits to and under the same terms and conditions as spouses. Because Health Net does not require verification of marriage, we do not require verification of domestic partnership.

7
Standard Paperwork Requirements

Paperwork requirements facilitate the establishment of the employer-employee relationship as well as the verification of Underwriting guideline and legislative compliance. All documents must be executed. The following paperwork guidelines must be adhered to for new business case submissions:

7.1
GSA

The GSA (Group Service Agreement), or Master Application, is a contract between the small employer and Health Net. It establishes legal parameters around Health Net's agreement to provide services to the small employer. A GSA with illegible information or scratched out selections leaves certain ambiguities. Any ambiguities could eventually result in the misinterpretation of coverage or misapplication of services. As such, the GSA must be complete and accurate. The authorized representative of the employer must initial such corrections clarifying any changes to the GSA. Under no circumstance will Health Net accept a GSA in which the employer's authorized representative has not initialed changes.

Additionally, since the GSA serves as a contract, it is imperative the signatures be within 60 days of the effective date, to ensure the most current information has been provided. As such, any GSA with a signature date over 60 days old will be considered stale dated and must be recompleted.

7.2 Enrollment Forms

The enrollment form serves as a contract between the employee, Health Net, and the employer. It serves to show that the employee was offered coverage regardless of enrollment choice. Like the GSA, the enrollment form must be completed fully. However, unlike the GSA, changes throughout the form do not require initials except for the plan, signature, and declination sections. Any changes or corrections to the plan section must be initialed by the employee. Any changes or corrections to the signature or declination sections, such as the case with an enrollee who signs in the wrong section, must be re-signed and initialed by the employee.

As is the case with the GSA, any enrollment form with a signature date over 60 days from the effective date, will be considered stale dated. All such stale dated enrollment forms must be recompleted.

7.3 DE-9C

The DE-9C is a quarterly wage/withholding report, required by the State, which reveals the following information: employer name, employer address, employer id number, social security numbers, employee name, total wages, and total withholdings. It establishes a bona fide employer-employee relationship by indicating what the employer paid each given employee per calendar quarter. As such, any group that has been in business long enough to have a DE-9C must submit a DE-9C. The only exception to this standard is for those employers who utilize the services of a professional payroll service (i.e. Easy Pay, ADP, etc.). If the payroll service does not release the DE-9C to its clients, but prepares a quarterly wage report instead, the wage report will be accepted in lieu of the DE-9C.

DE-9C information comes in many forms and will be considered as such. Any DE-9C submitted by a group that has completed its most recent DE-9C without using the form supplied by EDD or has supplied handwritten information, may be required to submit evidence of filing or alternate documentation, such as filed ownership documents or payroll, at the discretion of the underwriter.

The employer must reconcile the DE-9C by indicating the current status next to each employee. Reconciled DE-9Cs should use the following codes:

- 'T' for terminated (must always include date for groups in which the termed plus active employees exceed 100).
- 'E' for eligible and enrolling.
- 'W' for eligible and waiving coverage.
- 'S' or 'Seasonal' for seasonal employees.
- 'Temp' for temporary employees.
- Covered by another carrier, use 'K' for Kaiser, 'BC' for Blue Cross, etc.
- 'U' for union employees.
- 'PT' for part-time employees.
- 'WP' for waiting period (must include a date of hire).

7.4 Payroll

Payroll is used to supplement the DE-9C for cases in which employees do not appear on the DE-9C or the status of the employee seems to be contradicted by the amount of wages earned. In either case a minimum of 2 weeks of payroll is required to establish eligibility. If the payroll submitted is not sufficient to show the employee normally works the minimum eligible hours, Underwriting may request additional payroll. This requirement is for all eligible enrollees regardless of enrollment status. At a minimum, the payroll information must include the name of the employer, the name of the employee, pay period, wages paid, and withholdings held. Under no circumstances will payroll with less information be considered. Pay stubs may be considered as an acceptable substitute if it is from a payroll service such as Easy Pay or ADP. W-2's and W-4's are not acceptable alternatives. Health Net reserves the right not to accept payroll or pay stubs from a given group for any reason.

