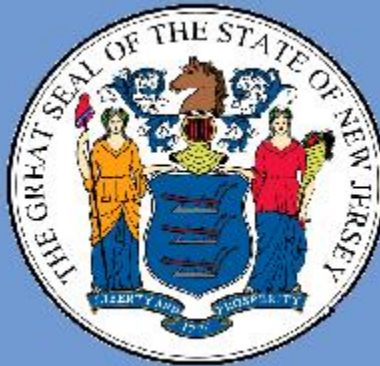


The New Jersey Small Employer Health Benefits Program **BUYER'S GUIDE**



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Introduction

Purpose of this Buyers' Guide

This Buyers' Guide explains the basic rules that apply to health coverage for small employers in New Jersey. Also, it contains examples and answers to some frequently asked questions. This guide can help you: determine if you are eligible for coverage in the small employer market; understand your rights and obligations if you purchase coverage in the small employer market; and, understand the coverage options that may be available to you. You still may need to consult a carrier, broker or agent, an accountant or an attorney to help determine if you are a small employer, and how to structure a benefits program for your group. If you purchase coverage, read your health benefits plan contract carefully for the details of your specific rights and obligations under the terms of the contract.

Overview of the Law and Small Employer Health Benefits Program

In 1992, New Jersey enacted the Individual Health Coverage (IHC) Program Act (codified at N.J.S.A. 17B:27A-2 et seq.), and the Small Employer Health Benefits (SEH) Program Act (codified at N.J.S.A. 17B:27A-17 et seq.). These laws established that eligible individuals and small groups have guaranteed access to health coverage, and will not lose coverage because of changes in health status. The two laws limit the use of pre-existing condition limitation clauses, require forms of community rating for both markets, and established Boards of Directors to oversee each program, giving each Board the authority to develop standard health benefits plan for the separate markets.

In 1996, the federal government passed the Health Insurance Portability and Accountability Act (HIPAA), which established some of the same rights and restrictions already addressed by New Jersey law, and also set standards regarding [privacy](#) and [security](#) of health information. (The [U.S. Department of Labor](#) provides information about HIPAA regarding access and portability of health coverage. The U.S. Department of Health and Human Services provides HIPAA-related information about [privacy](#) and [security](#) of transactions.) In March of 2010, the federal government enacted the Patient Protection and Affordable Care Act, or PPACA (Public Law 111-148, as amended by the Health Care and Education Reconciliation Act, Public Law 111-152). PPACA revises some of the terms for individual and small employer coverage, and may alter the way some individuals and small employers purchase health coverage beginning in January 2014.

At present, the SEH Program applies to groups of two to 50 full-time employees. The law defines "full-time employee" for purposes of SEH Program eligibility, establishes the percentage of full-time employees who must participate in the small employer's program in order to obtain and keep the small employer health benefits plan, and sets forth the minimum percentage of premium that an employer must contribute to the group coverage in order to obtain and keep the small employer health benefits plan. Please be aware not every employer with two to 50 employees will qualify as a small employer for purposes of the SEH Program.

If ineligible to purchase coverage through the SEH Program, you may be eligible to purchase coverage for yourself (and your family) through the IHC Program, which applies to individuals purchasing health coverage on a non-group basis. See the [IHC Program Buyer's Guide](#) for more information.

Eligibility for Small Employer Coverage

In order for an employer to be eligible to purchase a health benefits plan in the small employer market, an employer must:

- Meet the definition of a small employer;
- Meet employee participation requirements; and
- Meet employer contribution requirements.

What is a Small Employer?

The SEH Program Act provides the definition of a small employer. There are three tests that a company must meet in order to be considered a small employer for purposes of the SEH Program. Your company must:

- Employ an average of at least two but no more than 50 [eligible employees](#) on business days during the [preceding calendar year](#);
- Employ at least two eligible employees on the first day of the [plan year](#); and
- Have a majority of the eligible employees working at a location in New Jersey.

Eligible Employees

For purposes of the SEH Program, an eligible employee is a [bona fide](#) employee who works for an employer 25 or more hours per week every week. Eligible employees **may include** the owner(s) (partners and proprietors) of a business **if** the owner is a [bona fide](#) employee of the business.

Eligible employees **do not include** employees who are covered as members under a union's collectively bargained welfare arrangement. **But if** the employee's union has not collectively-bargained for health coverage, *or* the employee has decided not to participate in the collectively-bargained health coverage even though eligible, *and* he or she also works 25 or more hours per week on a regular basis, *then* you must include the union employee in the count of eligible employees.

Eligible employees **do not include** independent contractors, employees hired on a temporary or substitute basis, or seasonal employees, regardless of the number of hours worked. Carriers have underwriting guidelines that define whether employees are temporary, seasonal or otherwise *bona fide* employees.

When a company is [affiliated](#) with one or more other companies, all of the companies in the affiliation are treated as one company, and all eligible employees of all affiliated companies – including employees of out-of-state affiliates – are considered in determining small employer status for purposes of the SEH Program. If, when combined, the number of eligible employees of affiliated companies is more than 50, none of the affiliated companies is eligible for small group coverage.

Worksheet for Determining Small Employer Status		SubTtls	Total
A1	Total <i>bona fide</i> employees in the prior calendar year of all affiliated companies		
	If the total of A1 is less than 2 , STOP, the employer is not a small employer as defined by New Jersey law.		
A2	Employees hired on a temporary or seasonal basis		
A3	Employees with work schedules of less than 25 hours/week		
A4	Employees in the union's collectively-bargained health plan		
A5	Add rows A2, A3 and A4		
A6	Subtract row A5 from row A1 to get total eligible employees		
	If row A6 is more than 50 , STOP, the employer is not a small employer as defined by New Jersey law If row A6 is less than 2 , STOP, the employer is not a small employer as defined by New Jersey law. If row A6 is less than 51 but more than 1 , PROCEED to row A7		
A7	Employees working at locations outside of New Jersey		
A8	Subtract row A7 from row A6 to get total eligible employees in New Jersey		
	If row A8 is greater than row A7, the employer is a New Jersey small employer. If row A8 is equal to or less than row A7, the employer is NOT a New Jersey small employer.		

Affiliated Companies

Whether companies are affiliated for purposes of the SEH Program depends upon whether the companies are considered a single employer pursuant to paragraphs (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 ([26 U.S.C. § 414](#)(b), (c), (m) or (o)). An employer will need to obtain a statement from a tax accountant or tax attorney as to whether multiple companies are considered affiliated for federal tax purposes.

Newly-formed business

In general, the determination of a company's average number of eligible employees is based on the company's activity in the calendar year prior to the year in which the company is seeking to begin or renew a small group health benefits plan. However, when a company is in its first year of operation, the determination of how many eligible employees the company has will be based on the average number of eligible employees that it is reasonably expected the employer will employ on business days in the current calendar year. A company does not have to wait a calendar year in order to apply for and obtain health coverage, but the employer must employ at least two eligible employees on the effective date of coverage.

Plan year

"Plan year" refers to the duration of the contract for the health benefits plan(s). In general, a health benefits plan contract runs for 12 months. In the group market the plan year can start at any time, but carriers may limit the beginning of a plan year to the 1st or 15th of a month. Regardless of when a plan year starts, in order to be considered a small employer, the employer must have two eligible employees at the start of the plan year.

What is a Participation Requirement?

At least 75 percent of a small employer's [eligible employees](#) must participate in coverage as a condition of obtaining a small group health benefits plan. However, no carrier may require that 75 percent of the eligible employees participate in any one *carrier's* health benefits policy. Instead, an eligible employee is considered to be participating in a health benefits plan – and counts towards the group's total 75 percent participation goal – if the employee:

- ☑ Is covered as a dependent through any group health plan, including any of the policies offered by the employer's group health plan;
- ☑ Is covered through a [group health plan](#) offered by another employer, whether as an employee, former employee continuing coverage (for instance, through COBRA), or as an eligible dependent;
- ☑ Is covered through [Medicare](#);
- ☑ Is covered through [Medicaid](#); or
- ☑ Is covered through [NJFamilyCare](#).

Example 1 (Employer offers one coverage option): Mike's Bike Shop wants to offer coverage to its 12 eligible employees under one carrier's health policy. To do so, at least 75% of the eligible employees must elect coverage under the policy offered, or submit a valid waiver showing the employees have coverage as indicated above. That is, at least 9 employees must either enroll or waive enrollment for valid reasons that count toward participation. So, if

3 eligible employees enroll AND
3 eligible employees waive enrollment because they are covered through Medicare AND
4 eligible employees waive enrollment because they are covered through a spouse's group plan BUT
2 eligible employees waive enrollment for other reasons

then Mike's Bike Shop meets the 75% participation requirement, because 3 enrollments PLUS 3 waivers due to Medicare PLUS 4 waivers due to spousal group coverage equals 10 eligible employees.

Example 2 (Employer offers multiple coverage options): Mike's Bike Shop wants to offer policies from multiple carriers to its 12 eligible employees. Each carrier requires Mike's Bike Shop to meet the 75% participation requirement. So, if

3 eligible employees enroll in Carrier A's contract AND
3 eligible employees waive enrollment because they are covered through Medicare AND
4 eligible employees waive enrollment because they are covered through a spouse's group plan AND
2 eligible employees enroll in Carrier B's contract

then Mike's Bike Shop meets the 75% participation requirement for both carriers. Carrier A counts its 3 enrollees PLUS the 3 waivers due to Medicare PLUS the 4 waivers due to spousal group coverage for a total of 10 eligible

employees. Carrier B counts its 2 enrollees PLUS the 3 waivers due to Medicare PLUS the 4 waivers due to spousal group coverage for a total of 9 employees.

A carrier *is not required* to count eligible employees covered under another carrier's contract issued to the same employer.

A carrier must offer at least one policy to a small employer's group if the employer meets the participation requirements. A carrier may permit a small employer to offer more than one of the carrier's small group health benefits policies to employees; however, the carrier may limit the number of additional policies it will issue, based on the carrier's "[underwriting guidelines](#)" available on the SEH Board's website (www.state.nj.us/dobi/division_insurance/ihcseh/shop_seh.htm). If a carrier does not provide underwriting guidelines to the SEH Board for posting, then the carrier does not limit the number of contracts it will issue to a small employer's group.

Group Health Plan

A "group health plan" means an employee welfare benefit plan, as defined in Title I of section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" ([29 U.S.C.s.1002\(1\)](#)), to the extent that the plan provides medical care, including items and services paid for as medical care to employees or their dependents directly or through insurance, reimbursement or otherwise. Most plans offered by employers are considered group health plans, including small employer health benefits plans. However, for purposes of calculating participation, the term group health plan *does not* include the self-funded plans offered by the same employer, and *is not required* to include employees covered under policies issued by another carrier to the same employer (see the carrier's underwriting guidelines, if any, available on the [SEH Board's website](#)).

Classes of Employees and Participation

An employer is permitted to limit the offer of coverage to employees by class, subject to some limitations. Classes must be based on *bona fide* conditions of employment – for instance, hours worked per week, salary versus hourly wage, or union versus non-union.* But for purposes of meeting the participation requirement, *all* eligible employees are considered in the count. For example, if an employer with 30 eligible employees – 15 of whom work 35 hours per week and 15 of whom work 30 hours per week – wants to offer coverage only to employees working 35 hours per week, he may do so, but the group must meet the participation requirement based on 30 eligible employees. So, at least 23 employees must be covered under the employer's group health plans(s) or another group health plan, Medicare, Medicaid or NJFamilyCare for the employer to meet the participation requirement.

*Please note: beginning in 2011, federal law makes most group health plans that unfairly discriminate in favor of highly compensated employees subject to tax and other potential penalties. However, the [Internal Revenue Service](#) has stated in [Notice 2011-1](#) that it will not require employers to comply with the requirement until the agency has adopted regulations further explaining the law.

Changes in a Carrier's Underwriting Guidelines

Occasionally, a carrier may change its underwriting guidelines. Any revisions will be posted on at www.state.nj.us/dobi/division_insurance/ihcseh/shop_seh.htm, and will apply only to new business or renewals with plan changes occurring on or after the date the revisions to the guidelines are effective.

What is an Employer Contribution Requirement?

A small employer is required to pay 10 percent of the total cost of a health benefits plan issued to the employer's group. A small employer may, of course, elect to pay a greater percentage – up to 100 percent – but a carrier may not require the employer to pay more than 10 percent as a condition of issuing the small employer a small group health benefits plan.

Note that the employer's contribution obligation is based on the total cost of the health benefits plan, not just the cost related to employees or a class of employees. For example, if the total cost of a plan for all employees and dependents is \$10,000 per year, the minimum employer contribution would be \$1,000 per year.

For purposes of insurance law, it is possible for an employer to limit its contributions to the group premium by class of employee or by employee coverage only (thus, requiring some classes of employees to pay more of the premium than other classes, or requiring employees to pay the full cost of dependent coverage, if offered). However, the employer's contribution obligation remains at least 10 percent of the **total** cost for the health benefits plan.

SEH Program Features for Health Benefits Plans

All small group health benefits plans must meet certain minimum requirements that are "SEH Program features." Small group health benefits plans must:

- Be guaranteed issue;
- Be guaranteed renewable;
- Comply with restrictions on the use of pre-existing condition limitation clauses;
- Comply with restrictions on rating criteria and standards;
- Include rights of coverage continuation for members of groups not governed by COBRA; and
- Be standard plans (*at the option of the employer*, such plans may include one or more riders offered by the carrier in the SEH market).

Guaranteed Issue

A carrier may not refuse to issue a small group health benefits plan to any [eligible small employer](#) or any member of the group for which the small employer is purchasing coverage because of anyone's health, prior claims experience, age, gender, occupation, nature of the business, or the location of the business in New Jersey.

Guaranteed Renewal

In general, a small employer may continue to renew a small group health benefits plan at the discretion of the small employer.

A carrier may nonrenew a small employer health benefits plan ONLY if:

- The employer fails to provide the completed Annual Certification as required;
- The employer ceases to be eligible because it no longer has at least 2 eligible employees;

- ☑ The small employer is no longer eligible because it fails to meet contribution requirements or fails to meet participation requirements; or
- ☑ Following the approval of the Commissioner of the New Jersey Department of Banking and Insurance, the carrier withdraws the health benefits plan from the small employer market.

