State of New Jersey
DEPARTMENT OF BANKING AND INSURANCE
SMALL EMPLOYER HEALTH BENEFITS PROGRAM
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ADVISORY BULLETIN
10-SEH-03

April 20, 2010

To: SEH Program Member Carriers that Issue Coverage
SEH Program Interested Parties

From: Ellen DeRosa
Executive Director

Re: Carrier Obligations in the Implementation of the American Recovery and Reinvestment Act of 2009 as amended by the Department of Defense Appropriations Act, 2010 and the Temporary Extension Act of 2010 and the Continuing Extension Act of 2010 for New Jersey Small Employers that are Subject to New Jersey Continuation

On March 9, 2009 we issued Advisory Bulletin 09-SEH-01 discussing features of the American Recovery and Reinvestment Act of 2009 (ARRA) as related to New Jersey Continuation. On March 26, 2009 we issued Advisory Bulletin 09-SEH-02 to further address the vital role New Jersey small employer carriers must play in the implementation of the premium reduction for former employees electing continuation under N.J.S.A. 17B:27A-27. On November 16, 2009 we issued Advisory Bulletin 09-SEH-04 to address guidance concerning the timing for the request for treatment as an assistance eligible individual. On January 4, 2010 we issued Advisory Bulletin 10-SEH-01 to address the amendments to ARRA made by the Department of Defense Appropriations Act, 2010 which extended the premium reduction for an additional 6 months and allowed for terminations of employment through February 28, 2010. On March 16, 2010 we issued Advisory Bulletin 10-SEH-02 to address the amendments made by the Temporary Extension Act of 2010.

The purpose of this Advisory Bulletin, 10-SEH-03 is to address the amendments made by the Continuing Extension Act of 2010.

Date of Involuntary Termination of Employment

ARRA originally considered involuntary terminations of employment between September 1, 2008 and December 31, 2009 which was later extended until February 28, 2010. The Temporary Extension Act of 2010 further extended the date until March 31, 2010 and the Continuing

Extension Act of 2010 again extended the date until **May 31, 2010**. Some sources suggest that the May 31, 2010 date may again be extended.

Reduction in Hours Followed by Involuntary Termination of Employment

As discussed in Advisory Bulletin 10-SEH-02 the Temporary Extension Act of 2010 provided that an employee whose hours were reduced between September 1, 2008 and March 31, 2010 triggering a continuation right and who subsequently is involuntarily terminated between March 2, 2010 and March 31, 2010 is eligible for the premium reduction as a result of the involuntary termination of employment. The Continuing Extension Act of 2010 extends the March 31, 2010 date until May 31, 2010.

Catch Up… Again

Since the Continuing Extension Act was not signed until after the expiration of the time periods permitted under the Temporary Extension Act, there are likely some number of employees whose employment was terminated from April 1, 2010 through the present. Those persons need to be given notice of their opportunity under ARRA. Carriers are asked to mail the updated ARRA materials to persons who were terminated on or after April 1, 2010 as soon as possible. Since these persons may have thought it impossible to elect NJ continuation due to cost, the time for electing NJ continuation should run from the date the carriers provide the notice of the premium reduction under ARRA. Please do not hold these persons to making a continuation election during the 30-day period following the loss of coverage.

What Carriers Must Mail

Attached is an amended notice package. The package updates the existing notice and forms for persons whose employment terminates on or before May 31, 2010

Newly terminated employees (no prior reduction in hours)
Carriers should mail the amended notice and forms upon receipt of information that an employee has been terminated.

- New Jersey Continuation Coverage Notice of Continuation Option and Election of Premium Reduction
- New Jersey Continuation Election Form
- Form for Switching Plan Options
- Employer Information and Verification
- Request for Treatment as an Assistance Eligible Individual
- Participant Notification

Terminated employees (following a reduction in hours)
Carriers should mail the amended notice and forms upon receipt of information that an employee has been terminated.