7.5
Ownership Documents

Ownership documents are specifically required to establish ownership or when owners are not reflected on the DE-9C. For cases in which the ownership rests with a single individual, a DE-9C must also be submitted to be considered for coverage.

Acceptable ownership documents, listed below by business type, are legal ownership documents that must tie said owner(s) to the business and thereby establish eligibility. Note: Groups of 25 or more enrolling employees that are enrolling eligible sole proprietors, partners, or officers that are not on the DE-9C may submit the Proof of Eligibility Statement for Sole Proprietor, Partner, or Corporate Officer, in lieu of ownership documentation. Please see Section 7.5.2 for additional information.

For corporations, officers who are not on the DE-9C must be listed on the Statement of Information. Directors must be on the DE-9C in order to be considered eligible.

For Limited Liability Companies, LLC Members are eligible only if they are responsible for running the day-to-day activities of the company. Otherwise, only the LLC Member Manager and/or any appointed officers are eligible.

Acceptable Ownership Documents

1. Sole Proprietor (One Owner)
   a) IRS Form 1040 Schedule C, OR
   b) Fictitious Business Name Filing, OR
   c) A CA business license

2. Corporation
   a) IRS Form 1120 (as long as all owners and percentage of stock owned is listed), OR
   b) Articles of Incorporation (Filed and listing names of all officers), OR
   c) Statement by Domestic Stock Corporation/Statement of Information. Note: For information on submitting an unstamped SOI, please refer to 12.5.1, AND
   d) Statement and Designation by Foreign Corporation (if business is a foreign corporation)

3. S Corporation
   a) IRS Form 1120S Schedule K-1, OR
   b) Articles of Incorporation (filed and listing names of all officers), OR
   c) Statement of Information from original C-corporation. Note: For information on submitting an unstamped SOI, please refer to 12.5.1, OR
   d) Form 2553 (only if accompanied by IRS approval letter), AND
   e) Statement and Designation by Foreign Corporation (if business is a foreign corporation)

4. Nonprofit Corporation
   a) IRS Form 990 (as long as all owners and percentage of stock owned is listed), OR
   b) Articles of Incorporation (filed and listing names of all officers), OR
   c) Statement by Domestic Stock Corporation/Statement of Information. Note: For information on submitting an unstamped SOI, please refer to 12.5.1, AND
   d) Statement and Designation by Foreign Corporation (if business is a foreign corporation)

5. Limited Liability Company (LLC)
   a) IRS Form 1065 Schedule K-1, OR
   b) IRS Form 1120 (as long as all owners and percentage of stock owned is listed), OR
   c) Articles of Organization including the Operating Agreement, OR
   d) Statement by Domestic Stock Corporation/Statement of Information. Note: For information on submitting an unstamped SOI, please refer to 12.5.1, AND
   e) Limited Liability Company Application of Registration (if business is a foreign LLC)

6. Partnership
   a) IRS Form 1065 Schedule K-1 for all eligible owners, OR
   b) Statement of Partnership Authority (General Partnerships), OR
   c) Partnership Agreements (deemed acceptable per underwriter's discretion), OR
   d) Fictitious Business Name Statement showing both names, OR
   e) Tax certificate showing both names

7. Limited Partnership
    a) IRS Form 1065 Schedule K-1 for all eligible owners, OR
    b) Certificate of Limited Partnership, OR
    c) Partnership Agreement (deemed acceptable per underwriter's discretion, OR
    d) Fictitious Business Name statement showing both names, OR
    e) Tax Certificate showing both names, AND
    f) Foreign Limited Partnership Application of Registration (if business is a foreign LP)