In addition, if the small employer has obtained coverage through membership of the business entity in an association, the carrier may nonrenew the health benefits plan if the business is no longer eligible for the association membership, or the small employer chooses to discontinue membership. Nonrenewal occurs only upon the anniversary date of the coverage and only after appropriate notice is provided to employers.

When a small employer grows to more than 50 eligible employees, the carrier will renew the small employer policy at the employer's request, but the premiums may no longer be the carrier's SEH market rates. If the employer changes the policy *in any way*, the employer loses the protections (and restrictions) arising from small employer status entirely. So, the carrier will offer the employer different policies and riders using different rating methodologies, and might apply different participation and different contribution requirements to the employer.

Of course, regardless of the employer's status, a carrier may terminate the coverage if the employer fails to pay premiums timely or has acted fraudulently or intentionally made material misrepresentations of information relevant to the issuance of the health benefits plan. Termination can occur immediately.

Restrictions on Pre-Existing Condition Exclusions and Limitations

A "pre-existing condition" is an illness or injury existing before an individual obtains health coverage. Sometimes carriers limit coverage for treatment of a person's pre-existing conditions. However, New Jersey and federal law restrict how carriers may use pre-existing condition limitations in the small group market.

Specifically, the SEH Program Act does not allow carriers to look back more than 6 months at a person's medical or treatment history for purposes of limiting coverage, and does not allow a carrier to consider any condition as pre-existing unless the condition was actually diagnosed or treated, or treatment was recommended or prescribed medications were taken for the condition. And under no circumstance may a carrier consider a pregnancy to be a pre-existing condition.

In addition:

- ☑ State law prohibits the application of pre-existing condition limitation periods to any members of a small group with 6 to 50 eligible employees, except in the case of late enrollees;
- ☑ State law prohibits the application of a pre-existing condition limitation period to groups of 2 to 5 eligible employees for more than 6 months following the enrollment date in the health benefits plan;
- ☑ State law prohibits the application of a pre-existing condition limitation period to late enrollees for more than 6 months following the effective date of the late enrollee's coverage;

- ☑ State law prohibits the application of a pre-existing condition limitation period to late enrollees altogether when 10 or more late enrollees ask to enroll in a small employer's group health plan within the same 30-day period;
- ☑ Federal and state law prohibits the application of a pre-existing condition limitation period to children and federal law prohibits the application of a pre-existing condition limitation to anyone under the age of 19 years old; and
- ☑ Federal law requires carriers to reduce a pre-existing condition limitation period applied against a person by the amount of time that the person had prior creditable coverage, not including periods of time occurring prior to any lapse in coverage of more than 90 days.

Note that when a pre-existing condition limitation period applies to a person, the limitation has no impact with respect to treatment of illnesses or injuries that are not related to the pre-existing condition(s).

Late Enrollees

The initial offer of coverage to an employee must include at least a 30-day enrollment period. After the initial enrollment period, an employee may still enroll (along with his or her dependents) – there is no requirement to wait for an open enrollment period – but the employee and dependents may be considered late enrollees. Late enrollees become subject to a pre-existing condition limitation period (not to exceed 180 days) that might not have applied had the employee enrolled when coverage was initially offered. There is an exception for late enrollees who are under the age of 19 because they are never subject to a preexisting condition limitation.

However, not all "late" requests for coverage result in employees or their dependents being considered late enrollees. An employee and/or his or her dependents will not be considered late enrollees if:

- ☑ The employee initially waived coverage because coverage was available through another employer plan, and s/he seeks coverage under the small employer plan within 90 days following termination of coverage under the other employer plan;
- ☑ The employee or dependent had coverage under a COBRA continuation provision and, within 30 days after exhaustion of the COBRA right, the employee requests enrollment for him- or herself and/or his or her dependent;
- ☑ A court of competent jurisdiction orders coverage to be provided for a spouse or minor child under a covered employee's health benefits plan and the employee makes the request for enrollment within 30 days after issuance of that court order;
- ☑ The small employer offers multiple health benefits plans and an employee elects to change from one to another of the offered health benefits plans during an open enrollment period.
- ☑ The employee enrolls himself and his dependents during a *special enrollment period*.

Special enrollment periods arise due to individual employee life events: marriage of the employee, or birth or adoption of a child. When one of these events occur, if an employee seeks coverage for himself and/or his or her dependent(s) within 30 days following the marriage, birth or adoption, neither the employee nor any of the employee's dependents are considered to be late enrollees.

What does all of this mean in practice? It depends on the size of the employer.

For small employers with 6 to 50 eligible employees, a preexisting condition limitation period ONLY applies to someone who is a late enrollee. If a person can avoid being classified as a late enrollee for one of the reasons stated above, then s/he (and his or her dependents) will not be subject to the late enrollee pre-existing condition limitation period. Of course, individuals under age 19 are not subject to a preexisting condition limitation period *even if* they are classified as late enrollees.

For small employers with 2 to 5 eligible employees, a preexisting condition limitation period applies whether or not a person age 19 or older is considered a late enrollee. So even if an employee enrolls during a special enrollment period, the enrolling employee (and his or her dependents **other than** a child) will be subject to a pre-existing condition limitation period anyway. Please note: "Child" includes newborns, adopted children, and children placed for adoption who are younger than 19 years old upon the date of enrollment.

Creditable Coverage

If a covered person is subject to a pre-existing condition limitation, he or she is entitled to have the pre-existing condition limitation period reduced, or even eliminated, if he or she had prior *creditable* coverage. Credit for prior coverage enables both small employers and their employees to switch health benefits plans and carriers without worrying about facing new pre-existing condition limitations each time. This is what is referred to as *portability*.

Most, but not all, types of coverage that pays for medical and hospital costs is creditable. Creditable coverage *includes* individual health benefits plans, coverage through [group health plans](#) (whether insured or self-funded), and any federally funded health benefits program (e.g. [Medicare](#), [Medicaid](#)). However, even if coverage is creditable, it may only be used to reduce or eliminate application of a pre-existing condition limitation clause so long as there is not more than a 90-day lapse between the termination date of the prior creditable coverage and the enrollment date under the new small employer group health plan. (*Note: The permissible lapse period is 63 days when moving to large group coverage, and generally 31 days if moving to individual coverage.*)

A carrier generally will reduce the amount of the pre-existing condition limitation period by the amount of time the individual in question had prior creditable coverage. So, if an employee was covered at least 6 months under prior creditable coverage, and there was no more than a 90-day lapse between the prior coverage and the enrollment date for current small group coverage, no pre-existing condition limitation period would apply.

An employee or dependent may be required to produce a certificate of creditable coverage to prove that he or she had such coverage. The carrier or other plan sponsor of the prior coverage has an obligation under federal law to provide the certificate to the employee or dependent upon termination of the prior coverage, and upon request. However, alternate documentation of prior coverage may be substituted, if necessary.

Waiting Periods

An employer may institute a waiting period for new employees, subject to some restrictions. Currently, a waiting period of up to 6 months is permissible, but beginning in 2014, the waiting period can be no longer than 90 days beginning in 2014 under federal law. Institution of a waiting period may be by class of employee, so long as the class is a *bona fide* condition of employment (for instance, based on hours or employment, salary versus hourly wage or union versus non-union). An employee will not be considered to have health coverage while in a waiting period for purposes of determining his or her total amount of creditable coverage. On the other hand, a waiting period does not count against an

employee for purposes of determining a lapse between prior creditable coverage and the enrollment date under a current small group health benefits plan.

Rating Restrictions

The SEH Program Act requires that premiums for small group health benefits plans be determined using a modified community rating basis. Carriers may consider only the age, gender, and rating tier of eligible employees (for example, "Employee Only," "Employee & Child(ren)"), and the location of the employer in New Jersey in determining the premium for the group. The rules for the SEH Program set forth the permissible age and territorial rating classifications.

Carriers may not rate any small group, or member of the group, on any other factors. Accordingly, it is impermissible for a carrier to rate based on an individual's health status, the claims experience of eligible employees or the group as a whole, the industry classification of the employer, or the employer's type of business. Carriers must provide a reduced premium rate or rating factor for those situations in which an employee or spouse is covered by [Medicare](#) and Medicare is the primary coverage. (The carrier may apply the reduction directly to the Medicare-covered employee or may apply the reduction to the rate for the entire group, in which case, the reduction may not be readily apparent in the rate quote.)

So, a carrier's rates will not consider whether a small business is a floral shop, an accounting service, or an automotive repair shop, but will consider whether the business is located in Bergen County or Atlantic County. A carrier's rates will not consider whether the small business has employees with chronic health conditions, but will consider the number of men and women who work for the business and their ages.

Using the permissible rating factors, carriers are required to limit the range of premiums for a health benefits plan from the highest risk group to the lowest risk group so that premiums do not exceed a two-to-one ratio between the groups.

Although your premiums will vary based on the specifics of your group, you can make some comparisons among carriers before requesting a rate quote by reviewing the [Premium Comparison Chart](#) for sample small groups.

Rating Errors

If a carrier discovers that it has undercharged a small employer, the carrier must provide the small employer with notice of the error at least 60 days prior to charging the small employer group the corrected premium amount. The carrier is not permitted to try to collect or offset for the undercharges.

If a carrier discovers that it has overcharged a small employer, the carrier must stop doing so immediately, provide notice to the small employer about the overcharges as soon as possible, and refund or credit the full amount of the overcharges to the small employer within no more than 30 days after discovering the error. (See [N.J.A.C. 11:21-9.6](#))

Continuation of Coverage

Small employer health benefits plans must contain continuation of coverage provisions that may be exercised when certain covered persons lose eligibility. Some small employers will be subject to the continuation rights established by the federal law referred to as [COBRA](#). Most small employers will be subject to the continuation rights established by New Jersey

law, referred to as the New Jersey State Group Continuation (NJSGC) right. The laws are similar, but there are some differences. In addition, New Jersey law sets forth a special continuation right for certain employees that terminate employment due to total disability.

Brief comparison of COBRA and NJSGC

Both [COBRA](#) and NJSGC:

- Establish continuation rights for most of the same groups of qualified beneficiaries – employees, spouses and child dependents – if covered under the health benefits plan immediately preceding the qualifying event.
- Establish continuation rights as the result of most of the same types of qualifying events.
- Establish continuation periods of the same duration.
- Permit the employer to require that the person who elects to continue the coverage pay 100 percent of the cost of the coverage, plus a 2 percent administrative fee (that is, 102 percent of the cost).

NJSGC *differs* from [COBRA](#) in that:

- Domestic partners and civil union partners have a right to make an NJSGC election upon the death of the employee or dissolution of the partnership if covered under the health benefits plan immediately before these qualifying events.
- COBRA entitles a former employee's spouse to maintain the continued coverage for the duration of the continuation period even after the former employee enrolls in Medicare, but NJSGC does not.
- COBRA applies to employers with 20 or more employees, with some exceptions (such as church plans).
- NJSGC applies to employers with 2 to 50 employees, including employers to whom COBRA does not apply, if the employer purchases a small group health benefits plan.

Groups with 20 to 50 eligible employees must comply with *both* COBRA and NJSGC. So, groups of 20 to 50 eligible employees must provide for continuation for domestic partners and civil union partners although COBRA would not require it. Likewise, a group with 20 to 50 eligible employees must allow a former employee's spouse to maintain continued coverage even after the former employee enrolls in Medicare because COBRA provides that protection to spouses, although NJSGC would not require it. In addition, church plans of employers with 2 to 50 employees must comply with NJSGC, even though they do not have to comply with COBRA at all. For more detail, refer to Advisory Bulletin 07-SEH-02, at http://www.state.nj.us/dobi/division_insurance/ihcseh/bulletins/sehblt07_02.pdf

The information that follows is specific to the NJSGC. For more information about COBRA, see "An Employee Guide to Health Benefits Under COBRA," published by the Employee Benefits Security Administration of the U.S. Department of Labor (available online at: <http://www.dol.gov/ebsa/pdf/cobraemployee.pdf>).

Employees, qualifying events and duration of continued coverage

The NJSGC requirement specifies that an employee be given the option to continue coverage when:

- the employee is terminated for reasons other than cause;

- the employee's hours are reduced, causing him or her to be ineligible for the small group coverage; or
- the employee ends employment.

An employee is entitled to continue the coverage he or she had immediately prior to his or her ineligibility, including covering dependents who were covered prior to the employee's ineligibility. An employee is entitled to continue coverage for 18 months, unless he or she is [disabled](#) within 60 days after the qualifying event, in which case, he or she may continue coverage for 29 months. The determination of disability is made by the Social Security Administration.

Dependents, qualifying events and duration of continued coverage

The NJSGC only specifies that a covered spouse, civil union partner or domestic partner be given the independent option to continue coverage when he or she would otherwise lose eligibility for coverage because of:

- Death of the covered employee; or
- Divorce or other legal action that results in termination of the marriage, or dissolution of the civil union or domestic partnership with the covered employee.

The NJSGC only specifies that a covered child dependent be given the independent option to continue coverage because of:

- Death of the covered employee;
- Divorce or other legal action that results in termination of the marriage, or dissolution of the civil union or domestic partnership with the covered employee; or
- The child ceases to be an eligible dependent (for instance, because s/he marries or attains the policy's limiting age for dependent children).

When a dependent makes a continuation election, he or she is entitled to continue coverage for up to 36 months.

Limits on the duration of coverage

Continued coverage pursuant to NJSGC may end earlier than the prescribed continuation period if:

- the employer ceases to offer any health benefits plan;
- the covered person fails to make appropriate payment (subject to a 31-day grace period);
- the covered person becomes covered under another health benefits plan that applies no pre-existing condition limitation to the covered person and anyone else under the continued health benefits plan; or
- the covered person becomes entitled to [Medicare](#).

Employer's obligation

Employers have a legal obligation to notify their employees of the right to continue coverage at the time of termination or at the time the employee assumes part-time status. An employer has an obligation to remit the premium paid to the employer by the employee/former employee or dependent on continuation as part of the employer's regular premium payment. In other words, the employer is obligated to serve as a conduit for the

premium payment to the carrier. However, employers are not required to contribute to the premium or otherwise “front” the money for the employee.