- New Jersey Continuation Coverage Reduction in Hours Followed by Termination of Employment
- New Jersey Continuation Election Form (specific form that addresses reduction followed by termination)
- Form for Switching Plan Options (same as for newly terminated employee)
- Employer Information and Verification (same as for newly terminated employee)

- Request for Treatment as an Assistance Eligible Individual (same as for newly terminated employee)
- Participant Notification (same as for newly terminated employee)

General Information

Information concerning ARRA is found on the U.S. Department of Labor's website which is http://www.dol.gov/ebsa/COBRA.html

CMS's website is http://www.cms.hhs.gov/COBRAContinuationofCov.

Maximus is the contractor that handles premium assistance appeals. The website is http://www.continuationcoverage.net.

The IRS website also contains a lot of good information: http://www.irs.gov/newsroom/article/0,,id=204505,00.html?portlet=7.

Information concerning New Jersey Continuation and ARRA is found on the Department of Banking and Insurance website which is http://www.state.nj.us/dobi/division_consumers/insurance/arra.html

Questions

If you have any questions concerning New Jersey continuation or the treatment of assistance eligible individuals please contact me by email at ellen.derosa@dobi.state.nj.us or by phone at 609-633-1882 ext. 50302.

[Carrier letterhead/logo]
[Use this notice for new terminations]

New Jersey Continuation Coverage
Notice of Continuation Option and Election for Premium Reduction

[Date][Or, if a carrier wants to make this a generic piece, omit the date]

Dear Former Employee: *[Carriers may include employee name or may leave as generic]*

This notice contains important information about your option to continue your medical coverage under your former employer's group health benefits plan. Please read the information contained in this notice very carefully.

The American Recovery and Reinvestment Act of 2009 (ARRA) as amended by the Department of Defense Appropriations Act, 2010 and the Temporary Extension Act of 2010 and the Continuing Extension Act of 2010 reduces the continuation premium in some cases. According to information we received from your former employer, your medical coverage terminated between September 1, 2008 and May 31, 2010. You may be eligible for a temporary ARRA premium reduction for up to fifteen months. To help determine whether you can get the ARRA premium reduction you should read this notice and the attachments very carefully.

Involuntary Termination of Employment between April 19, 2009 and May 31, 2010 or such later date as may be specified in Federal law

If you think you meet the criteria for the premium reduction, and have elected to continue your coverage under New Jersey Continuation, complete the "Application for Treatment as an Assistance Eligible Individual" and mail it to your former employer. Your mailing to the former employer must also include the Employer Information and Verification Form. Coverage will be effective as of the day after your coverage ended, meaning there will be no break in coverage. The premium reduction will last no more than 15 months. Such 15-month premium reduction period neither extends nor reduces the 18 months available for New Jersey Continuation.

If your former employer offers more than one medical plan option to active employees you may elect to continue coverage under the other medical plan option(s) provided the cost is the same or less than the cost for the plan you had when your coverage ended. Check with your former employer regarding alternate options and the cost for such options. The election for the alternate plan must be noted on the New Jersey Continuation Election Form and the Form for Switching Plan Options must be attached

You will be required to pay the first premium which will cover the period from the date continuation coverage begins through the current period *within 30 days* of the date you make the election for New Jersey Continuation. Send all premium payments to your former employer who will add such payments to the premium being sent to us (the carrier) for the coverage for active employees. If you qualify for the premium reduction, the premium you must pay will be 35% of the cost for the New Jersey Continuation coverage. *[Specific premium information is enclosed.] [Carriers, if it is not enclosed, say how the former employee can get it]*

Mail these completed forms to your former employer.

- ✓ New Jersey Continuation Election Form (if you are electing continuation now)
- ✓ Form for Switching Options (if you are electing another option)
- ✓ Request for Treatment as an Assistance Eligible Individual
- ✓ Employer Information and Verification

If you have any questions concerning an election for New Jersey Continuation or the premium reduction, please contact *[carrier member services at phone]*

Sincerely,
[Carrier]

New Jersey Continuation Election Form

For involuntary terminations of employment between September 1, 2008 and May 31, 2010 or such later date as may be specified in Federal law

Instructions:

This Election Form can ONLY be used to elect New Jersey Continuation in the event of in the event of an *involuntary* termination of employment occurring between September 1, 2008 and May 31, 2010 or such later date as may be specified in Federal law. For *all other* elections of New Jersey Continuation please consult the employer that provided the group coverage under which you were covered.

