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DEPARTMENT OF BANKING AND INSURANCE
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ADVISORY BULLETIN
10-SEH-01

January 4, 2010

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

From: Ellen DeRosa
Executive Director

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

On March 9, 2009 we issued Advisory Bulletin 09-SEH-01 discussing features of the American Recovery and Reinvestment Act of 2009 (ARRA) as related to New Jersey Continuation. On March 26, 2009 we issued Advisory Bulletin 09-SEH-02 to further address the vital role New Jersey small employer carriers must play in the implementation of the premium reduction for former employees electing continuation under N.J.S.A. 17B:27A-27. On November 16, 2009 we issued Advisory Bulletin 09-SEH-04 to address guidance concerning the timing for the request for treatment as an assistance eligible individual.

The purpose of this Advisory Bulletin is to address the amendments to ARRA made by the Department of Defense Appropriations Act, 2010.

Duration of Premium Reduction

The duration of the premium reduction for an Assistance Eligible individual (AEI) has been extended for 6 months, allowing a total of 15 months for the premium reduction. The extension applies both to AEIs whose 9 months were exhausted as well as current or future AEIs.

Note that the extension of the premium reduction does not operate to extend the maximum period for New Jersey continuation in the event of termination of employment which remains 18 months.

Date of Involuntary Termination of Employment

ARRA originally considered involuntary terminations of employment between September 1, 2008 and December 31, 2009. The amendments extend the period until February 28, 2010.

Additionally, the amendments require only that the involuntary termination of employment occur within the September 1, 2008 through February 28, 2010 timeframe. The first date of continuation may occur later than February 28, 2010.

<u>What Carriers Must Do</u>
Attached is an amended notice package. In addition to updating the existing notice and forms for persons whose employment terminates on or before February 28, 2010, there are two additional documents for persons who already qualified as AEIs.

Newly terminated employees
Carriers should mail the amended notice and forms upon receipt of information that an employee has been terminated.

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

Assistance Eligible Individuals:
AEIs whose premium reduction has expired as well as AEIs currently entitled to the premium reduction must immediately be sent the following:

- New Jersey Continuation Coverage Extension of Premium Reduction
- Request for Additional Six Months of Premium Reduction for New Jersey Continuation Coverage

In order for AEIs to be in a position to reinstate coverage they may have dropped within a meaningful timeframe, it will be most helpful if carriers can very quickly send information, particularly to those whose period for premium reduction expired December 31, 2009 and earlier.

You will note that the Request for Additional Six Months of Premium Reduction Form has a space for carriers to specify a mailing address at the carrier. While continuation elections and premiums generally pass through the former employer, this extension of the premium reduction is unique. Since carriers advance the 65% premium reduction for the AEIs and it is imperative that AEIs whose premium reduction expired can be reinstated as quickly as possible, the extension paperwork and payment will flow directly from the AEI back to the carrier.

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

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

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

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

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

Questions

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

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

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

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

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

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

The American Recovery and Reinvestment Act of 2009 (ARRA) as amended by the Department of Defense Appropriations Act, 2010 reduces the continuation premium in some cases. According to information we received from your former employer, your medical coverage terminated between September 1, 2008 and February 28, 2010. You may be eligible for a temporary ARRA premium reduction for up to fifteen months. To help determine whether you can get the ARRA premium reduction you should read this notice and the attachments very carefully.

Involuntary Termination of Employment between April 19, 2009 and February 28, 2010

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

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

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

Mail these completed forms to your former employer.

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

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

Sincerely,
[Carrier]

New Jersey Continuation Election Form

For involuntary terminations of employment between September 1, 2008 and February 28, 2010

Instructions:
This Election Form can ONLY be used to elect New Jersey Continuation in the event of in the event of an *involuntary* termination of employment occurring between September 1, 2008 and February 28, 2010. For *all other* elections of New Jersey Continuation please consult the employer that provided the group coverage under which you were covered.

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

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

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

I. Terminated Employee Information

Name: ________________________________ SS# ________________________
First MI Last or other identifier

Address ____
Street City State Zip Code

Dates: ______________________ ______________________
Employment Ended Medical Coverage Ended

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

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

II. Dependent Information

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

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

III. Plan Selection

Check one

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

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

IV. Signature

______________________________ ______________________________

Signature of Terminated Employee Date

Form for Switching Plan Options

For involuntary terminations of employment between September 1, 2008 and February 28, 2010

Instructions:
This Form for Switching Plan Options can ONLY be used if you have elected or are electing New Jersey Continuation following an *involuntary* termination of employment occurring between September 1, 2008 and February 28, 2010.