Continuation in the event of total disability

New Jersey law (N.J.S.A. 17B:27-51.12 and N.J.S.A. 17:48E-32) requires that when a covered employee terminates employment due to total disability, the employee may continue coverage (including coverage for his or her dependents) under the group’s health benefits plan. The employee must have been covered under the health benefits plan at least three months prior to termination of employment. The employee may be required to pay the group rate for the continued coverage. An election must be made within 31 days after the date the coverage would otherwise terminate. *An employee’s eligibility for Medicare does not limit the right to continue coverage under the group health benefits plan.*

Under this election, continued coverage will end:

- for the employee and any covered dependents if the employee fails to pay the required premium
- for the employee and any covered dependents when the employee is again employed and eligible for another group health plan
- for a dependent when that dependent stops being an eligible dependent or becomes eligible for another group health plan
- for the employee and any covered dependents if the employer ceases to offer a group health benefits plan to all employees.

In the event the employer replaces the group health benefits plan with another such plan, the disabled employee has the right to become covered under the replacement group health benefits plan.

Please note: **all** small employer health benefits plans have terms and conditions in compliance with this New Jersey continuation requirement, including those offered by HMOs. However, in the larger group market, New Jersey law does not require HMO’s to provide continuation coverage specifically for termination due to total disability.

Other Important Features

Domestic Partners and Civil Union Partners

New Jersey law currently recognizes domestic partnerships and civil unions in addition to marriages between individuals of opposite gender. Civil unions may be created only among individuals of the same gender. Domestic partnerships include individuals of the same gender or of opposite genders, but for purposes of health coverage (and this Buyer’s Guide), only same-gender domestic partnerships are considered. Note that same-gender domestic partnerships are no longer formed as a matter of law in New Jersey as of February 19, 2007.

In general, the rights of spouses and partners of civil unions are the same for purposes of health coverage under New Jersey law. If an employer offers dependent coverage to employees, the employer must permit an employee to cover a civil union partner. Employers do not have to offer coverage to domestic partners when offering coverage to spouses or partners of civil unions. However, when an employer opts to offer coverage to domestic partners, the employer must treat all domestic partners consistently.

Neither an employer nor a carrier may discriminate in the coverage of a child the employee claims as a dependent based on whether the child becomes a dependent of the employee pursuant to birth, adoption, marriage, civil union or domestic partnership.

“Dependent Under 31” Continuation Election

New Jersey law permits an employee’s child who no longer qualifies as a child dependent under the terms of an employer’s health benefits plan to elect to remain covered as an “over-age” dependent until the child’s 31st birthday, so long as s/he meets the other eligibility requirements associated with the “Dependent Under 31” continuation election. In the case of a child who is aging-out of a parent’s coverage, the Dependent Under 31 continuation election right is *in addition to* the aging-out child’s right to make either a COBRA or NJSGC election. Beginning with plan years on or after September 23, 2010, federal law (PPACA) requires that, when dependent coverage is offered, an employee be permitted to cover a child until the child is 26 years old, without regard to the child’s marital, financial or educational status. Thus, upon aging-out on his or her 26th birthday (or such later date as may be stated in the health benefits plan), a child covered under a small employer health benefits plan may make a continuation election pursuant to COBRA or NJSGC with the expectation of continuing coverage for up to 36 months, or may make a Dependent Under 31 (DU31) election with the expectation of continuing coverage until age 31, so long as he continues to be DU31-eligible.

There are pros and cons to making a DU31 election instead of a COBRA or NJSGC election. The cost of continuing coverage pursuant to a DU31 election will be lower for the over-age child than will be the cost of continuing coverage pursuant to a COBRA or NJSGC election because DU31 election coverage is priced at a child’s rate rather than the single adult rate. However, an over-age child has more eligibility criteria to meet in order to maintain coverage pursuant to a DU31 election. For instance, an over-age child will lose coverage continued pursuant to a DU31 election when he or she marries, obtains a dependent child or moves outside of New Jersey (and is not a full-time student in an institution of higher education). These types of events will not result in a loss of coverage under a COBRA or NJSGC election.

The right to make a DU31 election is not limited to the time period of the child’s age-out. An over-age child may make a DU31 election whenever he or she can establish eligibility by showing proof of having had prior creditable coverage. The Department of Banking and Insurance has a more detailed discussion of the [DU31 election](#), with questions and answers and a comparison chart between COBRA, NJSGC and DU31 on at http://www.state.nj.us/dobi/division_consumers/du31.html.

Appealing Unfavorable Medical Necessity Decisions

The SEH Program health benefits plans permit carriers to consider whether many of the services covered under the contract or policy are medically necessary and appropriate for purposes of treatment of the covered person’s condition. If a carrier determines that a service is not medically necessary and appropriate (including determinations that the service is experimental or investigational, cosmetic, or dental instead of medical), the covered employee or dependent has the right to appeal the unfavorable determination.

In New Jersey, carriers are required to have a two-stage internal appeal process. In addition, if the outcome continues to be unfavorable and the employee or dependent continues to disagree, the appeal may be taken to an external independent utilization

review organization through the [Independent Health Care Appeals Program](#), which is under the auspices of the New Jersey Department of Banking and Insurance.

The covered employee or dependent may authorize a health care provider to make the appeals on behalf of the covered employee or dependent by providing written consent. The small employer does not have to become involved with either the internal or external appeal process.

The New Jersey Department of Banking and Insurance has a more detailed discussion of the right to [appeal medical necessity determinations](#) both internally and through the Independent Health Care Appeals Program on the Department's website.

The Standard Small Employer Health Benefits Plans

The SEH Program Board of Directors has adopted 5 standard small employer health benefits plans, generically known as Plans A through E, plus a standard HMO plan.

Plan A

Plan A is the most limited of the standard small employer health benefits plan, and is designed primarily to cover facility charges and other health care provider charges related to services rendered while a person is hospitalized. Plan A limits coverage to 30 days of inpatient hospitalization per calendar year. Inpatient hospital days may be exchanged on a 2:1 basis for services provided in an extended care/rehabilitation facility, through home health care, or hospice. Plan A provides coverage of childhood immunizations, and includes some benefits for other preventive services. Plan A has a specified [deductible](#), [coinsurance](#) and [maximum out-of-pocket \(MOOP\)](#) amount for which the covered person is responsible before the carrier begins paying 100% of the allowed charges.

Plans B, C, D and E

Plans B through E all provide comprehensive inpatient and outpatient hospital and medical coverage, including the following health care services:

- office visits
- hospital care
- prenatal and maternity care
- immunizations and well-child care
- screenings, including mammograms, pap smears and prostate examinations
- x-ray and laboratory services
- biologically based mental illness services
- certain non-biologically based mental illness and substance abuse services
- therapy services
- prescription drugs

Like Plan A, Plans B through E have no lifetime maximum benefit.

Plans B through E **differ** from one another because of the **level of benefits** they offer – that is, because of the amount of allowed charges for which the carrier agrees to be responsible. Carriers may offer Plans B through D with a variety of [deductible](#) options among which employers may choose, ranging from a low of \$250 to a high of \$5,000 per person. Plans B through D have specified [coinsurance](#) levels, with the carrier agreeing to pay 60% of the allowable charges for Plan B, 70% for Plan C, and 80% for Plan D. The [MOOP](#) amount is variable for each health benefits plan, and can be offered by the carrier in a range from \$2,000 to \$10,000. Plan E has a specified deductible of \$150 per person, and a coinsurance level of 90%, with a specified MOOP of \$1650 per person.

HMO Plan

The HMO plan covers the same comprehensive set of services that Plans B through E cover, but generally restricts covered individuals to utilization of a specified network of health care providers. However, carriers may offer the HMO plan with a point-of-service (POS) design, which allows the utilization of some services out-of-network.

The carrier may offer the HMO plan (including HMO plans with a POS design) with a variety of copayment options among which the employer may choose, with a \$15 copayment or 50% coinsurance requirement for prescription drugs. In addition, the carrier may offer the HMO plan with deductibles ranging from \$250 to \$2,500 per person, and coinsurance ranging from 50% to 90%, plus some copayments. Coinsurance and copayments cannot apply to the same health care services. For instance, when the HMO plan includes coinsurance requirements, copayments will apply to primary care office visits and maternity visits, and deductible and coinsurance may apply to most other services. When a deductible and coinsurance apply generally, then the HMO plan will also have a MOOP requirement of no more than \$5,000.

Snapshot of the Standard Small Employer Health Benefits Plans

The following chart highlights the cost-sharing requirements and options of the standard small employer health benefits plans (SEH Plans) when offered with a network design. That is, the plans are shown when offered as Preferred Provider Organization (PPO), Point-of-Service (POS) or closed Health Maintenance Organization (HMO) products. Carriers typically choose to offer the SEH Plans with a network feature, and employers typically choose to purchase the SEH Plans with a network feature. Remember that, except for Plan A, the SEH Plans cover the same set of health care services, so the primary difference among the plans is the cost-sharing requirements, and the networks. Networks and cost-sharing are discussed more following the chart.

Snapshot of the Standard Small Employer Health Benefits Plans (with Network Features)							
	Plan A	Plan B	Plan C	Plan D	Plan E	HMO	HMO POS
Covered services (before riders)	hospital, limited medical	hospital, medical, therapies, home health, prescription drugs	hospital, medical, therapies, home health, prescription drugs	hospital, medical, therapies, home health, prescription drugs	hospital, medical, therapies, home health, prescription drugs	hospital, medical, therapies, home health, prescription drugs	hospital, medical, therapies, home health, prescription drugs
Deductible ¹ IN-NETWORK	medical - \$250/individual; \$500 or \$750/family	\$250 to \$2500/individual; family = 2x or 3x indiv.	\$250 to \$2500/individual; family = 2x or 3x indiv.	\$250 to \$2500/individual; family = 2x or 3x indiv.	\$150 to \$2500/individual; family = 2x or 3x indiv.	\$250 to \$2500/individual; family = 2x individual	\$250 to \$2500/individual; family = 2x individual
Deductible OUT-OF-NETWORK	medical - \$250/individual; \$500 or \$750/family	up to 3x in-network individual; family = 2x out-of-network individual	up to 3x in-network individual; family = 2x out-of-network individual	up to 3x in-network individual; family = 2x out-of-network individual	up to 3x in-network individual; family = 2x out-of-network individual	n/a	up to 3x in-network individual; family = 2x or 3x out-of-network individual
Coinsurance ² IN-NETWORK	hospital: 100% medical: 70%	60%	70%	80%	90%	n/a OR 50% on Rx AND/OR 50%-90% when copays do not apply	varies
Coinsurance ² OUT-OF-NETWORK	hospital: 20% medical: 50%					n/a	
Copayments ³ IN-NETWORK	n/a	may use the HMO copayment options	may use the HMO copayment options	may use the HMO copayment options	may use the HMO copayment options	Office: \$5/10/15/20/30/40/50; Prenatal: same as above OR \$25; Rx: \$15; ER: \$50/75/100; Hospital: \$75/100/150/200/300/400/500 daily to max of \$750 to \$5000 yearly	Office: \$5/10/15/20/30/40/50; Prenatal: same as above OR \$25; ER: \$50/75/100; Hospital: \$75/100/150/200/300/400/500 daily to max of \$750 to \$5000 yearly
Maximum Out of Pocket ¹ IN-NETWORK	up to \$7500 per individual	up to \$7500 per individual; 2x or 3x individual per family	up to \$7500 per individual; 2x or 3x individual per family	up to \$7500 per individual; 2x or 3x individual per family	up to \$7500 per individual; 2x or 3x individual per family	up to \$7500 per individual; 2x individual per family (copay, deductible & coinsurance)	up to \$7500 per individual; 2x individual per family (copay, deductible & coinsurance)
Maximum Out of Pocket OUT-OF-NETWORK	up to 3x the in-network MOOP	up to 3x the in-network individual; 2x or 3x out-of-network individual per family	up to 3x the in-network individual; 2x or 3x out-of-network individual per family	up to 3x the in-network individual; 2x or 3x out-of-network individual per family	up to 3x the in-network individual; 2x or 3x out-of-network individual per family	na	up to 3x the in-network individual; 2x or 3x out-of-network individual per family

¹ Carriers may require family deductibles and the family MOOP to be satisfied by separate individuals (when 2x) or by the family in the aggregate (when 2x or 3x).

² Coinsurance is shown as the percentage the carrier will pay. Either the in- or out-of-network coinsurance **must** be: 60% for B, 70% for C, 80% for D, and 90% for E.

³ For B, C, D and E, copays may substitute for the deductible on: practitioner visits, emergency room use and hospital admission. HMOs **must** offer a copay option; for prenatal, the copay applies to the initial visit only; Rx is subject to a copay **or** coinsurance; ER copays are in addition to other required cost-sharing.

More about Health Benefits Plan Designs and Options

Delivery Systems: Indemnity and Network-based Health Benefits Plans

Plans A through E may be offered as traditional indemnity plans. This means that the covered person has the ability to go to any health care provider he or she chooses. Under an indemnity plan, the covered person often pays bills for covered services directly and then is reimbursed by the carrier.

Plans A through E are most often offered with a network, as a PPO or POS product. A PPO or POS product gives an individual the option to access services in the carrier's network, or go to out-of-network health care providers. The individual receives greater benefits when he or she uses in-network health care providers, and will not be responsible for any charges in excess of what has been negotiated between the carrier and health care provider. POS products require members to obtain referrals to in-network specialists, but PPO products do not. PPO and POS products may apply a deductible and coinsurance to both in-network and out-of-network services. When the covered person obtains services in-network, his or her share of the coinsurance is less than what it would be for out-of-network services, the determination of what is owed is based on a negotiated fee, and the covered person is not responsible for any charges in excess of the negotiated fee. Alternatively, PPO and POS products often apply copayments for in-network services and deductible and coinsurance for out-of-network services.

The HMO plan is a network-based product, with services provided through a network of health care providers under contract with the carrier. The HMO Plan must be offered as a closed network product, meaning services and supplies are covered only if rendered by in-network providers. The covered person selects a primary care physician (PCP) who generally coordinates the health care services the covered person needs, or refers the covered person to an in-network specialist when necessary. HMOs will permit a specialist to be designated as the PCP for individuals with chronic conditions, if appropriate.

Carriers may also offer the HMO Plan as a POS product, which allows an individual to use in-network services, but also allows the option of obtaining services outside of the HMO's network while still receiving benefits. The individual will have to pay more in out-of-pocket costs, and may incur charges in excess of allowed charges when he or she goes out-of-network.