To elect to continue medical coverage under New Jersey Continuation, the terminated employee must complete the following form and mail it to the former employer. The completed election form must be postmarked ***within 30 days*** of the date your coverage ended.

If medical coverage under New Jersey Continuation is already in effect, do not complete this election form again.

I elect to continue medical coverage for myself and all dependents listed in item II below.

I. Terminated Employee Information

Name: _____ SS# _____
First MI Last — or other identifier

Address _____
Street City State Zip Code

Dates: _____ _____
Employment Ended Medical Coverage Ended

Was the termination an involuntary termination of employment? ☐ Yes ☐ No

If No, do not submit this form. Contact your former employer for information on New Jersey Continuation.

II. Dependent Information

List all dependents who were covered under your former employer's medical plan on the date before your employment was involuntarily terminated and who you wish to cover under New Jersey Continuation. *Note*: Dependent coverage can ONLY be continued if the former employee elects to continue coverage for him/herself.

Name	Date of Birth	Relationship To employee	SS# or other identifier

III. Plan Selection

Check one

☐Same coverage that was in effect on the day before coverage ended or such other replacement coverage as is currently offered to active employees

☐Alternate coverage. You must complete the Form for Switching Plan Options

IV. Signature

_____ _____

Signature of Terminated Employee Date

Form for Switching Plan Options

For involuntary terminations of employment between September 1, 2008 and May 31, 2010 or such later date as may be specified in Federal law

Instructions:

This Form for Switching Plan Options can ONLY be used if you have elected or are electing New Jersey Continuation following an *involuntary* termination of employment occurring between September 1, 2008 and May 31, 2010 or such later date as may be specified in Federal law.

Contact your former employer and ask the following:

1. Does the employer offer a medical plan for active employees other than the plan under which you were covered prior to your termination of employment? If yes, proceed to item 2. If no, you have no opportunity to switch plan options.
2. Is the cost for the alternate plan the same or less than the cost for the plan under which you were covered prior to your termination of employment? If yes, proceed to item 3. If no, you have no opportunity to switch plan options.
3. Ask your former employer for the name of the carrier issuing the alternate plan, the exact plan name of the alternate plan along with information on the applicable copayments, deductible and coinsurance. If the employer is not sure of this information, suggest that he or she ask the broker for these details. The carrier will verify the availability of the alternate plan.

For new elections of New Jersey Continuation the alternate plan will be effective as of the effective date of continuation coverage.

If New Jersey Continuation is already in effect, the alternate plan will be effective as of the start of the first period of coverage on or after this election is received.

I elect New Jersey Continuation coverage for myself and my covered dependents under the alternate plan option as stated below.

I. Terminated Employee Information

Name: _____ SS# _____
First MI Last or other identifier

Address _____
Street City State Zip Code

Dates: _____ _____
Employment Ended Medical Coverage Ended

II. Alternate Plan Election

Name of carrier issuing alternate plan: _____

Name of alternate plan: _____

Copayment: _____ Deductible: _____ Coinsurance: _____

III. Signature

_____ _____
Signature of Terminated Employee Date

American Recovery and Reinvestment Act of 2009 (ARRA)
Employer Information and Verification

Dear Former Employer:

I received information from the insurance carrier regarding New Jersey Continuation coverage and have completed the "Request for Treatment as an Assistance Eligible Individual" The carrier also sent me this Employer Information and Verification to send to you to complete.

In order for the carrier to determine if I am eligible for the ARRA Premium Reduction please complete the following and return it to the carrier along with my Request for Treatment as an Assistance Eligible Individual and my continuation election form, if it is enclosed. Please complete and mail immediately so the carrier may process my request.

