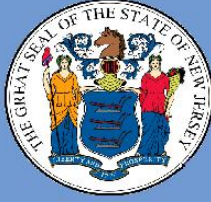


# A Health Insurance Primer for New Jersey Small Employers From the Small Employer Health Benefits Program

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## How Do I Get Started?

Learn if you are a “small” or “large” employer, or an “individual.” Different rules apply to different purchasers.

One advantage for small employers is guaranteed access to small employer standard health benefits plans, regardless of industry, claims history or health status of employees. Similarly, eligible individuals are guaranteed access to individual standard health benefits plans regardless of health status or claims history. All group health plans and individual standard plans are guaranteed renewable regardless of any changes in the health status of anyone covered under the policy.

**To buy or renew** a health benefits plan in the small employer market, you must:

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

**To be considered a SMALL EMPLOYER for health insurance purposes, you must:**

- Employ an average of 2 to 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 (i.e., the date your coverage would start or your annual renewal date); and
- Have a majority of eligible employees working at a location in New Jersey.

**Eligible employees include** the business owner if s/he is an employee of the business, and the business' employees routinely working 25 or more hours weekly. Temporary and seasonal employees and employees covered under a union's collectively-bargained welfare arrangement are not eligible employees.

**If you have more than 50 or fewer than 2 eligible employees, see “What If I Am Not A Small Employer” at the end of this brochure.**

**At least 75 percent of a small employer's eligible employees MUST PARTICIPATE in coverage.**

However, 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 by a group health plan offered by another employer as: an employee, a former employee continuing coverage (e.g., COBRA), or as an eligible dependent;
- Is covered as a dependent through any of the policies offered by your group health plan;
- Is covered through Medicare;
- Is covered through Medicaid; or
- Is covered through NJ FamilyCare.

A small employer may offer more than one small group health benefits plan to employees, if participation is met for the group of eligible employees in total.

**A small employer MUST CONTRIBUTE 10% towards the total group premium.**

A small employer may elect to pay more, but a carrier may not require the employer to do so as a condition of issuing a small group health benefits plan. The employer's contribution requirement 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.

## What Are My Options?

Five standard health benefits plan options are available. As of 2009, carriers must offer at least three of the standard health benefits plan options. All standard health benefits plans:

- Restrict preexisting condition limitation periods;
- Are modified community rated;
- Include coverage continuation for members of groups not subject to COBRA; and

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- ☑ Meet standard benefit requirements.

**Plan A** is designed primarily to cover facility charges and other health care provider charges related to services provided while hospitalized. Insureds pay a deductible and coinsurance, up to a \$5,000 out-of-pocket maximum for an individual. Plan A includes:

- ☑ coverage for 30 inpatient days per calendar year; and
- ☑ limited benefits for preventive services.

**Plans B through E and the HMO Plan** provide inpatient and outpatient hospital and medical coverage, without lifetime maximums, including:

- ☑ prenatal and maternity care;
- ☑ immunizations and well-child care;
- ☑ screenings;
- ☑ x-ray and laboratory services;
- ☑ all biologically based mental illness services;
- ☑ certain non-biologically based mental illness and substance abuse services;
- ☑ therapy services (e.g., physical, speech); and
- ☑ prescription drugs.

**Plans B through E differ on the level of cost-sharing required** before the carrier agrees to pay for services covered under the contract.

Cost-sharing may include:

**Deductibles**—allowed charges paid out-of-pocket before carriers pay benefits, ranging from \$250 to \$5000 per person.

**Copayments**—a dollar amount paid per visit or service. All plans may use copayments for in-network services when offered as a PPO or POS plan.

**Coinsurance**—the percentage of allowed charges the carrier pays after the deductible is met, ranging from 60% (Plan B) to 90% (Plan E), until the *MOOP* is met.

**MOOP (maximum out of pocket)**—the total amount of allowed charges, ranging from \$2000 to \$10,000 per person, that must be satisfied before the carrier pays

100% of the allowed charges.

**The HMO Plan is a network-based plan** – it may be a closed network or have a point-of-service feature allowing out-of-network access. It usually has copayment options (\$10 to \$50), but an HMO plan may be offered with deductibles ranging from \$250 to \$2,500/person, coinsurance ranging from 50% to 100%, and a MOOP amount. Copayments and coinsurance do not apply to the same health care services.

**Riders** are also available. Standard riders enhance prescription drug coverage. Carriers may offer other riders increasing or decreasing benefits. Riders are selected by the small employer.

### I Need More Information

More information is available online at [www.state.nj.us/dobi/division\\_insurance/ihcseh/index.html](http://www.state.nj.us/dobi/division_insurance/ihcseh/index.html), including **The Small Employer Health Benefits Program Buyer's Guide**, FAQs, carrier contact information, a sample premium comparison survey, charts for calculating employees and participation, and web links to the [IRS](http://www.irs.gov), [U.S. Department of Labor](http://www.dol.gov) and [Centers for Medicare & Medicaid Services](http://www.cms.gov).

Licensed insurance agents or brokers can provide guidance. You also may contact the carriers directly.

Get a price quote before making any decisions. Submit completed application and employee enrollment forms with the required premium. You will receive notice on the application in 15 business days or sooner. If approved by the carrier, your effective date of coverage will be no later than the first of the month after notice, unless you request a later effective date.

To renew your coverage, the carrier will ask you to verify you still meet the definition of a small employer, employee participation requirements, and employer contribution requirements.

At application and upon 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, the policy will not be renewed.

### What If I'm Not A Small Employer?

It depends why you don't qualify. Your group may qualify to buy "large" group coverage – talk to an agent about it. Otherwise, you may be eligible to buy individual coverage.

More information on individual policies and the **Individual Health Coverage Program** is available online at: [www.state.nj.us/dobi/division\\_insurance/ihcseh/index.html](http://www.state.nj.us/dobi/division_insurance/ihcseh/index.html) .

## A Health Insurance Primer for New Jersey Small Employers

### From the Small Employer Health Benefits Program

| 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 <sup>1</sup> 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 out-of-network individual   |
| Coinsurance <sup>2</sup> IN-NETWORK   | hospital: 100%<br>medical: 70%                    | 60%   | 70%   | 80%   | 90%   | n/a OR 50% on Rx<br>AND/OR 50%-90% when copays do not apply  | varies  |
| Coinsurance <sup>2</sup> OUT-OF-NETWORK   | hospital: 20%<br>medical: 50%                     |   |   |   |   | n/a  |   |
| Copayments <sup>3</sup> 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:<br>\$5/10/15/20/30/40/50;<br>Prenatal: same as above OR \$25;<br>Rx: \$15;<br>ER: \$50/75/100;<br>Hospital:<br>\$75/100/150/200/300/400/500 daily to max of \$750 to \$5000 yearly | Office:<br>\$5/10/15/20/30/40/50;<br>Prenatal: same as above OR \$25;<br>ER: \$50/75/100;<br>Hospital:<br>\$75/100/150/200/300/400/500 daily to max of \$750 to \$5000 yearly |
| Maximum Out of Pocket <sup>1</sup> 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 out-of-network individual per family   |

<sup>1</sup> 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).

<sup>2</sup> 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.

<sup>3</sup> 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.