8. Limited Liability Partnership
    a) IRS Form 1065 Schedule K-1 for all eligible owners, OR
    b) Registered Limited Liability Partnership Registration, OR
    c) Partnership Agreement (deemed acceptable per underwriter's discretion, OR
    d) Fictitious Business Name statement showing both names, OR
    e) Tax certificate showing both names, AND
    f) Limited Liability Partnership Certificate of Registration (if business is a foreign LLP)

9. Miscellaneous documents at sole discretion of Underwriting
    a) Home Occupancy Permit
    b) Seller's Permit
    c) Minutes
    d) Pay Stubs
    e) Tax Receipts
    f) Personal Certificates
    g) Letter/Email Explanations
    h) Letter from a CPA
    i) Stock Certificates
    j) By laws or amendments to by laws
    k) Elections of Officers Document

Note: Government generated web-based documents are an acceptable alternative provided all relevant information appears.

7.5.1
Unstamped Statement of Information

Health Net will accept an unstamped Statement of Information only under the following conditions: 1) when the group has not been in business long enough to have filed a tax return; 2) when the Statement has been filed recently enough that the Secretary of State's office is still within their processing turnaround time to file it and return a stamped copy to the group; 3) it is accompanied by a printout from the California Business Portal showing that the Agent for Service of Process on the portal is also the Agent for Service of Process listed on the SOI in addition to being one of the officers on the SOI; and 4) the signature date on the Statement must be consistent with when the document was filed. Otherwise, the document must be stamped or contain a pre-printed file number from the State.

7.5.2
Proof of Eligibility Statement

Groups with 25 or more enrolling employees that have owners who do not appear on the DE-9C—whether sole proprietors, partners, or corporate officers—may fill out this form in lieu of providing ownership documentation.

Groups of any size that submit ownership documents are not required to fill out this form.

7.6 Binder Payment

Groups must submit a binder payment in the amount of 75% of the first month's premium, at minimum. Groups must submit an Electronic Check Form with a copy of a voided pre-printed business check attached whenever possible. In the rare instance in which a group cannot use the Electronic Check Form or is unable to produce a copy of a voided check, alternative methods of payment may be available. However, this must be arranged with the Small Group Underwriting department in advance of case submission. If the group is enrolling on a 15th of the month effective date, six weeks of premium is required. Although the address on the copy of the voided check should coincide with the address indicated on the GSA and DE-9C (if applicable), this may not always be the case as a group may change location or indicate a billing address. However, an explanation should accompany any check with an out of state address.

If the group does not have a business checking account, the copy of the voided check must be drawn from the owner's personal checking account. At no time will a money order or cashier's check be accepted.

7.7 Health Questionnaires

7.7.1 Group Level Health Questionnaires

Medical history and health risk are not used to adjust an employer group's premium; therefore, group level health questionnaires are not required for any reason.

7.7.2 Individual Health Questionnaires

Medical history and health risk are not used to adjust an employer group's premium; therefore, individual health questionnaires are not required for any reason.

7.8 Group Size Attestation Form

Beginning with small group coverage effective 1/1/2016, employers with 101 or more total employees on their DE-9C or payroll will be required to fill out this form to determine if the group meets the definition of a small employer. The form asks for the number of full time employees and full time equivalents the employer has, and whether the employer used the Prior Calendar Quarter Test or the Prior Calendar Year Test to make that determination. Please see Section 1.1.2 for detailed information on determining group size.

7.9 Explanation of Benefits (EOB)

Any individual looking to document the satisfaction of a deductible with their prior carrier must submit an EOB, indicating the portion of the deductible and/or out of pocket maximum previously satisfied. If a covered person has satisfied any portion of the deductible under the prior carrier plan, the credit will be applied to the satisfaction of the covered person's initial calendar year deductible under the policy. Please refer to Section 6.2 for more information on which products this applies to.

7.10 Copies of Medical ID Cards

Health Net reserves the right to request medical ID cards at the underwriter's discretion.