Please understand that your cooperation in providing this information will **not** result in you being required to pay the 65% reduction. The carrier will pay it. Without this information I may not be able to take advantage of the premium reduction. While the carrier and I anticipate you will cooperate, the New Jersey Department of Labor and Workforce Development has indicated it will take necessary action if an employer fails to cooperate. Further, if you fail to complete the Employer Information and Verification the carrier will deny my request for treatment as an assistance eligible individual which will entitle me to appeal rights with the U.S. Department of Health and Human Services.

Former Employee Name: _____
Employee fill in your name

To be completed by Former Employer

Date Employment Terminated: _____

Was the termination an *involuntary* termination of employment? ☐ Yes ☐ No
If no, the premium reduction is not available. Briefly describe the circumstances of the termination:
_____
_____
Date medical coverage terminated: _____

Do you currently offer group medical coverage to active employees? ☐ Yes ☐ No
If no, continuation is not available and neither is the premium reduction.

Has your company continuously maintained group medical coverage under our plan or under a succeeding carrier's plan since the date the employee was terminated? ☐ Yes ☐ No
If no, continuation is not available and neither is the premium reduction.

Do you offer more than one plan option to employees? ☐ Yes ☐ No
If yes, name the carriers and identify the other plans.

Carrier name	**Plan** (name and brief description)
_____	_____
_____	_____

Is your current group medical coverage issued by another carrier? ☐ Yes ☐ No
If yes, identify the carrier _____
If yes and your former employee was involuntarily terminated from employment between September 1, 2008 and May 31, 2010, or such later date as may be specified in Federal law, please send a copy of this

form to this other carrier at the address you currently use for new enrollments so the former employee may secure New Jersey Continuation coverage and the premium reduction under that carrier's plan.

_____	_____	
Employer – Signature	Date	
_____	_____	_____
Employer – Printed name	Telephone	E-mail

Instruction to Former Employer: Send this Employer Information and Verification form along with the New Jersey Continuation Election Form, if any, Form for Switching Plan Options, if any and the Request for Treatment as an Assistance Eligible Individual to *[carrier, address]*.

To apply for ARRA Premium Reduction, complete this form and send it to your former employer along with your Election Form if newly electing New Jersey Continuation. Also send the Employer Information and Verification form to your former employer.

You may also send this form in separately. If you choose to do so, send the completed "Request for Treatment as an Assistance Eligible Individual" along with the Employer Information and Verification to your former employer.

[*Insert Carrier Name*]	**REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL**	[*Insert Carrier Mailing Address*]

PERSONAL INFORMATION

Name and mailing address of employee (list any dependents on the back of this form)	Telephone number E-mail address (optional)

To qualify, you must be able to check 'Yes' for all statements.

1. The loss of employment was involuntary.	☐ Yes	☐ No
2. The loss of employment occurred at some point on or after September 1, 2008 and on or before May 31, 2010 or such later date as may be specified in Federal law.	☐ Yes	☐ No
3. I elected (or am electing) continuation coverage.	☐ Yes	☐ No
4. I am NOT eligible for other group health plan coverage (or I was not eligible for other group health plan coverage during the period for which I am claiming a reduced premium).	☐ Yes	☐ No
5. I am NOT eligible for Medicare (or I was not eligible for Medicare during the period for which I am claiming a reduced premium).	☐ Yes	☐ No

I make an election to exercise my right to the ARRA Premium Reduction for myself and my eligible dependents. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → _____ Date → _____

Type/print name → _____ Relationship to employee → _____

FOR CARRIER USE ONLY

This application is: ☐ Approved ☐ Denied ☐ Approved for some/denied for others (explain in #4 below)

Specify reason below and then return a copy of this form to the applicant

REASON FOR DENIAL OF TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

☐1. Loss of employment was voluntary.

☐2. The involuntary loss did not occur between September 1, 2008 and March 31, 2010 or such later date as may be specified in Federal law.

☐3. Individual did not elect continuation coverage.