Contact your former employer and ask the following:

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

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

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

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

I. Terminated Employee Information

Name: ________________________________ SS# ________________________
First MI Last or other identifier

Address ____
Street City State Zip Code

Dates: ______________________ ______________________
Employment Ended Medical Coverage Ended

II. Alternate Plan Election

Name of carrier issuing alternate plan: ____

Name of alternate plan: ____

Copayment: _________ Deductible: _________ Coinsurance: _________

III. Signature

____ ________________________
Signature of Terminated Employee Date

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

Dear Former Employer:

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

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

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

Former Employee Name: ___________________________
Employee fill in your name

To be completed by Former Employer

Date Employment Terminated: ____________________________

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

____

____

Date medical coverage terminated: ________________________

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

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

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

Carrier name	**Plan** (name and brief description)
_________________________________	____
_________________________________	______________________________________

Is your current group medical coverage issued by another carrier? ☐ Yes ☐ No
If yes, identify the carrier ____
If yes and your former employee was involuntarily terminated from employment between September 1, 2008 and February 28, 2010, please send a copy of this form to this other carrier at the address you

currently use for new enrollments so the former employee may secure New Jersey Continuation coverage and the premium reduction under that carrier's plan.

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

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

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

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

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

PERSONAL INFORMATION

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

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

Statement	Yes	No
1. The loss of employment was involuntary.	☐ Yes	☐ No
2. The loss of employment occurred at some point on or after September 1, 2008 and on or before February 28, 2010.	☐ Yes	☐ No
3. I elected (or am electing) continuation coverage.	☐ Yes	☐ No
4. I am NOT eligible for other group health plan coverage (or I was not eligible for other group health plan coverage during the period for which I am claiming a reduced premium).	☐ Yes	☐ No
5. I am NOT eligible for Medicare (or I was not eligible for Medicare during the period for which I am claiming a reduced premium).	☐ Yes	☐ No

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

Signature → ____ Date → _____________________________________

Type/print name → __________________________________ Relationship to employee → ____________________

FOR CARRIER USE ONLY

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

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

REASON FOR DENIAL OF TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

☐1. Loss of employment was voluntary.

☐2. The involuntary loss did not occur between September 1, 2008 and February 28, 2010.

☐3. Individual did not elect continuation coverage.

☐4. Other (please explain)

Signature of party responsible for continuation coverage administration

→ ____ Date → _____________________

Type/print name → ____

Telephone number → _____________________________________ E-mail address → _______________________

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

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

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

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

Signature → ____ Date → ______________________________

Type/print name→ ____________________________________ Relationship to employee → ______________

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

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

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

Signature → ____ Date → ______________________________

Type/print name→ ____________________________________ Relationship to employee → ______________

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

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

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

Signature → ____ Date → ___________________________

Type/print name→ ____________________________________ Relationship to employee → ___________

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

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

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

PERSONAL INFORMATION

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

PREMIUM REDUCTION INELIGIBILITY INFORMATION – Check one

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

IMPORTANT

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

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

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

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

Signature → ____________________________ Date → __________________

Type/print name → ____

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

____________________________ ____________________________

____________________________ ____________________________

[Carrier letterhead/logo]
[Use this notice for ALL former and current Assistance Eligible Individuals]

New Jersey Continuation Coverage
Extension of Premium Reduction

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

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

This notice contains important information about the premium reduction under Federal law. Please read the information contained in this notice very carefully.

The American Recovery and Reinvestment Act of 2009 (ARRA) as amended by the Department of Defense Appropriations Act, 2010 reduces the continuation premium for up to fifteen months (increased from nine months). According to our records you qualified as an Assistance Eligible Individual and thus received or are receiving a 65% premium reduction for the premium for your New Jersey Continuation coverage.

Original Nine Months of Premium Reduction Has Expired

As originally enacted ARRA allowed for a maximum period of nine months of premium reduction. For some persons the nine month period for the premium reduction under ARRA has expired. Several things could have happened. Some people may have stayed on New Jersey Continuation, and paid the full premium. Some people may have found individual coverage that was less expensive than the full premium for continuation coverage and thus dropped continuation so as to pick up an individual plan. Some people may have decided the full cost for continuation or an individual plan was more than they could afford and they are now uninsured.

To request the premium reduction for up to six additional months complete the enclosed **Request for Additional Six Months of Premium Reduction for New Jersey Continuation Coverage** and return it to us at the address included on the form.

If you have paid the full continuation premium to your former employer we will provide a refund/credit of the excess amount.

If you bought an individual policy you must contact the carrier that issued the policy and request that it be retroactively terminated to the effective date. The carrier may question your request. Explain you just received information about an extension of the premium reduction and you wish to take advantage of it. You may show the carrier a copy of this notice. When your individual policy is terminated you will receive a refund of the premiums you paid. Any claims that were paid will be recovered. You may submit them for payment under the continuation coverage. You must pay the premium for the continuation coverage at the 35% rate back to the date the continuation ended up through the present. Continuation coverage must be continuous meaning it must go back to the date it ended. Whether you used the coverage or not you cannot request a later effective date. You must pay the premium for the continued coverage no later than February 17, 2010, or 30 days from receipt of notice from the insurance company, whichever is later. Please understand that the coverage will not be reinstated until we have received your payment.