There are many ways carriers may design PPO and POS products for the standard plans. There may be a common deductible for the in- and out-of-network benefits or separate deductibles; there may be a common MOOP for the in- and out-of-network benefits or separate MOOPs. The family deductible (at 2 times the individual deductible) can require satisfaction of the deductible by two separate family members, or by the family in the aggregate. The out-of-network MOOP can be up to 3 times that of the in-network MOOP. There may be two sets of coinsurance, or the carrier may require the payment of copayments in-network and coinsurance out-of-network. The carrier may require the payment of both copayments and deductible in-network, but not for the same health care services.

Riders

A rider is a document that changes the terms of a standard small employer health benefits plan. Riders add to the number of coverage options available to employers and their employees by offering a benefit not otherwise covered under the standard plan, or revising the way a service is covered under the standard small employer health benefits plan. The standard small employer health benefits plans have several standard riders providing

options for the delivery of prescription drug benefits using a prescription drug card program or a mail order program and copayment options (otherwise, prescription drugs are covered pursuant to a deductible/coinsurance requirement).

Carriers are permitted to offer their own riders to standard small employer health benefits plans. The riders may either increase the benefits of the plan (subject to review of the SEH Program Board) or decrease the benefits of the plan (upon approval of the New Jersey Department of Banking and Insurance). Carriers that offer a rider with a standard plan must offer the rider to all groups who are interested, but the choice to purchase the rider rests with the employer. Most carriers offering standard health benefits plans offer one or more of their own optional riders.

Carriers MUST offer every standard health benefits plan to every small employer with AND without optional riders; the employer chooses whether to buy the plan with a rider. Also, carriers MUST NOT condition the purchase of one rider upon the purchase of another rider.

Health Savings Accounts and Other Tax-favored Options

Plans B through D and the HMO Plan can all be designed as “high deductible health plans” (HDHP) that may qualify for use with a Health Savings Account (HSA) or an Archer Medical Savings Account (Archer MSA), both of which permit money to be set aside in a federally tax-favored savings vehicle for subsequent distribution without a federal tax liability if used to pay for qualifying medical expenses, [set forth in IRS Publication 502](#). (HDHPs with MSAs may only be available for **renewal** after 2007.) There are differing minimum and maximum deductible and MOOP amounts that an HDHP must meet to qualify for combination with one of the savings accounts. Not all plans with high deductibles necessarily qualify as HDHPs. Carriers may market both the HDHP and the savings account, or an employer may purchase an HDHP from a carrier and obtain the savings account through another financial institution. For more information, consult [IRS Publication 969](#). In addition, [IRS Publication 969](#) provides information about other employer-sponsored, federally-tax-favored health accounts, such as Flexible Spending Accounts (FSAs) and Health Reimbursement Arrangements (HRAs), which permit employees to pay for [qualified medical expenses](#) using pre-tax dollars.

More about Cost-Sharing Requirements for the Standard Plans

Deductibles

The deductible is the amount of the allowed covered charges that the covered person must satisfy before the carrier agrees to pay anything towards covered charges. Deductibles are set forth as a specified dollar amount, and are usually determined per person and per family when more than one person in a family is covered. The employer may choose among the options available for the per person deductible. The carrier chooses whether to offer the plan with the family deductible at 2x the per person charge (satisfied by two separate family members or, for Plans B, C, D and the HMO Plan, in the aggregate), or 3x the per person charge (satisfied by the family in aggregate when 3x the per person charge is an option).

Coinsurance

The coinsurance is the percentage of the allowed charges that are shared by the carrier and the covered person after the deductible is satisfied. The carrier and covered person both contribute a specified percentage to the allowed charges until the MOOP amount is satisfied. Depending upon what plan is chosen, the carrier will pay 50% to 90% of the allowed charges, and the covered person will pay 10% to 50% of the allowed charges until the MOOP amount is reached. Note that, except with respect to HDHPs, the carrier may determine whether coinsurance for prescription drug charges will accumulate towards the

MOOP. If a carrier chooses not to have prescription drug charges accumulate towards satisfaction of the MOOP, then a coinsurance charge for prescription drugs will still apply after the MOOP is satisfied for other services.

Copayments

A copayment is a specified dollar amount that a covered person pays per visit, per day or per service. Typically, an HMO Plan or the in-network component of a POS plan will specify a copayment for office visits. A copayment may be applied for each day in the hospital (for a limited number of days). A copayment applies for use of a hospital's emergency department (but the copayment – which is more akin to a penalty – is waived if the person is admitted to the hospital). Copayments accumulate towards the MOOP amount. Services subject to a copayment may not also be subject to a deductible or coinsurance.

Maximum Out-of-Pocket (MOOP)

MOOP is the term used to refer to the total amount of covered charges that a covered person is expected to pay in a calendar year for health care services after which the carrier pays 100% of the covered charges. The MOOP is satisfied by the covered charges incurred by the covered person as part of the deductible, coinsurance and copayments required under the health benefits plan. In policies covering more than one person, the MOOP is usually 2x (but sometimes 3x) the per person MOOP, as specified by the carrier. The following do not count towards satisfying the MOOP:

- Charges incurred by the covered person for services that are not covered under the terms of the health benefits plan.
- Charges that exceed the amount that the carrier considers reasonable and customary (or allowed charges) for the covered services.
- Prescription drug charges when the plan specifically states that the charges will not satisfy the MOOP.

Allowed Charges

Carriers will not cover or pay for charges associated with services or supplies that:

- are excluded under the terms of the health benefits plan;
- exceed limits set forth for the services or supplies in the health benefits plan; or
- are not considered medically necessary and appropriate by the carrier. (*Remember, the covered person may appeal the determination.*)

If a health care service or supply is excluded or exceeds the limitations under the health benefits plan, the covered person is responsible for the charges related to the health care service. A covered person may or may not be responsible for the costs of services that a carrier determines are not medically necessary and appropriate, depending upon:

- whether the services were obtained from a health care provider in a carrier's network; and
- the terms of the contract between the carrier and the in-network health care provider, when services were obtained from a health care provider in a carrier's network.

The carrier will issue the covered person an explanation of benefits (EOB) indicating whether costs for services and supplies are the responsibility of the covered person when the carrier determines the health care services or supplies are not medically necessary and

appropriate. An individual may appeal the carrier's medical necessity determination even if the individual is not considered responsible for the related costs.

In addition, **a carrier will only pay for what the carrier determines are reasonable costs** for the covered services. Carriers and in-network health care providers come to an agreement on reasonable compensation for health care services as part of the contract between them. Health care providers that are not in a carrier's network may charge fees as they see fit for the services they provide. However, carriers may only pay what they consider to be a "reasonable and customary" charge for the services. Currently, the SEH Program requires carriers to use the 80th percentile of the Prevailing Healthcare Charges Schedule (PHCS) owned by a private company, Ingenix, for charges billed using the Current Procedural Terminology (CPT) codes developed and owned by the American Medical Association.

In New Jersey, under the terms of the contract between the carrier and **in-network** health care providers, health care providers may not try to collect from a carrier's covered person charges that are more than the fees agreed to between the carrier and the health care provider. However, a **non-network** health care provider may bill charges in excess of the 80th percentile of the PHCS. The carrier will determine its payment using the 80th percentile of the PHCS, and the covered person is responsible for any amounts that exceed the 80th percentile of the PHCS.

Other Information Available

To read the laws governing the SEH Program, access the statutes ([N.J.S.A. 17B:27A-17 et seq.](#)), at www.njleg.state.us, and the rules and forms (in [N.J.A.C. 11:21](#)) at http://www.state.nj.us/dobi/division_insurance/ihcseh/sehmain.htm, or www.lexisnexis.com/njoal.

This buyers' guide and other information (Questions & Answers, premium comparison information based on *sample* groups, carrier contact information) are available on the SEH Program web site at www.state.nj.us/dobi/division_insurance/sehmain.htm.

A buyer's guide for individual insurance is available online at www.state.nj.us/dobi/division_insurance/ihcseh/shop_ihc.htm, or is available free by mail by calling: 1-800-838-0935. The New Jersey Department of Banking and Insurance publishes an HMO performance report, for those considering purchasing an HMO product. The report is available at www.state.nj.us/dobi/division_consumers/insurance/health.htm.

Obtaining and Renewing Coverage

After reviewing this Buyers' Guide, review the list of participating carriers and the premium comparison sheets for sample small groups. You may also want to look at information available through www.healthcare.gov, sponsored by the Federal government. Contact the carriers offering coverage in the small group market for specific plan information, or a licensed insurance producer (agent or broker), who can help you evaluate choices for your group's needs. Find agents under "Insurance" or "Health Insurance" in your local phone book or the Yellow Pages online. Note: not all carriers use agents or brokers, and no agent or broker offers information about *all* carriers. Review the materials you receive from the carrier(s) or agent(s) and select the carrier and health benefits plan that best meets your group's needs. Obtain a price quote from the carrier or its agent before making any

decisions. A carrier should provide a price quote within 10 business days after you give the carrier all necessary information.

Complete the selected carrier's application form. Carriers' forms may look differently, but the information requested is standardized. Submit a completed employee enrollment form (sometimes called the HINT form) and waiver form with the initial application, if required. Employee enrollment forms are also standard from one carrier to another. Mail your completed application, completed employee enrollment forms and/or waivers, if required, and any required premium (typically, one month of premium) to the carrier. Carriers should approve or deny an application within 15 business days after receiving it. If approved, the group's effective date of coverage will be no later than the first of the month following the date of notice of approval, unless **you** request a later effective date.

The carrier will issue ID cards to covered employees (and dependents, if appropriate) as proof of the group coverage. Remember to inform the carrier or its agent as employees' circumstances change. Note: you may request a waiting period of up to 6 months for employees to be considered eligible for enrollment.

Every year thereafter, in order to renew your coverage, the carrier will ask you to verify:

- Whether you still meet the definition of a small employer;
- Whether your group continues to meet employee participation requirements; and
- Whether your group continues to meet employer contribution requirements.

At the time of initial application and upon annual renewal, the carrier may require documentation verifying an employee's employment status. IF you fail to meet the requirements to keep your coverage in effect, or if you fail to return the annual certification, then the policy will not be renewed.

Questions & Answers & Some Examples

Eligibility, Participation and Contribution Issues

1. [How do I determine whether I am a small employer?](#)
2. [How is "eligible employee" determined?](#)
 - a. [Example A](#)
 - b. [Example B](#)
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 - d. [Example D](#)
3. [If some of my employees work outside of New Jersey, does that change the way eligible employee is determined and whether I am a small employer that can buy coverage under the SEH Program?](#)
 - a. [Example](#)
4. [Does it matter what order you use to determine your employee count?](#)
5. [What if I define "full-time" as 35 or 40 hours per week or "part-time" as less than 25 hours?](#)
 - a. [Example](#)
6. [How is "temporary" or seasonal employee defined?](#)
7. [If I own multiple businesses, do I count my employees for all businesses together, or separately?](#)
 - a. [Example A](#)
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8. [Does the law require that I provide health benefits for my employees?](#)
9. [May a self-employed husband and wife obtain group coverage under the small employer health benefits program?](#)
10. [What if my business didn't have employees in the previous calendar year?](#)
11. [If I decide to offer coverage, must I offer it to all employees?](#)
 - a. [Example](#)
12. [May a small employer provide coverage to independent contractors?](#)
13. [May a small employer provide coverage to employees who work fewer than 25 hours per week?](#)
14. [If I offer my employees a health benefits plan, may I impose a waiting period before they can enroll?](#)
15. [May I impose a waiting period that is different for some employees?](#)
16. [May a carrier require that a certain number of my employees "participate" if I offer a health benefits plan?](#)
17. [What happens for purposes of the participation requirement if some of my eligible employees decline to participate in the carrier's standard SEH plan?](#)
 - a. [Example A](#)
 - b. [Example B](#)
18. [Could I offer my employees more than one standard SEH policy through my group health benefits plan and still meet the participation requirements?](#)
 - a. [Example A](#)
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19. [If I offer my employees coverage, do I have to contribute to the premium?](#)
20. [If I offer coverage to my employees, do I have to permit coverage of dependents?](#)
21. [If I permit my employees to cover dependents, do I have to contribute to the premium for dependents?](#)
22. [If I contribute to health savings account for my employees, does that amount count towards the required contribution for the health benefits plan?](#)
23. [May I change my contribution levels?](#)
24. [Does my group have to continue to meet eligibility requirements?](#)

25. [What happens to my group's coverage if the number of my eligible employees eventually exceeds 50?](#)
26. [What happens to my group's coverage if the number of my eligible employees eventually falls below 2 or the majority of my eligible employees no longer work in New Jersey?](#)

1. How do I determine whether I am a small employer?

You have to determine how many eligible employees you have – an “eligible employee” is defined by the SEH Program Act. You must employ at least 2 but no more than 50 eligible employees in the prior calendar year, and at least 2 eligible employees at the beginning of each plan year. Also, the majority of your eligible employees must work at a location in New Jersey.

2. How is “eligible employee” determined?

In general, the SEH law defines “eligible employee” as a *bona fide* employee who works a normal work week of 25 or more hours. For purposes of determining whether an employer is a small employer, “eligible employee” does not include employees: (a) who work less than 25 hours a week; (b) who are independent contractors (sometimes called 1099 employees); (c) who are hired on a temporary or substitute basis; or, (c) who *participate* in an employee welfare arrangement under a collective bargaining agreement. The employer can be an eligible employee.

Note: Eligible employees as defined by the SEH Program do not include all employees as defined by federal and state tax and employment laws. As illustrated in the examples below, it is possible for an employer to have employees on his or her payroll for whom the employer must collect and remit taxes, but who are not eligible employees for purposes of determining the business’ small employer status under the SEH Program.