☐4. Other (please explain)

Signature of party responsible for continuation coverage administration

→ _____ Date → _____

Type/print name → _____

Telephone number → _____ E-mail address → _____

DEPENDENT INFORMATION (Parent or guardian should sign for minor children.)

Name Date of Birth Relationship to Employee SSN (or other identifier)

a. _____

1. The former employee elected (or is electing) continuation coverage.	☐ Yes	☐ No
2. I (the dependent) am NOT eligible for other group health plan coverage.	☐ Yes	☐ No
3. I (the dependent) am NOT eligible for Medicare.	☐ Yes	☐ No

To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → _____ Date → _____

Type/print name→ _____ Relationship to employee → _____

Name Date of Birth Relationship to Employee SSN (or other identifier)

b. _____

1. The former employee elected (or is electing) continuation coverage.	☐ Yes	☐ No
2. I (the dependent) am NOT eligible for other group health plan coverage.	☐ Yes	☐ No
3. I (the dependent) am NOT eligible for Medicare.	☐ Yes	☐ No

To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → _____ Date → _____

Type/print name→ _____ Relationship to employee → _____

Name Date of Birth Relationship to Employee SSN (or other identifier)

c. _____

1. The former employee elected (or is electing) continuation coverage.	☐ Yes	☐ No
2. I (the dependent) am NOT eligible for other group health plan coverage.	☐ Yes	☐ No
3. I (the dependent) am NOT eligible for Medicare.	☐ Yes	☐ No

To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → _____ Date → _____

Type/print name→ _____ Relationship to employee → _____

This form is designed for issuers to distribute to New Jersey continuees who are paying reduced premiums pursuant to ARRA so they can notify the carrier if they become eligible for other group health plan coverage or Medicare.

Use this form to notify your carrier that you are eligible for other group health plan coverage or Medicare.

[*Carrier Namei*]	**Participant Notification**	[*Carrier mailing address*]

PERSONAL INFORMATION

Name and mailing address	Telephone number
	E-mail address (optional)

PREMIUM REDUCTION INELIGIBILITY INFORMATION – Check one

I am eligible for coverage under another group health plan. *If any dependents are also eligible, include their names below.* Insert date you became eligible: _____	☐
I am eligible for Medicare. Insert date you became eligible: _____	☐

IMPORTANT

If you fail to notify your carrier of becoming eligible for other group health plan coverage or Medicare AND continue to pay reduced continuation coverage premiums you could be subject to a fine of 110% of the amount of the premium reduction.

Eligibility is determined regardless of whether you take or decline the other coverage.

However, eligibility for coverage does not include any time spent in a waiting period.

To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → _____ Date → _____

Type/print name → _____

If you are eligible for coverage under another group health plan and that plan covers dependents you must also list their names here:

_____ _____

_____ _____

[Carrier letterhead/logo]
[Use this notice for any person who previously qualified for New Jersey Continuation as a result of a reduction in hours, and whose employment is terminated between March 1, 2010 and May 31, 2010, or such later date as may be specified in Federal law]

New Jersey Continuation Coverage
Reduction in Hours followed by Termination of Employment

[Date][Or, if a carrier wants to make this a generic piece, omit the date]

This notice contains important information about your option to continue your medical coverage under your former employer's group health benefits plan. Please read the information contained in this notice very carefully.

The American Recovery and Reinvestment Act of 2009 (ARRA) as amended by the Department of Defense Appropriations Act, 2010 and the Temporary Extension Act of 2010 and the Continuing Extension Act or 2010 reduces the continuation premium in some cases. According to information we received from your former employer, you experienced a reduction in hours between September 1, 2008 and May 31, 2010 and a subsequent termination of employment between March 2, 2010 and May 31, 2010 or such later date as may be specified in Federal law. You may be eligible for a temporary ARRA premium reduction for up to fifteen months, or for the balance of the available period of continued coverage, if less. To help determine whether you can get the ARRA premium reduction you should read this notice and the attachments very carefully.