7.11
Union Employee Paperwork

Small employers with union employees who are covered by a labor fund must provide both the collective bargaining agreement and employer contribution report. Small employers who are required to cover their employees directly must provide the collective bargaining agreement but are not required to provide the employer contribution report. In either scenario, all standard paperwork requirements apply.

7.11.1
Collective Bargaining Agreement

The collective bargaining agreement is the written agreement between the employer and union detailing the conditions and benefits of the union employees, such as work hours, wages, promotions, hiring and firing, workplace safety, and health benefits. The agreement must indicate whether the employer is required to provide coverage directly for the union employees or if a labor fund will administer those benefits on behalf of the employer.

7.11.2
Employer Contribution Report

The employer contribution report is a monthly report that lists all of the union employees currently working for the employer, the number of hours each union employee worked, and the contribution that the employer must pay to the union for each union employee. The report submitted must be the most current. Any discrepancies on the report may result in a request for additional paperwork.

8
Non Standard Guidelines

8.1
Startup Groups

A startup group is a business that has recently formed, or an existing business that has recently hired its first W-2 employee, so has not been in business long enough to have a DE-9C. Health Net will consider the group on a guarantee issue basis as long as the group is able to provide 2 weeks of payroll, with the first day of the payroll period being on or before the effective date of coverage. Note: groups that have been in business long enough to have a DE-9C are not startup groups and must provide their DE-9C.

8.2
Spin-Offs

Newly formed groups that are spinning off from another company may use the Startup Groups guideline. Note: if the parent company has an active Health Net policy, this request will be processed by Health Net's Account Management department.

8.3
Professional Employer Organization (PEO) Subgroups

A PEO is a business providing employer groups with human resource services, payroll services, workers' compensation, health insurance, and/or other value-added services. Generally, the PEO is able to procure very competitive workers' compensation and health insurance rates by combining all of the various employees under their umbrella. When a PEO offers more than just payroll services to a business, they are acting as co-employer, making the business the PEO's subgroup. PEO subgroups that do not want to obtain health insurance through the PEO may choose to provide health insurance for their employees on their own.

8.3.1
PEO Subgroups Staying with a PEO

PEO subgroups must submit the most current quarterly wage report prepared by the PEO. If the PEO does not prepare one, the most current 2 weeks of payroll from the PEO may be substituted.

8.3.2
PEO Subgroups Leaving a PEO

Businesses that terminate their contract with a PEO must submit the most current quarterly wage report prepared by the PEO. If the PEO does not prepare one, the most current 2 weeks of payroll from either the PEO or the group may be substituted.

8.4 Temporary Staffing Agencies

A temporary staffing agency is a business that provides companies with employees on a non-permanent basis. Some of the services offered by this type of staffing company are recruiting, screening, and job placement. During the time in which the temporary employee is under contract to the staffing agency, he or she is an employee of the staffing company and will appear on the staffing company's DE-9C.

A staffing agency seeking coverage through Health Net will not be able to provide coverage for their temporary employees, as these employees are not contemplated under the definition of an eligible employee. Only those employees who work on a permanent and full-time basis, for the minimum required number of hours per week, at the employer's regular places of business, and in the conduct of the business, may be considered eligible for coverage.

Because temporary assignments can range anywhere from one day of work to several months, some temporary employees may have quarterly wages that are as much as or exceed the wages of some permanent employees. As a result, in order to distinguish between eligible and ineligible employees on a staffing agency's DE-9C, we will require a letter from the employer group on their letterhead stating the name, SSN, and job title of each eligible employee, whether enrolling or waiving. Any employee with a job title that is not consistent with the recruiting or staffing industry will not be considered eligible for coverage.

8.5 Religious Organizations

The legislation governing small business groups does not differentiate by type of business. As long as a group can be considered an employer entity (even if functioning on a non-profit basis), and meets the criteria for a small employer, coverage will be considered under the Small Group book of business.

