Optimized level funding option FAQ

Plan/Benefits

Q: If an employer selects the Optimized Level Funding Option (OLFO), can the employer also offer other co-existing fully funded health plans?

A: No.

Q: How many plan options can a group have with the OLFO?

A: 2-9 enrolled members = one plan.
10+ enrolled members = two plans.
Note: Each plan must enroll at least 25 percent of the enrolled population.

Q: What Rx formulary is available with the OLFO?

A: The Optimized formulary is the formulary for all small group plans.

Q: Will members have access to all Priority Health tools and services?

A: Yes, members will have access to all Priority Health tools and services including Cost Estimator powered by Healthcare Bluebook, PriorityRewards, Find a Doctor, the Approved Drug List (ADL), virtual care services and more.

Q: Can an employer with a pre-ACA plan keep their current benefit design if they select the OLFO?

A: No. They must choose an ACA plan from the current product portfolio.

Q: Can a group select the OLFO and then switch back to their fully funded ACA or pre-ACA plan if they do not receive a satisfactory renewal?

A: They can only switch back to an ACA option.

Q: Is the OLFO available on a tiered network product?

A: Yes, West MI Partners and Southeast MI Partners are available.

Q: Will employers be able to customize benefits if they want?

A: No. Employers must select from the small group menu (excluding PriorityHRA and PPO plans) with the Optimized formulary.

continued>

Eligibility/Enrollment

Q: How is new hire eligibility and enrollment managed?

A: New groups need to submit census and underwriting information for new hires in their waiting period that intend to enroll in the plan.

New hires from existing groups enrolling during the plan year will need to complete the applicable enrollment form depending on group size. Enrollment forms for groups of 2-4 will include medical questions.

Q: Do employees not enrolling in health coverage need to complete the medical questions?

A: No, employees waiving coverage do not need to answer the medical questions, but they will need to complete a waiver.

Q: Are retirees eligible?

A: No, neither pre- nor post-65 retirees are eligible.

Q: Will members be required to name a PCP?

A: Yes. However, we do NOT require a PCP referral to see an in-network specialist.

Q: What are the minimum-hours-worked requirement for an employee to be eligible for benefits?

A: The minimum-hours-worked requirement is 17.5 hours per week.

Underwriting/Funding

Q: What is the provision of the stop-loss contract?

A: 12/30 (incurred/paid) with terminal liability built in.

Q: What are the medical underwriting requirements?

A: Groups with 2-4 enrolled members (employees, spouses, or dependents) – health statements are required for those seeking coverage. Groups with 5+ enrolled members (employees, spouses, or dependents) – underwritten from census data.

Q: What happens if a group terms before the end of their plan year?

A: Priority Health will collect two months of total cost to provide run-out protection and claims servicing. *Note: Total cost = stop-loss premium + aggregate claim funding + admin fees.*

Q: What percentage of excess employer funding is returned and when?

A: 50 percent is returned within two months of the end of the plan year.

Q: What is stop-loss insurance?

A: Stop loss is insurance that protects the employer from large or unexpected claim expenses that exceed amounts in the funding account.

continued>

Q: Will the employer need to purchase specific stop-loss coverage?

A: No. The employer will never pay more than the projected monthly claims cost. Specific reinsurance which is designed to protect the employer against large unexpected individual claims, will not be needed.

Q: Could an employer owe money at the end of the plan year if their claims exceed their employer funding and /or stop-loss premium?

A: No. Groups are protected by aggregate stop loss. Claims exceeding the aggregate claims funding will be covered by the stop-loss policy.

Q: Will existing Priority Health groups need to complete medical questionnaires or go through pharmacy underwriting?

A: No, existing Priority Health groups that qualify do not need to complete medical questionnaires or go through pharmacy underwriting. The agent of record will receive an OLFO quote on the groups behalf.

Q: Will the group receive a surplus payment if they move from OLFO to a fully funded plan with Priority Health?

A: No. A group that transitions out of the OLFO plan, even if it is to a fully funded Priority Health plan, will not be eligible to receive any surplus payment.

Q: Will rates change mid-year?

A: Rates may be evaluated mid-year if there is a significant enrollment change. Rates will not change based on a group's claim experience.

Q: What is the exposure to the group if they decide to leave the OLFO?

A: There is no post-term exposure provided they leave at the end of the plan year.

Q: What does run out mean?

A: Run out is the 18-month period following the 12-month plan year. Claims incurred during the plan year are paid during the run-out period. This is included in the OLFO with no additional cost to the employers.