Involuntary Termination of Employment between March 2, 2010 and May 31, 2010 or such later date as may be specified in Federal law

If you think you meet the criteria for the premium reduction, and have elected or will elect to continue your coverage under New Jersey Continuation, complete the "Application for Treatment as an Assistance Eligible Individual" and mail it to your former employer. Your mailing to the former employer must also include the Employer Information and Verification Form. If you previously elected continuation as a result of the reduction in hours, that continuation coverage will remain in effect for the balance of the 18 months. If you either did not make a continuation election upon the reduction in hours or made an election then later terminated the continuation, you have an opportunity upon termination of employment to make an election for continuation. The coverage for such an election will be effective as of the first period of coverage on or after the involuntary termination of employment, but the 18-month period for continuation will be measured from the date coverage ended upon reduction in hours. While there will be a period where there was no coverage such lapse in coverage will not be counted against you for pre-existing conditions credit purposes. The premium reduction will last no more than 15 months. Such 15-month premium reduction period neither extends nor reduces the 18 months available for New Jersey Continuation.

If your former employer offers more than one medical plan option to active employees you may elect to continue coverage under the other medical plan option(s) provided the cost is the same or

less than the cost for the plan you had when your coverage ended. Check with your former employer regarding alternate options and the cost for such options. The election for the alternate plan must be noted on the New Jersey Continuation Election Form and the Form for Switching Plan Options must be attached

If you are newly electing continuation upon the termination of employment following the prior reduction in hours you must make the election for continuation within 30 days after receiving this package of information. You will be required to pay the first premium *within 30 days* of the date you make the election for New Jersey Continuation. Send all premium payments to your former employer who will add such payments to the premium being sent to us (the carrier) for the coverage for active employees. If you qualify for the premium reduction, the premium you must pay will be 35% of the cost for the New Jersey Continuation coverage. *[Specific premium information is enclosed.] [Carriers, if it is not enclosed, say how the former employee can get it]*

Mail these completed forms to your former employer.

- ✓ New Jersey Continuation Election Form (if you are electing continuation now)
- ✓ Form for Switching Options (if you are electing another option)
- ✓ Request for Treatment as an Assistance Eligible Individual
- ✓ Employer Information and Verification

If you have any questions concerning an election for New Jersey Continuation or the premium reduction, please contact *[carrier member services at phone]*

Sincerely,
[Carrier]

New Jersey Continuation Election Form

For persons who first experienced a reduction in hours followed by an involuntary termination of employment between March 2, 2010 and May 31, 2010 or such later date as may be specified in Federal law

Instructions:
This Election Form can ONLY be used to elect New Jersey Continuation in the event of in the event of a reduction in hours followed by an *involuntary* termination of employment occurring between March 2, 2010 and May 31, 2010 or such later date as may be specified in Federal law. For *all other* elections of New Jersey Continuation please consult the employer that provided the group coverage under which you were covered.

To elect to continue medical coverage under New Jersey Continuation, the terminated employee must complete the following form and mail it to the former employer. The completed election form must be postmarked ***within 30 days*** of the date you receive this package.

If medical coverage under New Jersey Continuation is already in effect, do not complete this election form again.

I elect to continue medical coverage for myself and all dependents listed in item II below.

I. Terminated Employee Information

Name: _____ SS# _____
First MI Last or other identifier

Address _____
Street City State Zip Code

Dates: _____ _____
Reduction in hours Date Medical Coverage Ended as a result of the reduction

_____
Termination of employment

Was the termination an involuntary termination of employment? ☐ Yes ☐ No
If No, do not submit this form.

II. Dependent Information

List all dependents who were covered under your former employer's medical plan on the date before your hours were reduced and who you wish to cover under New Jersey Continuation. *Note*: Dependent coverage can ONLY be continued if the former employee elects to continue coverage for him/herself.

Name	Date of Birth	Relationship To employee	SS# or other identifier

III. Plan Selection

Check one

☐Same coverage that was in effect on the day before coverage ended or such other replacement coverage as is currently offered to active employees

☐Alternate coverage. You must complete the Form for Switching Plan Options

IV. Signature

_____ _____

Signature of Terminated Employee Date