Because of the nature of religious organizations, standard paperwork requirements do not always apply. Specifically, many religious organizations have individuals who are compensated through allowances or stipends that may not be reported on the DE-9C. Any employee receiving a majority of their income through such allowances will be required to submit a minimum of 2 weeks of payroll showing the value of all compensation received.

However, any individual exempt from taxes who is not receiving any compensation reported on the wage and tax report, and is not receiving any allowances or stipends, will be required to submit a stamped IRS Form 4361 (Exemption from Self Employment Tax for use by Ministers, Members of Religious Orders, and Christian Scientist Practitioners) with their request for coverage.

HSC §1367.25 allows religious employers to request coverage that excludes contraceptive methods that are contrary to the religious employer's religious tenets. However, Health Net will provide their eligible employees and dependents coverage for women's contraceptive services at no additional cost to them.

8.6 Multiple Groups Enrolling as a Single Employer

Groups that would like to be considered a single employer for the purpose of obtaining health coverage may do so as long as they qualify as one of the following:

- Affiliated companies that are eligible to file a combined tax return for state taxation
- Controlled groups of corporations
- Trades and businesses, whether or not incorporated, under common control
- Affiliated service groups

Only those employers that still meet the definition of a small employer as a combined entity are allowed to take advantage of this option. A letter from a CPA certifying which one of the above scenarios applies to the groups seeking coverage is required. The CPA must not be an owner or employee of the groups seeking coverage. The letter must be on CPA letterhead and it must explicitly state how the groups are eligible to enroll under a single policy.

8.7 Employee Only Groups

Health Net will not provide an employee-only contract to any employer. However, the employer, at its discretion, may choose to limit its offering of coverage to employees only.

8.8 Officer Only Corporations

An officer-only corporation may meet the definition of a small employer as long as there is at least one officer who is an eligible W-2 employee and not an owner, nor the spouse of an owner, and is covered by the group's workers' compensation policy. In this scenario, we will require the following:

- Most current filed Statement of Information listing a minimum of 2 officers
- Most current DE-9C (or 2 weeks of payroll for groups that have not been in business long enough to file a DE-9C) showing the non-owner officer listed on the Statement of Information with eligible wages

8.9 Large Groups Losing Coverage Due to a Reduction in Group Size

Groups covered by a Large Group plan are typically those with a minimum of 101 employees. However, employers who have recently undergone a reduction in staff may no longer qualify for a Large Group plan and may be required to seek coverage in the Small Group segment. For such a group, 2 weeks of payroll to verify that the group currently has fewer than 101 employees will be required.

8.10 Groups over 100 Eligible Employees

Health Net will not consider any group with more than 100 eligible employees, which does not meet the definition of a small employer by meeting the previous calendar quarter or year test established in the legislation. Groups of over 100 eligible employees who meet the definition of a small employer shall be offered coverage on a guaranteed issue basis subject to Health Net's standard paperwork requirements and underwriting guidelines.

8.11 Carve-Outs

A carve-out is the offering of coverage to a portion of employees usually based on job class, such as management vs. non-management or salary vs. hourly employees. However, ACA non-discrimination requirements prevent employers from discriminating in favor of highly compensated employees. As a result, carve-outs will not be considered.

For information on submitting groups with union employees, please see Section 1.2.1.2 for Health Net's policy on union employees and Section 7.11 for paperwork requirements.

8.12 Foreign Embassies and Consulates

Foreign embassies and consulates are found in satellite offices in a variety of cities throughout the United States. The staffs of embassies and consulates report to their governments so are employed by the governments they represent. As a result, an individual embassy or consulate constitutes a small part of a larger entity, so cannot be considered for small employer coverage.

8.13 Trusts and Other Legal Entities

A trust or other legal entity that has been created to manage personal assets or property is not a business or service as required by the legislation and is therefore not eligible for coverage as a small employer.