Example A: An employer had a total of 100 employees last calendar year, including the partners who own the company. All of the employees are employed in New Jersey. 75 of the employees worked more than 25 hours per week, and 25 worked less than 25 hours per week. The 25 employees who work fewer than 25 hours per week are not eligible employees, and so, are not included in the count when determining the employer’s size. Of the 75 employees that worked more than 25 hours per week, 50 were hired to work for approximately four months in the calendar year. Although the employees hired on a temporary basis worked more than 25 hours per week, because they were temporary, they also are not considered eligible employees, and are excluded from the count when determining the employer’s size. So:

	Employee Types	Subttls	Totals
1	Total employees in the prior calendar year of all affiliated companies		100
2	Employees hired on a temporary basis	50	
3	Employees with work schedules of less than 25 hours/week	25	
4	Employees in the union’s collectively-bargained health plan	0	
5	Add rows 2, 3 and 4		75
6	Subtract row 5 from row 1 to get Total Eligible Employees		25

Consequently, the employer is considered to have had an average of 25 (or fewer) eligible employees in the prior calendar year. If the employer has at least 2 eligible

employees when seeking or renewing coverage, then the employer will be considered a small employer.

Example B: An employer had a total of 100 employees last calendar year, all employed in New Jersey. Of that total, 40 participate in a collectively-bargained health plan, and are not considered eligible employees, regardless of the number of hours they work per week. Of the remaining 60 employees, 10 worked fewer than 25 hours per week each, and are not considered eligible employees. So:

	Employee Types	Subttls	Totals
1	Total employees in the prior calendar year of all affiliated companies		100
2	Employees hired on a temporary basis	0	
3	Employees with work schedules of less than 25 hours/week	10	
4	Employees in the union's collectively-bargained health plan	40	
5	Add rows 2, 3 and 4		50
6	Subtract row 5 from row 1 to get Total Eligible Employees		50

This means that the employer averaged 50 or fewer eligible employees in the prior calendar year. If the employer has at least 2 eligible employees when seeking or renewing coverage, then the employer will be considered a small employer.

Example C: An employer has four employees, all working in New Jersey. One employee works 40 hours per week, and the other three each work 20 hours per week. Only one employee is an eligible employee. The employer is not a small employer for purposes of purchasing health insurance in New Jersey because the employer has fewer than two eligible employees.

	Employees Types	Subttls	Totals
1	Total employees in the prior calendar year of all affiliated companies		4
2	Employees hired on a temporary basis	0	
3	Employees with work schedules of less than 25 hours/week	3	
4	Employees in the union's collectively-bargained health plan	0	
5	Add rows 2, 3 and 4		3
6	Subtract row 5 from row 1 to get Total Eligible Employees		1

Example D: A New Jersey business owner wishes to obtain health coverage. The business employs three people, all of whom work 30 hours per week in New Jersey; however, the owner is not one of the business' employees. The owner qualifies as a small employer, but the owner is not eligible to be covered under the small employer group plan, because he does not work 25 or more hours per week for the business.

3. If some of my employees work outside of New Jersey does that change the way eligible employee is determined and whether I am a small employer that can buy coverage under the SEH Program?

There is no difference in determining who is and is not an eligible employee for purposes of the SEH Program Act based on an employees' work location(s). A small employer must have the majority of its eligible employees working in a physical location in New Jersey in order for the employer to be eligible to purchase SEH Program health benefits plans for the group. An employee that works from his or her home located outside of New Jersey is not considered to be working in New Jersey, even if the employer's offices are located in New Jersey.

Example: An employer with a total of 40 employees had business locations in multiple states in the prior calendar year. All 40 employees had a work schedule of more than 25 hours per week, and none were hired on a temporary basis. None of the employees were part of a collective bargaining agreement. *However*, of the 40 employees, 25 worked at locations outside of New Jersey. So:

	Employees Types	Subttls	Totals
1	Total employees in the prior calendar year of all affiliated companies		40
2	Employees hired on a temporary basis	0	
3	Employees with work schedules of less than 25 hours/week	0	
4	Employees in the union's collectively-bargained health plan	0	
5	Add rows 2, 3 and 4		0
6	Subtract row 5 from row 1 to get Total Eligible Employees		40
7	Employees working at locations outside of New Jersey		25
8	Subtract row 7 from row 6 to get Total Eligible Employees in New Jersey		15
	If row 8 is greater than row 7 , the employer is a small employer eligible to purchase an SEH plan. If row 8 is equal to or less than row 7 , the employer is not eligible to purchase an SEH plan.		

Because the law requires that the majority of eligible employees work in New Jersey in order for an employer to meet the definition of a small employer, this employer is not considered to be a small employer, and would not be eligible to purchase small employer coverage in New Jersey.

4. Does it matter what order you use to determine your employee count?

Not really. However, if you have multi-state employment locations, you need to determine the total number of eligible employees you have before determining whether a majority of them work in New Jersey. In other words, it doesn't matter what order you use to subtract union employees, employees with work schedules of less than 25 hours, or temporary employees. But you first must subtract union employees (who participate in a collectively-bargained health plan), part-time employees and temporary employees to determine the total number of eligible employees before you determine whether the majority of eligible employees work in New Jersey. In addition, please note that you can not include any independent contractors, only *bona fide* employees, when determining whether an employer is a small employer.

5. What if I define "full-time" as 35 or 40 hours per week or "part-time" as less than 25 hours?

An employer is permitted to establish a definition for full-time and part-time that differs from the SEH Program Act, and offer fringe benefits to employees based on the employer's definitions. However, for purposes of meeting the *health benefits plan* participation requirement, *all* eligible employees as defined by the SEH Program Act have to be taken into consideration. So, regardless of who the employer offers health coverage to, the group's eligibility to be covered through the SEH Program depends on whether 75% of the eligible employees as defined by the SEH Program Act participate in health coverage recognized by the SEH Program Act.

Example: A small employer has 5 eligible employees. The small employer wants to offer coverage to only the two employees that work 40-hours/week. The carrier would request information about all 5 eligible employees. The 40-hour/week employees compose only 40% of the total eligible employees. If coverage is only being offered to the 40-hour/week employees, and the other eligible employees do not have even the option to waive coverage (for example, because they are covered through a spouse), this group cannot possibly meet the 75% participation requirements for the SEH market.

6. How is “temporary” or seasonal employee defined?

The SEH Program Act does not define what constitutes “temporary” or seasonal, and the SEH Board has not defined the terms by regulation. Carriers establish criteria for who is considered a temporary or seasonal employee, and so the standards may differ slightly from one carrier to another. An employer or a broker should consult with a carrier on this issue.

7. If I own multiple businesses, do I count my employees for all businesses together, or separately?

Whenever there are affiliated businesses, the first determination that must be made is whether the businesses are treated as a single employer under subsections (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 ([26 U.S.C. §414](#)). The employer will need to obtain a statement from a tax accountant or a tax attorney specifying whether or not the affiliated companies are a single employer for tax purposes. If the affiliated companies are considered a single employer under the federal tax code, then the combined employment base is considered in the analysis of whether the affiliated companies are a small employer. If the affiliated companies are considered to be separate employers under the federal tax code, then the analysis of whether a small employer exists is performed separately for each company. So:

Example A: Company A and Company B are affiliated and according to the companies’ tax accountant, constitute a single employer pursuant to the federal tax code. Company A is located in Texas and employs 35 workers there. Company B is located in New Jersey, and employs 45 workers in New Jersey. All of the employees meet the definition of eligible employee. Because there is a total of 80 eligible employees, neither Company A nor Company B would be considered to be a small employer for purposes of the SEH Program.

Example B: Company C and Company D have a connection, but according to the companies’ tax accountant, they are not a single employer pursuant to the federal tax code. An analysis of whether Company C is a small employer would be performed separately from the analysis of whether Company D is a small employer.

8. Does the law require that I provide health benefits for my employees?

No, the law does not require any employer to provide coverage to employees. However, if you provide small group health coverage, you must comply with the requirements of the law.

9. May a self-employed husband and wife obtain group coverage under the small employer health benefits program?

Yes, if both spouses are full-time eligible employees of the business. A carrier may ask for tax records or some other documentation for you and your spouse as proof that you are both bona fide employees. If only one spouse is working full-time and there are no other eligible employees, the couple may obtain only individual health

coverage. The process would be the same for partners in a civil union or domestic partnership.

10. What if my business didn't have employees in the previous calendar year?

If the business is in its first year of operation, and so had no employees in the prior calendar year, the employer does not have to wait a whole year to purchase coverage. Instead, the number of eligible employees will be based on the average number of eligible employees the business is *reasonably* expected to employ on business days in the current calendar year **and** the employer must have at least two eligible employees on the effective date of coverage.

If the business is not in its first year of operation, but is just now hiring one or more additional eligible employees, then the carrier will consider the prior calendar year employment average. Such a business might not meet the definition of a small employer even when it employs at least two eligible employees.

11. If I decide to offer coverage, must I offer it to all employees?

No. You may elect to offer coverage to one *class* of employee and not another *class*. However, distinctions in classes of employees must be based on *bona fide* conditions pertaining to employment, such as job title, length of service, hours worked, salary, etc. Even if you decide to offer coverage to a class of employees, you still must meet the small group participation requirements based on the *total number of eligible employees*, not just the class of employees to which you offer coverage.

Example: A group has 10 eligible employees, 8 working 40 hours per week, and 2 working 30 hours per week. The employer establishes employee class by hours per week worked, and may offer coverage only to the eligible employees who work 40 hours per week. However, the 75% participation requirement applies to all 10 eligible employees, not just the 8 to whom the employer has offered coverage.

12. May a small employer provide coverage to independent contractors?

Yes, the SEH Program Act permits it. However, there are a number of issues an employer should consider before deciding whether to cover independent contractors.

First, a small employer must elect to cover *all* independent contractors *or none*, **and** there must be at least 2 eligible employees (not classified as independent contractors) working for the small employer.

Second, to be eligible for coverage, the independent contractor must meet the SEH Program Act's definition of an eligible employee (even though independent contractors will not be counted as eligible employees). In general, a person who is an independent contractor can be an "eligible employee" for purposes of the SEH Program Act if he/she: (1) is performing a service for the employer pursuant to a written contract for monetary or other legal consideration; (2) works 25 or more hours per week for the employer; (3) works on other than a temporary or substitute basis; and, (4) the independent contractor relationship has been established to serve a substantial business need of the employer and is not intended primarily to obtain insurance coverage.

Third, and probably most importantly, federal and state tax and employment laws and the regulators that enforce such laws may consider an "independent contractor" who meets the standards for coverage under the SEH Program Act to be an employee of the employer through which coverage was obtained, unless the situation qualifies as a statutory nonemployment scenario or the employer otherwise proves the individual is correctly classified as an independent contractor. The IRS

and the U.S. Department of Labor (as well as the New Jersey Department of Labor) provide information on their websites regarding classification of workers and the criteria that will be considered in determining if someone is an employee or independent contractor (in particular, see IRS Publications [15-A](#) and [15-B](#)). Misclassification of employees may result in significant financial consequences for the employer. Employers should consult an accountant or tax attorney with questions regarding employment status.

13. May a small employer provide coverage to employees who work fewer than 25 hours per week?

No, they are not eligible employees under the SEH law.

14. If I offer my employees a health benefits plan, may I impose a waiting period before they can enroll?

Yes, you currently have the option of requiring a service waiting period of up to six months. Beginning in 2014, federal law will permit waiting periods of no more than 90 days.

15. May I impose a waiting period that is different for some employees?

Yes, although no waiting period can exceed six months, and the differing treatment of employees must be based on class distinctions established on *bona fide* conditions of employment, such as hours worked, salary, title, etc.

16. May a carrier require that a certain number of my employees “participate” if I offer a health benefits plan?

Carriers are permitted by law to impose a participation requirement. However, the SEH Program Act does not permit carriers to require more than a 75% participation requirement. In addition, carriers are required by law to credit towards the 75% participation requirement all eligible employees that have certain other health coverage: Medicare, Medicaid or NJ FamilyCare, coverage as an employee through another employer’s group health plan, or coverage under any group health plan as a dependent. Carriers are not required to count the employer’s employees covered under another carrier’s policy offered by the employer. Note that even if an employer pays 100% of the cost of coverage, a carrier cannot require greater than 75% participation.

17. What happens for purposes of the participation requirement if some of my eligible employees decline to participate in the carrier’s standard SEH plan?

An eligible employee’s decision not to take up the offer of coverage under a particular carrier’s standard SEH policy does not necessarily mean the eligible employee will not count towards satisfying the carrier’s participation requirement. It depends on why the eligible employee is declining coverage under the carrier’s standard SEH policy. For purposes of satisfying a participation requirement, the carrier must count all eligible employees that: (1) elect coverage under the carrier’s standard SEH policy; (2) are covered as a dependent spouse under any other small employer policy you may make available; (3) are covered under any group health plan option available through the eligible employee’s spouse or parent; and, (4) are covered under a governmental program, such as Medicare, Medicaid or NJFamilyCare. A carrier is **not required** to count all eligible employees towards the participation requirement if the employees are enrolled in another carrier’s small employer policy that YOU make available. An eligible employee who declines the offer of coverage under a carrier’s standard SEH policy because he or she decides it

is unaffordable or thinks insurance is unnecessary will count against your group's satisfaction of the participation rate.

Example A: If an employer has 20 eligible employees, the 75% participation requirement means that at least 15 of the eligible employees must participate in coverage. If 5 of the eligible employees decline because they are dependents under their spouse's group coverage, 1 eligible employee declines because he is covered by Medicare, 5 eligible employees decline for unspecified reasons not related to having other health coverage, and 9 eligible employees elect to become covered, then the employer has met the participation requirement. This is so because the carrier must add together the 6 eligible employees who have coverage elsewhere with the 9 eligible employees who took up the employer's coverage offer to determine the total number of participants. The total number of eligible employees participating is 15, which meets the carrier's minimum participation requirement.

Example B: An employer has 20 employees, but only 16 are "eligible employees." The employer must have 12 eligible employees that meet the participation requirement in order to provide coverage to the eligible employees ($16 \times .75 = 12$). The employer may not offer coverage under the SEH Plan to the four ineligible employees. Seven of the eligible employees will take up the employer's offer. Four of the eligible employees decline the employer's offer because three have group coverage through another employer (by whom they are also employed) and one is still covered by a parent. Because only 11 eligible employees would be considered participating, the employer's group does not satisfy the participation requirements.

18. Could I offer my employees more than one standard SEH policy through my group health plan and still meet the participation requirements?

It is possible. Each of the eligible employees that takes up coverage counts towards the participation rate for both of the policies, if the policies are through the same carrier. So, you could offer both PPO and HMO coverage from Carrier O, and even if only 50% of the eligible employees chose each coverage option, you could still meet the participation requirement.