If you have been uninsured since the premium reduction ended you may reinstate the continuation coverage. To reinstate your New Jersey Continuation coverage you must pay the premium at the 35%

rate back to the date the continuation ended up through the present. Continuation coverage must be continuous meaning it must go back to the date it ended. Whether you used the coverage or not you cannot request a later effective date. You must pay the premium for the continued coverage no later than February 17, 2010, or 30 days from receipt of notice from the insurance company, whichever is later. Please understand that the coverage will not be reinstated until we have received your payment.

In order to qualify for the premium reduction and remain qualified for the premium reduction you must not be eligible for coverage under another group plan and you must not be eligible for Medicare. As long as you remain ineligible for coverage under another group plan and remain ineligible for Medicare, the premium reduction may continue for six additional months. If you do become eligible under a group plan or under Medicare you must immediately complete the Participant Notification form we sent with your original package of materials. If you lost it, contact us and we'll send you a copy.

Please note: The maximum period for New Jersey Continuation in the event of termination of employment is 18 months. The six months extension of the premium reduction will *not* operate to allow continuation beyond 18 months. If you originally qualified for the premium reduction through the special election period last year even though your nine months of premium reduction began in March 2009 the 18 months for continuation is measured from the date your coverage ended which may have as early as September 2008. The full period of continuation for a loss of coverage beginning September 1, 2008 would expire February 28, 2010. So while the extended 6 months for the premium reduction would not have run out, the continuation will expire February 28, 2010 and the premium reduction will cease at that same time.

Original Nine Months of Premium Reduction has Not Expired

In order to qualify for the premium reduction and remain qualified for the premium reduction you must not be eligible for coverage under another group plan and you must not be eligible for Medicare. As long as you remain ineligible for coverage under another group plan and remain ineligible for Medicare, the premium reduction will continue for six additional months. You do not need to complete a request for the extension. If you do become eligible under a group plan or under Medicare you must immediately complete the Participant Notification form we sent with your original package of materials. If you lost it, contact us and we'll send you a copy.

If you have any questions concerning the extension of the premium reduction, please contact *[carrier member services at phone]*

Sincerely,
[Carrier]

Request for Additional Six Months of Premium Reduction for New Jersey Continuation Coverage

For involuntary terminations of employment between September 1, 2008 and February 28, 2010

Instructions:
This Request form is to be completed by persons who qualified for as Assistance Eligible Individuals and whose nine months of premium reduction has or will expire on or after November 30, 2009.

This form must be completed and returned to the insurance company no later than February 17, 2010, or 30 days from receipt of notice from the insurance company, whichever is later. If payment is required, payment must be made no later than February 17, 2010, or 30 days from receipt of notice from the insurance company, whichever is later.

Return this form and payment, if required, directly to the insurance company. *[Carriers: add the address to be used]*

I. Terminated Employee Information

Name: ________________________________ SS# ________________________
First MI Last or other identifier

Address ____
Street City State Zip Code

Dates: __________________ __________________ __________________
Employment Ended Medical Coverage Ended Premium Reduction Ended

I. If you have already received the premium reduction for 9 full months check one of the following:

☐ I **paid** the full continuation premium to my former employer when the 9 months of premium reduction ended so I could remain covered under New Jersey Continuation. I am not eligible for coverage under another group plan or under Medicare. Please process my refund/credit.

☐ I did **not** pay the full continuation premium to my former employer when the 9 months of premium reduction ended so my New Jersey Continuation ended. I bought an individual policy. I am sending the carrier a request to retroactively terminate that individual policy. I want to reinstate my New Jersey Continuation coverage. I understand I must pay premiums for the period from the time my continuation ended through the present. I am not eligible for coverage under another group plan or under Medicare.

☐ I did **not** pay the full continuation premium to my former employer when the 9 months of premium reduction ended so my New Jersey Continuation ended. I want to reinstate my New Jersey Continuation coverage. I understand I must pay premiums for the period from the time my continuation ended through the present. I am not eligible for coverage under another group plan or under Medicare.

Note: If you request to reinstate New Jersey continuation coverage the premiums for the period from the date it ended through the present must be paid no later than February 17, 2010, or 30 days from receipt of notice from the insurance company, whichever is later.

II. If you have not already received the premium reduction for 9 full months, it will automatically be extended for an additional 6 months. You do not need to complete and return this form. However, if you become eligible for coverage under another group plan or Medicare then you must complete the Participant Notification form.

III. **Signature**

____ _____________________________

Signature of Assistance Eligible Individual (terminated employee) Date