However, if you want to offer one plan from two different carriers, meeting the 75% participation rate for each carrier may be more difficult if either carrier will not count employees enrolled in the other carrier's policy. You can find out whether a carrier will or won't count the employees enrolled in the other carrier's policy by reviewing the carriers' [underwriting guidelines](http://www.state.nj.us/dobi/division_insurance/ihcseh/shop_seh.htm) (available on the SEH Board's website at www.state.nj.us/dobi/division_insurance/ihcseh/shop_seh.htm). Most carriers will not count employees enrolled in another carrier's policy issued to the same employer.

Note that even if a carrier will not normally count employees enrolled in another carrier's policy issued to the same employer, carriers must count employees covered under a spouse's group health plan under all circumstances. So, in those instances in which a married couple works for the same employer, the employee covered as a dependent spouse will count towards the 75% participation rate for all carriers, even though the employee does not.

Example A: An employer has 4 eligible employees and wants to offer two different SEH standard policies from different carriers. One eligible employee elects coverage with Carrier A, and one elect coverage with Carrier B. One employee has coverage pursuant to COBRA under another group plan with a different employer, and one employee has coverage through a spouse's group health plan, so both of these

employees waive coverage offered by their employer. The employer has met the participation requirement for both policies because each of the carriers must count 3 or the 4 eligible employees towards the participation goal even though neither carrier counts employees who are enrolled in a policy issued to the employer by another carrier.

Example B: Employer has 11 eligible employees, and wishes to offer coverage from two different carriers. Two eligible employees enroll in employer's plan for coverage through Carrier X, and three eligible employees enroll in the employer's plan for coverage through Carrier Y. Six of the eligible employees waive enrollment: two because they have coverage through Medicare, two because they have coverage through a spouse's group health plan, and two for reasons that are not specified. Neither Carrier X nor Carrier Y will count employees covered under a policy issued to the employer by another carrier. So, Carrier X counts six employees as participating, and Carrier Y counts seven employees as participating. Because $11 \times .75 = 8.25$, and 8.25 **must** be rounded up to the next whole number, which is 9, the employer's small employer group health plan fails to meet the participation requirements of both carriers.

19.If I offer my employees coverage, do I have to contribute to the premium?

You must contribute at least 10% of the total group's premium; of course, you can choose to contribute up to 100%. You are not required to contribute a specific percentage of each employee's premium, but can choose to vary contributions by *class* of employee, so long as your total contribution is 10% of the group's premium. Distinctions in classes of employees must be based on conditions pertaining to employment, such as job title, length of service, or salary.

20.If I offer coverage to my employees, do I have to permit coverage of dependents?

No. But if you permit one employee within a class to cover dependents, then you must permit all employees within that class to cover dependents. Distinctions in classes of employees must be based on *bona fide* conditions pertaining to employment, such as job title, length of service, salary, etc.

21.If I permit my employees to cover dependents, do I have to contribute to the premium for dependents?

No. While you are required to contribute 10% of the total premium for your covered employees, you do not necessarily have to contribute to the premium related to dependent coverage. Because the dependent premium is part of the total premium, if you contribute nothing towards dependent coverage, you'll need to contribute more than 10% of the employee cost in order to satisfy the requirement to contribute at least 10% of the total premium. Of course, if you elect to contribute to the dependent premium, you may choose to contribute any amount you wish, by class of employee.

22.If I contribute to a health savings account for my employees, does that amount count towards the required contribution for the health benefits plan?

No.

23.May I change my contribution levels?

Yes. However, you may not contribute less than 10% of the group premium.

24.Does my group have to continue to meet eligibility requirements?

Yes, on an annual basis. Once a year – several months prior to the anniversary date of your policy – you will have to complete an annual certification regarding your group’s census and work locations, and verify that contribution and participation requirements continue to be met.

25. What happens to my group’s coverage if the number of my eligible employees eventually exceeds 50?

If your business grows to more than 50 eligible employees, you may become ineligible to purchase or amend small employer coverage, but not right away, because eligibility is based on average employment activity in the prior calendar year. So, even if you have 55 eligible employees today, the carrier will look at the number of eligible employees you had during the prior calendar year.

Once the number of eligible employees *during the prior calendar year* exceeds 50, an employer is no longer a small employer. If such an employer wishes to remain covered under the plan(s) purchased while the employer was a small employer, the employer may renew the previously purchased small employer plan(s) without any changes. However, the rates charged may no longer be the carrier’s SEH market rates. The carrier will refuse any application to make a change to the plan(s) in any way, no matter how minor, because the employer completing the application is no longer a small employer. Instead, the employer may apply for plans the carrier makes available to large employers.

26. What happens to my group’s coverage if the number of my eligible employees eventually falls below 2 or the majority of my employees no longer work in New Jersey?

Annually upon renewal, you must show that you have at least 2 eligible employees, and the majority of your eligible employees work in New Jersey, or your SEH policy will be non-renewed. If only one employee remains (for example, the owner), coverage may be obtained in the individual market. If there continue to be a number of employees in the group working outside New Jersey, coverage might be available in the non-reform market in New Jersey, or in the group market of another State.

Health, Dependents and Continuation Issues

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1. May a carrier ask my employees for health information?

Yes. However, health information cannot affect the premium and may not be used as a basis for denying coverage. It may only be used for the purpose of determining whether an injury or illness is a preexisting condition.

2. What is a preexisting condition?

A preexisting condition is an injury or illness that a covered person was diagnosed with and/or treated for, or for which treatment was recommended or prescribed medications were taken within the six months before enrolling in the small employer health benefits plan. A pregnancy is never considered a preexisting condition in the group market, even though it can be considered a preexisting condition in the individual market.

3. What is a preexisting condition limitation period?

A preexisting condition limitation period is a period of time – up to six months – following a covered person's enrollment date during which a carrier will not provide benefits for treatment of a covered person's preexisting condition. There is no impact upon benefits for health care services for treatment of a covered person's injuries, illnesses or health conditions not related to the preexisting condition during the preexisting condition limitation period. Note that, beginning with the first plan year on or after September 23, 2010, children under 19 years old are not subject to preexisting condition limitation periods.

Example: You hire a new employee, and the employee enrolls in your group plan. The employee has a history of ulcers with on-going treatment. If the employee is subject to a preexisting condition limitation, then the carrier will not provide any

benefits for treatment of the employee's ulcers for up to the first six months of the employee's coverage. However, if the employee goes to the doctor to treat a case of conjunctivitis and bronchitis during the same six months, the carrier would not exclude benefits for health care services related to treatment of either illness.

4. May a carrier impose a preexisting condition limitation period on my group?

If your group consists of two to five eligible employees, the carrier may impose a preexisting condition limitation period. If your group contains six or more eligible employees, the carrier is prohibited from imposing a preexisting condition limitation, *except in the case of late enrollees* – carriers may impose a preexisting condition limitation period to the late enrollee. For groups with 2 to 5 employees and late enrollees, the preexisting condition limitation period may not exceed six months following the covered person's enrollment date. Note that, beginning with the first plan year on or after September 23, 2010, children under 19 years old are not subject to preexisting condition limitation periods, regardless of the size of the group or whether the child might be considered a late enrollee.

5. I understand the pre-existing condition exclusion applies only to employer groups with fewer than 6 eligible employees, but how does this work if my group size fluctuates between, for example, 3 and 7 eligible employees during the year?

Group size is considered at the time of application and subsequently only once a year (upon anniversary). Changes in group composition in the interim have no impact upon either eligibility or application of preexisting condition limitation requirements. If the preexisting condition limitation applies to your group when you first purchase a group health benefits plan, that requirement will remain in place until your group's anniversary, even if you hire employees in the meantime. Likewise, if your group has at least six eligible employees when you first purchase the group health benefits plan and later the group size drops to five eligible employees, the preexisting condition limitation period will not suddenly apply to these five employees or to any new employee hired before the anniversary date.

Example A: We're Growing Places purchases coverage on January 1, 2008. The company has five eligible employees; consequently, all of the employees must satisfy a six-month preexisting condition limitation period. Additional eligible employees are hired during 2008, and both must satisfy the six-month preexisting condition limitation period. Upon its anniversary date, January 1, 2009, We're Growing Places is officially classified as having more than five eligible employees. Thus, when We're Growing Places hires one more eligible employee on February 1, 2009, the new hire does not have to satisfy a preexisting condition limitation period.

Example B: When Shrink to Fit purchases coverage on May 1, 2008, the group has six eligible employees; no one is required to satisfy a six-month preexisting condition limitation period. On November 1, two employees leave the company. When a new employee is hired on February 1, 2009, the employee does not have to satisfy a preexisting condition limitation period. On May 1, 2009, Shrink to Fit's census is determined to be only five eligible employees. So, when Shrink to Fit hires an additional employee on June 1, 2009, the new employee is required to satisfy a preexisting condition limitation period.

6. What is the "enrollment date" for coverage?

The "enrollment date" for a covered person is either the effective date of coverage or the first day of an employee's waiting period if any, whichever is earlier.

7. If I require employees to complete a waiting period before enrolling in the group plan, does that have an impact on their preexisting condition limitation period or benefits?

No. Because the preexisting condition limitation period runs from the enrollment date for coverage, and the enrollment date is measured from the first day of the waiting period, the preexisting condition limitation period and the waiting period are counted concurrently. Health conditions that may be diagnosed and/or treated during a waiting period will not be considered preexisting conditions. Of course, costs for health care services rendered during a waiting period will not be covered by the health benefits plan, and will not count towards satisfaction of any cost-sharing requirements.

8. What are late enrollees?

Generally, a late enrollee is someone who declined coverage when he or she was first eligible to enroll, and then seeks to enroll at a later date. *However*, someone who elected not to enroll because he or she had coverage under another group health plan (as an employee or dependent, or through continuation) or because of enrollment in a government program (Medicare, Medicaid, NJFamilyCare) is not considered to be a late enrollee if he or she chooses to enroll in your health benefits plan within 30 days after his or her coverage under the other group health plan or government program ends (involuntarily). In addition, an employee is not considered a late enrollee (and neither are his or her dependents) even though he or she previously declined coverage if he or she elects to enroll in your health benefits plan within 30 days following his or her marriage/civil union/domestic partnership, or the birth, adoption or placement for adoption of his or her child. (Note that, beginning with the first plan year on or after September 23, 2010, children under 19 years old are not subject to preexisting condition limitations anyway.)

Example: Three new employees decline coverage, one because she is covered under a spouse's group health plan, and two because of costs. Later, all three employees request coverage: one because her husband's employer changed health plans and no longer permits coverage of dependents; the second because he married and now wants to cover himself and his wife; and, the third because he is making more money and can afford it. The first employee is not a late enrollee, so long as she enrolls within 30 days after her coverage as her husband's dependent ends. The second employee is not a late enrollee, nor is his dependent, so long as he enrolls himself and his wife within 30 days following their date of marriage. The third employee, however, is a late enrollee.

9. What difference does it make whether someone is a late enrollee or not?

In the small group market, late enrollees are subject to a six month pre-existing condition limitation period, even if other enrollees in the group are not subject to such a requirement. Because employer groups with 2 to 5 eligible employees are subject to a six month pre-existing condition limitation anyway, late enrollees are treated no differently than other members of such groups. (Exception: children under age 19 are NOT subject to a preexisting condition limitation period even in groups with 2 to 5 employees, whether or not they are late enrollees.) However, in groups with six or more eligible employees, employees and dependents are not subject to a pre-existing condition limitation period *except* when classified as late enrollees (not including children). (But children under age 19 are NOT subject to a preexisting condition limitation whether or not they may be classified as a late enrollee.) Note, the pre-existing condition exclusion period will be reduced – or

possibly eliminated – if the late enrollee had prior creditable coverage that ended no more than 90 days prior to enrollment.

Under no circumstances are late enrollees required to delay enrollment until an “open enrollment period” or until the plan anniversary. Late enrollees may enroll at any time under a small employer plan.

10. What if the group or some of its members had coverage before enrolling in the current group plan?

A carrier will give consideration as to whether an employee had coverage before enrolling in the current group plan. Indeed, prior coverage may prevent a carrier from considering someone to be a late enrollee. When an employee may be subject to a preexisting condition limitation, either because of the size of the group, or because the employee is a late enrollee, prior coverage will be credited against the preexisting condition limitation period if the break between the person’s prior coverage and the current coverage is no more than 90 days, and the prior coverage is “creditable coverage.” The carrier will credit the amount of time that the person was covered under the prior creditable coverage against the preexisting condition limitation period, reducing the period, and sometimes eliminating it entirely. A person may be required to produce a certificate of creditable coverage to prove that s/he had prior creditable coverage. Alternate documentation of prior coverage may be substituted, if necessary.

Example: An employee joins a group with fewer than six employees. The employee is not covered under another group health plan or government program on the date he is hired, but previously was covered for 5 months under another group health plan. The employee’s previous coverage terminated within 90 days prior to his enrollment date for coverage under the current small employer’s health benefits plan. The carrier will credit the employee’s time covered under the prior creditable coverage against the preexisting condition limitation period applicable to small employer groups of fewer than six employees. Because the preexisting condition limitation period is 6 months, and the employee had only 5 months of prior creditable coverage, the employee will still have to satisfy a one month preexisting condition limitation period.

11. What is creditable coverage?

The term “creditable coverage” is defined in federal law as part of the [Health Insurance Portability and Accountability Act](#). Most health coverage that is insured (whether purchased on an individual or group basis), self-funded by an employer or employee organization (such as a union), or funded through government programs, including coverage through foreign government programs, is considered creditable coverage if it includes coverage for medical and hospital expenses. Policies that are for limited benefits (for instance, covering dental only), or that provide cash assistance while someone is hospitalized or disabled (such as, hospital confinement indemnity coverage) are not considered creditable coverage. In addition, policies in which health care services are covered in an incidental manner do not qualify as creditable coverage, so for instance, having personal injury protection coverage through an automobile insurance policy is not included as creditable coverage. Also, workers’ compensation coverage is *not* considered creditable coverage.

12. How is creditable coverage verified?

Carriers and/or plan sponsors are required to provide employees and covered dependents with certificates of creditable coverage following termination of coverage. Carriers and plan sponsors are also required to be cooperative with subsequent

employers and carriers in providing information about prior creditable coverage. The certificate of creditable coverage should include information about when the covered person became covered and when coverage was terminated.

13. If I offer coverage to my employees, do I have to permit coverage of dependents?

No. But if you permit one employee within a class to cover dependents, then you must permit all employees within that class to cover dependents. Distinctions in classes of employees must be based on conditions pertaining to employment, such as job title, length of service, or salary.

14. If I permit my employees to cover dependents, do I have to contribute to the premium for dependents?

No. While you are required to contribute 10% of the total premium for your covered employees, you do not necessarily have to contribute to the premium related to dependent coverage at all. Of course, if you elect to contribute to the dependent premium, you may choose to contribute any amount you wish, by class of employee.

15. Are dependents subject to preexisting condition limitation provisions?

Yes, if the dependent is 19 years old or older and the group is subject to preexisting condition limitation periods generally, or the dependent is 19 years old or older and is considered a late enrollee. Children under 19 years old are never subject to a preexisting condition limitation period. Eligible dependents enrolling in an employer's health benefits plan within 30 days following an employee's marriage/civil union/domestic partnership (if applicable), a birth, an adoption or placement for adoption, should never be considered late enrollees. (So, for instance, upon the birth of a child, an employee may enroll that child, as well as any other children the employee may have that he or she has not previously enrolled.) In addition, dependents enrolled pursuant to a court order are not considered late enrollees, and consequently, may not be subject to a preexisting condition limitation period. When a dependent is subject to a preexisting condition limitation period, a carrier will reduce the dependent's preexisting condition limitation period by the number of days of creditable coverage the dependent had prior to his or her enrollment date, but not days of creditable coverage that occur before a lapse in coverage of more than 90 days.

16. Who is considered an eligible dependent?

An eligible dependent includes a spouse, a civil union partner, and an employee's child through birth, marriage, civil union, adoption or placement for adoption. A domestic partner and his or her children may be considered dependents for purposes of coverage under a health benefits plan, at the option of the employer. When children are covered, they are covered up to a specified **limiting age**, which, beginning in September 2010, is at least to age 26 years old. "Over-age" children – those who have attained the limiting age, but who are not yet 31 years old – are also eligible to be covered through a continuation law referred to as "[Dependent Under 31](#)."

17. Can't carriers or employers impose limits on which child dependents under age 26 qualify based upon financial dependency, marital status, enrollment in qualified institutions of higher education, residency or other factors?

No. Federal law requires that, beginning with plan years on or after September 23, 2010, when a plan covers dependents, it must do so until a child reaches the age of 26, regardless of whether the child is in school, married or unmarried, still living at

home or even financially dependent upon the parent. However, there is an exception: group health plans in existence on March 23, 2010 may exclude adult children who are eligible to enroll in an employer-sponsored health plan other than the group health plan of the parent. This exception will no longer be applicable for plan years beginning on or after January 1, 2014.

18.If I allow my employees to cover dependents, are my employees allowed to cover dependent children who are working and have access to coverage through another group health plan?

Yes, the terms of the SEH health benefits plans permit employees to cover older children through the parent's employer's plan even though the child may have access to another group health plan through, for instance, the child's job. The only exception to this requirement is for a plan that qualifies as a grandfathered plan under the federal Patient Protection and Affordable Care Act.

19.What is "Dependent Under 31"?

The "Dependent Under 31" law became effective in May of 2006. The law permits children who age out of a group health benefits plan the option of continuing or enrolling in a parent's group health benefits plan until the child reaches his or her 31st birthday, marries, has a child, moves out-of-state (and does not become a full-time student), enrolls in other group or individual health coverage, or becomes entitled to Medicare. The over-age child may enroll upon age-out, but may also enroll whenever he or she becomes eligible. The Department of Banking and Insurance has more information about [Dependent Under 31](http://www.state.nj.us/dobi) on its website at www.state.nj.us/dobi.

20.What obligations do employers have with respect to Dependent Under 31?

Like other continuation options, employers have an obligation to provide employees and their dependents with information regarding the Dependent Under 31 election option. Employers cannot prevent an eligible over-age child from making a Dependent Under 31 election. There is no obligation for the employer to contribute to the over-age child's premium. However, the employer may have an obligation to collect the premium and remit it to the carrier (if that is the arrangement between the carrier and the employer). In those instances, the employer may retain a 2% administrative fee, based on the monthly rate. (In other words, the over-age dependent may be responsible for up to 102% of the dependent child rate.) For more detailed information, find [Dependent Under 31](http://www.state.nj.us/dobi) information on the Department of Banking and Insurance's website.

21.Do I have to offer a continuation option?

Yes, you must offer a continuation option to employees and their qualified beneficiaries upon the occurrence of qualifying events. If you have 20 or more employees, you are required to offer a continuation election option in accordance with the federal law referred to as [COBRA](http://www.dhs.gov/COBRA) as well as the New Jersey State Group Continuation (NJSGC) law. If you have fewer than 20 employees, you are required to offer a continuation election option in accordance with the NJSGC law only, simply because [COBRA](http://www.dhs.gov/COBRA) does not apply to employers with fewer than 20 employees.

But remember, in determining whether federal standards apply, all employees on the payroll are counted, not just "eligible employees" as defined by New Jersey law. In determining whether COBRA applies, part-time employees are included in the count as fractions of full-time employees.

22.To whom do I have to offer a continuation election?

In general, you must offer a continuation election option to an employee whenever he or she has been covered under the group plan, but is no longer eligible for such coverage. If the employee was covering dependents, the employee has the right to continue coverage for such dependents as well. However, a dependent who has been covered through the group plan has a separate right to continue coverage pursuant to [COBRA](#) or NJSGC in the event of death of the employee, divorce, or because he or she is no longer an eligible dependent. NJSGC (but not COBRA) applies when a dependent loses coverage due to dissolution of a civil union. In addition, you must offer a continuation election option in accordance with the [Dependent Under 31](#) law to child dependents that have aged-out.

23. Do I have to contribute to an employee's premium in the event he or she elects continuation if I was contributing to premium when he was covered as a regular group member?

Not generally. However, an employer subject to the requirements of the Family Medical Leave Act has to contribute to the premium related to an individual with continuing coverage when the employee is not working because of use of leave under the [Family Medical Leave Act](#).

24. What is the duration of the election period for an employee or dependent to make a continuation election?

[COBRA](#) permits an employee or dependent, as appropriate, to make an election within 60 days following notice of the opportunity to continue coverage. NJSGC permits an employee or dependent to make an election within 30 days following the occurrence of a qualifying event (loss of coverage). With respect to [Dependent Under 31](#) as it applies to small employer coverage, the child may make an election during the 30 days prior to aging-out and anytime thereafter while eligible.

Rates, Cost-Sharing and Administrative Issues

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1. How does a carrier determine the premium for my group?

Carriers determine a group's rates based on the plan of benefits selected and the characteristics of the group. The SEH Program permits carriers only to consider the age, gender, and family status of employees in the group, and the location of the business in New Jersey in determining the premium. Carriers may not consider the health status, nature of business, or past claims experience of a group in determining premium.

2. Are rates guaranteed for a specific period of time?

The SEH Program Act does not require that carriers guarantee their rates for any period of time. However, most carriers do. Ask the carrier or your broker or agent if rates are guaranteed and for how long.

3. How long should I expect to wait for a price quote?

In practice today, price quotes are run immediately, so you should not have to wait. (Technically, a carrier has up to 10 business days to provide you with a price quote after you have given the carrier all the information the carrier needs to develop the quote.)

4. If one or more of my employees incurs significant claims, can a carrier cancel the coverage or refuse to renew it?

No, a carrier may not terminate a small group's coverage based upon the claims experience of the group or specific members of the group. Small employer coverage is guaranteed renewable at the option of the employer, except when: the employer fails to pay the premium, the employer fails to provide the completed Annual

Certification; the employer has acted fraudulently with respect to the coverage; the carrier has elected to withdraw from the small employer market entirely; the employer no longer meets the definition of a small employer; or, the group no longer meets participation or contribution requirements.

5. If one of my employees incurs significant claims, can a carrier refuse to continue covering that employee?

No. Carriers cannot refuse to renew coverage for any member of a small employer group because of claims experience or health status-related factors.

6. If one or more of my employees incurs significant claims, should I expect to see a significant increase in rates because of it?

Not necessarily. Because of how rates are developed, your group's specific premium is not directly related to your group's specific claims. The SEH Program Act requires carriers to community rate health benefits plans, which means that the carriers blend the experience of all groups that purchase a health benefits plan to develop a community rate. The rate is then modified by group to take into consideration specific group characteristics as permitted by the SEH Program Act. Although the experience of your group will have an impact on the rate for the health benefits plan for your carrier, it will be blended with the rates of all other groups purchasing the same health benefits plan, and will not be tied directly to your premium.

7. What can I do if I am unhappy with the rates being charged by my current carrier?

You have several options. You are not required to stay with a specific health benefits plan indefinitely. You may have an option to change some of the cost-sharing requirements of your current health benefits plan, or add or remove coverage riders. You also may be able to switch to a lower cost plan offered by your current carrier. In addition, you may be able to switch to another carrier offering the same health benefits plan at lower rates. But note: changes in health benefits plans are not entirely unrestricted. Carriers are not required to honor *any* requests for plan changes unless the existing plan has been in effect for at least 12 months.

One of the goals of the reforms was to provide for "portability." Portability enables you to shop around for coverage from another carrier without having to worry about new pre-existing condition exclusions. For more information about restrictions on use of preexisting condition limitations, you may want to review questions and answers about Health, Dependents and Continuation Issues. And remember, even if your employees or their dependents are considered poor health risks, all carriers must accept your group for coverage, and the premiums charged may not be based on health status or prior claims history.

8. What are the standard health benefits plans for small employers?

Small employers have a variety of standard plans to choose from. Plan A is primarily designed to cover health care facility inpatient costs, although it covers a few office visits and outpatient services, too. Plans B, C, D, E and HMO cover a wide array of inpatient and outpatient medical and hospital services, as well as prescription drugs. The primary difference between Plans B through E is the cost-sharing requirements applicable to each of the plans. The HMO Plan is an HMO product, so it differs from Plans B, C, D and E not only with respect to the cost-sharing arrangement, but also in the degree to which the health care services are "managed" and requirements to use a specified network of providers except in emergency and other extraordinary circumstances.

9. What are the cost-sharing requirements for the standard health benefits plans?

See the [Snapshot of the Standard Small Employer Health Benefits Plans](#), contained in the New Jersey Small Employer Health Benefits Program Buyers' Guide. In addition, a broker can provide more information for the carriers he or she represents.

10. How do deductibles work, and what are the deductibles for the standard small employer health benefits plans?

Deductibles are the amount of allowed charges for which the covered person is responsible before the carrier agrees to pay anything towards covered charges. So, for instance, if a person has a policy with a \$2500 deductible, until the covered person pays \$2500 in allowed charges for covered services, the covered person is not entitled to have any of the charges reimbursed by the carrier.

In the standard small employer plans, Plan A has a \$250 deductible, and Plan E has a \$150 deductible per covered person. A carrier may offer a range of deductibles for Plans B, C and D from \$250 to \$5,000. A carrier may offer the HMO Plan with a deductible within a range of \$250 to \$2,500 per covered person. Carriers also have the option of offering all of the standard plans with a family deductible that is 2x the covered person deductible, or 3x the covered person deductible. If the family deductible is 2x the covered person deductible, then two separate people in the family must satisfy the full amount of the covered person deductible before allowed charges for all family members are considered for reimbursement. If the family deductible is 3x the covered person deductible, the deductible does not have to be satisfied separately by any member, but rather, incurred allowed charges for covered services of the family members are aggregated to reach the deductible limit. For more information, see the [Snapshot of the Standard Small Employer Health Benefits Plans](#) in this booklet.

Example A (Individual deductible): Mike is covered under Plan C with a \$500 covered person deductible and a 30% coinsurance paid by the covered person. Mike incurs a \$100 allowable charge every month beginning in January. Until June, Mike is responsible in full for the \$100 allowable charge every month. Beginning in June, because the deductible (\$500) has been met, the carrier pays 70% of the allowable charge.

Example B (family deductible satisfied by two separate individuals): Mike and his family (spouse and children) are covered under Plan C with a \$500 covered person deductible, and a 2x family deductible, to be satisfied by **two separate people**. Also, there is a 30% coinsurance requirement. Mike incurs \$500 in covered charges. His wife incurs \$300 in covered charges. The carrier is responsible to pay 70% of incurred allowable charges for Mike now that his deductible is satisfied. However, either his wife must incur \$200 more in allowable charges or one of the children must incur \$500 in allowable charges before the carrier pays 70% of allowable charges for Mike's wife and/or children.

Example C (family deductible satisfied in aggregate): Mike and his family are covered under Plan C with a \$500 covered person deductible, and a 3x family deductible (\$1,500), to be satisfied **by the family as a whole**. Also, there is a 30% coinsurance requirement. Mike incurs \$1,000 in allowable charges. Having satisfied the covered person deductible, the carrier is responsible to pay 70% of allowable charges for Mike. Mike's wife incurs \$400 in allowable charges. Once any family member incurs another \$100 in allowable charges, the carrier is responsible to pay 70% of allowable charges for all family members.

11. How does coinsurance work, and what are the coinsurance requirements for the standard health benefits plans?

“Coinsurance” is a term used to express the promise by the carrier to share, on a percentage basis, payment for allowed charges for covered health care services with the covered person. The standard small employer Plans A through E have specified coinsurance requirements, but the actual coinsurance amount may vary depending on whether the plan is offered with or without a network feature. That is, when the plan is offered without a network (a plain indemnity plan), the coinsurance is specified as follows: for Plan A, the carrier pays 80% of allowed hospital charges for covered services, and 50% of allowed charges for all other covered services; for Plan B, the carrier pays 60% of allowed charges for covered services; for Plan C, the carrier pays 70% of allowed charges for covered services; for Plan D, the carrier pays 80% of allowed charges for covered services; and, for Plan E, the carrier pays 90% of allowed charges for covered services. When the standard plans are offered with a network feature (that is, as PPO products), then the coinsurance percentages in-network and out-of-network may differ for in-network and out-of-network benefits, each ranging from 50% to 100%. For the HMO Plan, when coinsurance applies (and it only applies when copayments do not apply to a covered service), the carrier may offer the plan with a coinsurance specified within a range of 50% to 100%.

Example: Martha is covered under Plan D, which requires the carrier to pay 80% of allowed covered charges. Martha has already satisfied her deductible when she incurs another \$700 expense. The carrier considers the health care services to be covered and the full amount of the charges are allowed. The carrier pays \$560 of the \$700 charge ($\$700 \times .80 = \560), and Martha is responsible for the remaining \$140.

12. What is the Maximum Out-Of-Pocket (MOOP) amount and how does it work?

The MOOP is the maximum amount of allowed charges for covered services that a covered person/family is obligated to pay before the carrier agrees to pay for **all** of the allowed charges for covered health care services. For the standard health benefits plans, allowed charges the covered person pays towards the deductible, coinsurance and copayments help to satisfy the MOOP. The family MOOP is 2 or 3 times the covered person MOOP for traditional indemnity plans, or 2 times the covered person MOOP for network-based plans. Family MOOPs established as 2x the covered person MOOP may require two separate family members to satisfy the MOOP, or may permit all charges incurred by the family to satisfy the MOOP. Family MOOPs that are 3x the covered person MOOP *must* allow for aggregation of the family expenses.

Example A (satisfaction of the MOOP by two separate individuals): Rose has family coverage under a Plan C, with a deductible of \$500 (2x for the family), 30% coinsurance (meaning the carrier pays 70% of allowed charges), and a MOOP of \$3000 (2x for the family). Rose incurs \$3,500 in allowable charges, her husband incurs \$2,000 of allowable charges, and her daughter incurs \$1,000 of allowable charges. Both the covered person and family deductible have been satisfied. Rose has met the MOOP for a covered person, so the carrier is responsible for paying all of the allowable charges Rose now incurs. The carrier will be responsible for 70% of allowable charges for Rose’s husband and daughter until either her husband incurs another \$1,000 of allowable charges, or her daughter incurs another \$2000 of allowable charges.

Example B (satisfaction of the MOOP in the aggregate): Rose has family coverage under a Plan C, with a deductible of \$500 (3x for the family), 30% coinsurance (meaning the carrier pays 70% of allowed charges), and a MOOP of \$3000 (3x for the family). Rose incurs \$3,500 in allowable charges, her husband incurs \$2,000 of allowable charges, and her daughter incurs \$1,000 of allowable charges. Both the covered person and family deductible have been satisfied. Rose has met the MOOP for a covered person, so the carrier is responsible for paying all of Rose's allowable charges. The carrier will be responsible for 70% of allowable charges incurred by Rose's husband and daughter until the family has incurred an additional \$2,500 in satisfaction of the family MOOP.

13. Are there any charges that do not count towards satisfaction of the MOOP amount?

Yes, some charges may not count towards satisfaction of the MOOP.

Cost sharing for prescription drugs *often* does not count towards satisfaction of the MOOP amount, although there are exceptions. One exception is high deductible health plans (HDHP) – which are meant to be combined with a health savings account, or HSA. In addition, carriers can offer plan designs in which prescription drug charges apply towards the MOOP.

Charges for health care services that are not covered under the health benefits plan do not count towards the MOOP amount. In addition, charges for covered health care services that *exceed* the allowed amount – as determined by the carrier – are not counted toward the MOOP amount.

14. What does “allowed charges” refer to?

“Allowed charges” refers to either the charges billed by the health care provider or the amount of billed charges that a carrier considers eligible and covered under the health benefits plan, whichever amount is less. “Allowed charges” may also refer to the negotiated rate of payment. The amount of charges that a health care provider bills for his or her services, and the carrier's allowed charges may not be the same – sometimes the provider bills more than allowed charge, and sometimes the provider bills less. When determining amounts due to the provider subject to a coinsurance percentage, the carrier bases what it pays on either the allowed charges or the provider's billed charges, whichever amount is less. When there is a negotiated rate of payment, the provider's bill may reflect the negotiated rate, or it may be in excess of the negotiated rate, but the carrier will only pay the negotiated rate.

Example: A physician bills a covered health care service at \$1,000. The carrier determines the allowed charges to be \$800. If the carrier is paying 80% of the allowed charges, then the carrier will pay \$640 ($\$800 \times .80 = \640). The covered person would pay 20% of the allowed charge, or \$160. If the health care provider is an out-of-network physician, the covered person is also responsible for the remaining \$200 “excess” charge between what the provider billed and the allowed charges.

15. Aren't the standard plans usually offered with in- and out-of-network benefits?

Plans A through E can be offered with and without a network component. Carriers most often offer and sell Plans B through E with a network component.

When offered without a network, these plans are traditional indemnity plans. When offered with a network, these plans are referred to as Preferred Provider Option (PPO) or Point-of-Service (POS) products. When Plans A, B, C, D or E are offered

with a network, the plan will have both in-network and out-of-network benefits. The HMO Plan is always offered with a network component, but it may be offered as a closed network product (a traditional HMO product), or it may be offered with out-of-network coverage options, referred to as an HMO-POS product.

16. What's an in-network benefit versus an out-of-network benefit?

The in-network benefits are the benefits (reimbursement or monetary value) a covered person is entitled to when he or she receives covered services through an in-network health care provider. The out-of-network benefits are the benefits a covered person is entitled to when he or she receives covered services through an out-of-network health care provider. Because health care providers in a carrier's network have agreed with the carrier to a negotiated rate of payment, and have agreed not to collect charges in excess of the negotiated rate of payment from the carrier's covered persons, in-network benefits are almost always greater than out-of-network benefits for the covered person. When a covered person chooses to receive covered services outside of the carrier's network, the covered person is responsible for any charges that the health care provider may bill that exceed what the carrier considers to be reasonable and customary, and these excess charges do not count toward satisfying any deductible or maximum out-of-pocket (MOOP) requirements in the standard health benefits plan.

17. If a plan has both in-network and out-of-network benefits, are there separate deductibles, coinsurance, copayment and MOOP requirements for the in-network and out-of-network benefits?

The carrier has an option of whether to use two different deductibles and MOOP limits, or a common deductible and MOOP limit for in-network and out-of-network benefits. When the carrier uses two different deductibles and MOOP limits, the out-of-network deductible and MOOP limits cannot be more than 2 times greater than the in-network deductible and MOOP limits. When separate deductible and MOOP limits apply, the in-network and out-of-network cost-sharing requirements must be satisfied separately, and there is no cross-accumulation of expenses. That is, costs incurred out-of-network will only satisfy the out-of-network cost-sharing requirements, and costs incurred in-network will only satisfy the in-network cost-sharing requirements.

Example: Handyman, Inc. purchased a Plan D PPO product. The in-network component has a \$250 deductible, 80% coinsurance and \$2250 MOOP. The out-of-network component is like a Plan B, with a \$500 deductible, 60% coinsurance and \$3,500 MOOP. Handyman's employee, Dave, uses mostly in-network health care providers, but uses an out-of-network chiropractor. The charges billed by an in-network provider for services can be applied to satisfy the in-network cost-sharing requirements, but the charges billed by the out-of-network chiropractor cannot be applied in that same manner. Instead, the chiropractor's charges will be applied to satisfy the \$500 out-of-network deductible and will be paid at 60% of allowed charges thereafter by the carrier.

18. If an employer replaces a standard health benefits plan with another standard health benefits plan, do the covered persons have to start satisfying the deductibles all over again?

Not necessarily. When a standard health benefits plan is replaced by another standard health benefits plan, whether with the same carrier or another carrier, the carrier will count accumulated charges incurred by a covered person under the old

plan towards satisfaction of the new policy's deductible if: the covered person accumulated charges during the same calendar year in which the new policy takes effect; the new policy takes effect immediately upon termination of the old policy; and, the covered person was enrolled under the old policy upon the termination date.

19. Do the standard health benefits plans provide coverage for prescription drugs?

Plans B, C, D, and E – whether issued on a PPO, POS or indemnity basis – and the HMO Plan (including the POS versions) provide coverage for prescription drugs provided both while an inpatient and an outpatient. Plan A only covers prescription drugs provided while hospitalized.

20. What is a rider?

"Rider" is the term used to refer to a document that changes the benefits or some other term of the underlying plan. In the SEH market, a rider may be used to increase or decrease the benefits of the underlying plan (some riders feature a combination of increases and decreases). The increase or decrease in benefits will have an effect on the price of the plan.

Many carriers offer multiple riders. Many offer a rider that modifies the prescription drug benefit so that coverage may be obtained using mail order or through prescription card services. Carriers sometimes offer vision benefits, or enhance other benefits in the policies. Some carriers also offer riders that reduce some benefits, such as therapy services, coverage for home health and coverage for durable medical equipment. Be sure you fully understand what you are buying. Insist that you be given detailed information that allows you to identify what additions or limitations the rider makes to the underlying standard plan.

21. Do I have to buy a standard plan with a rider?

NO! Carriers may sometimes market standard plans with one or more riders almost as if the standard plan and the rider is a package deal. However, an employer *always* has the right to obtain a price quote and purchase a standard plan without any riders. To determine if the plan plus rider is really what you want, be sure to understand everything the rider does. If the plan plus rider is cheaper than the cost of the plan without the rider, it means the rider somehow limits the plan's coverage. You'll need to decide if you are willing to offer a plan with those limits to your group.

22. Is there a grace period for paying premiums?

Yes. If premiums are paid within 31 days following the premium due date, the policy will remain in effect. If an employer does not pay premiums by the end of the grace period, the coverage will lapse. To avoid potential problems and misunderstandings, it is always advisable to submit premiums by the due date.

Premiums continue to be owed while coverage is in effect. If a policy lapses at the end of a grace period, the employer remains liable for the premium for the period coverage was in effect.

23. After I have purchased a small employer health benefits plan, may a carrier continue to require me to complete forms?

Yes. The carrier will require you to fill out an Annual Certification form in order to determine the number of employees and your participation rate. Failure to provide this information will result in non-renewal of coverage.

24. What is "self-insurance" and "stop loss" or "excess risk" insurance?

Some employers, especially large employers, opt to provide health coverage to their employees through a self-funded arrangement. Under such an arrangement, the employer is liable for expenses for the health coverage offered to the employees. Most employers that self-fund elect to purchase "stop-loss" or "excess risk" insurance for some portion of their potential liability from claims under the contract for health coverage. Stop loss and excess risk insurance is designed to reimburse the self-funded arrangement for catastrophic, excess or unexpected claims expenses. Carriers may not legally offer stop loss or excess risk policies to small employers with "attachment points" of less than \$20,000 per person per plan year and 125% of expected claims per plan year. The attachment point is the line of demarcation between the employer's liability and the carrier's liability. That is, a stop loss policy with an attachment point of \$20,000 per person and 125% of expected claims per plan year means that the employer is responsible for at least \$20,000 per person and 125% of expected claims for the group per plan year before the carrier pays any of the health care expenses incurred by group members. Please note that employees covered under an employer's self-funded plan do not count when determining whether an employer has met participation requirements for SEH plans.

25. What is the impact on a small employer group when a full-time employee turns age 65 and becomes eligible for Medicare?

Eligibility for [Medicare](#) does not preclude eligibility for coverage under the employer plan. Thus, the employee may be covered under both Medicare and the group plan. On the other hand, if the employee prefers to be covered only under Medicare, that decision will not have a negative impact on the group participation requirements. Carriers are required to count eligible employees covered under Medicare towards the participation requirement.

If the employee elects to be covered under both Medicare and the group plan, there will be coordination of benefits between the plans. There are federal rules to determine which plan pays first and which plan pays second. The purpose of coordination of benefits is to allow a person to claim benefits from both Medicare and the employer plan, with the primary carrier paying benefits as if there were no other coverage, and the secondary carrier paying up to the difference between what the primary carrier paid and the amount of the allowable charge.

When the employer has fewer than 20 employees, Medicare is the primary carrier, and must pay first.* The employer's group plan is secondary, and pays after Medicare does. In fact, if the employee does not elect to enroll in Medicare (Part B) right away, the carrier will still pay as secondary (as though the employee had Medicare coverage), reducing the benefits available to the employee under the SEH plan accordingly.

When an employer has 20 or more employees,* the Medicare-eligible employee may choose whether Medicare or the group policy will be primary (the default in the event the Medicare-eligible fails to make an affirmative election is for the group health plan to be primary and Medicare secondary).

Lastly, there will be an impact on the group rate. Carriers consider Medicare eligibility of one or more of the group's members when establishing rates, thereby acknowledging the carrier's generally reduced liability when paying as a secondary carrier.

**When determining application of federal standards to employer groups, each employee on the payroll is considered, NOT just eligible employees as defined by the New Jersey Small Employer Health Benefits Program Act. (Federal law may look at*

independent contractors – so-called 1099s – differently than state insurance laws. Employers should consult with an accountant regarding the status of those performing work for the business.) The federal Medicare secondary payer rules state that upon the day an employer has 20 or more employees for 20 or more work weeks (consecutive or not) in the preceding calendar year, the group health plan MUST be the primary payer of claims for a Medicare eligible individual covered under the group health plan.

26. How do I go about terminating a policy?

If you wish to terminate a policy, whether you are canceling it sometime during the plan year, or electing not to renew the policy upon its anniversary, you should give affirmative notice of your intentions to the carrier or the carrier's agent. Remember, small employer health benefits plans are issued for a term of one year (12 consecutive months), and are guaranteed renewable by the employer. Upon submission of the annual employer certification, the carrier will renew the policy for another term unless you advise that you do not want to renew it.

You may cancel a policy before the end of the 12-month period. Although a carrier cannot require that an employer provide advance notice of an intention to terminate a policy, a carrier is only required to honor prospective termination requests, not retroactive termination requests. If you make a prospective request to terminate the policy, the carrier will terminate the policy as of the date you specify. You are liable for payment of premiums for the period of time during which the contract remains in force, but the carrier will refund any premiums you have already paid for time periods exceeding the date of termination.

With respect to requests for retroactive termination, the carrier will terminate your policy on the date the carrier receives the notice, and refund premium for any remaining days. So, if you pay a month of premium on April 1st, and then on April 25th send notice to the carrier to terminate the policy as of April 15th, the carrier is only obligated to terminate the policy as of April 25th, not April 15th. The carrier would be required to refund 5 days worth of premium, not 15 days of premium.