FINAL
MINUTES OF THE MEETING OF THE
NEW JERSEY INDIVIDUAL HEALTH COVERAGE PROGRAM BOARD
AT THE OFFICES OF THE
NEW JERSEY DEPARTMENT OF BANKING AND INSURANCE
TRENTON, NEW JERSEY
June 14, 2016

Directors participating: Sandi Kelly (Horizon); Lisa Levine (United/Oxford); Tom Pownall (Aetna); Brendan Peppard (DOBI); Tony Taliaferro (AmeriHealth)

Others participating: Ellen DeRosa, Executive Director; Chanell McDevitt, Deputy Executive Director; Rosaria Lenox, Program Accountant; Eleanor Heck, Deputy Attorney General

I. Call to Order

E. DeRosa called the meeting of the IHC Board to order at 10:03 A.M. E. DeRosa announced that notice of the meeting had been published in three newspapers of general circulation and posted at the Department of Banking and Insurance ("DOBI"), on the DOBI website, at the Office of the Secretary of State, and submitted to the State House Press Corps, in accordance with the Open Public Meetings Act. A quorum was present. She stated that voting would be by roll call because some directors were participating by phone.

II. Minutes – *May 10, 2016*

B. Peppard made a motion, seconded by T. Pownall, to approve the minutes of the May 10, 2016 Board meeting. By roll call vote, the motion carried.

III. Staff Report

Expense Report/Transfer of Funds

R. Lenox presented the expense report for June, totaling $6,200.61, partly for the IHC Board's share of salaries and fringe, and partly for legal services. She noted that salaries and fringe were lower in this cycle due to overbilling in previously. R. Lenox explained that the Board needs to transfer $6,200 from its Wells Fargo Money Market Account to its Wells Fargo checking account in order to pay the expenses, if approved.

S. Kelly made a motion, seconded by B. Peppard, to approve payment of the June expenses, and authorizing the transfer of $6,200 from the Board's Wells Fargo Money Market Account to the Board's Wells Fargo checking account to pay the approved expense. By roll call vote, the motion carried.

Good Faith Marketing

C. McDevitt summarized the materials that had been submitted by carriers as evidence of compliance with the statutory good faith marketing requirement and N.J.A.C. 11:24.6. She noted that one carrier, Health Republic, had failed to submit the information timely, but was responsive to a reminder from staff. She noted that all of the carriers complied with the requirement that the application form name the requisite number of standard plans on the form,

with a slight exception from AmeriHealth, which uses a separate sheet to identify all of its plans and rates with the application form.

C. McDevitt explained that each carrier submitted additional information, usually including some website reference, and a brochure, and in some instances, in-person events; however, she and E. DeRosa expressed reservations with respect to materials submitted by Cigna and Oxford. It was noted that Oxford submitted material provided to brokers, but that such material did not actually discuss the standard IHC plans. It was further noted that Oxford submitted materials used by Inside Sales, but without explanation, which was problematic because some of the materials involved offerings by affiliated companies not doing business in the IHC market. With respect to Cigna, it was noted that the company submitted a copy of a webpage, accessible through a secondary path, that provided along with unrelated topics an "800" telephone number to call for more information about New Jersey along. C. McDevitt explained that Cigna also submitted its SBC for its HMO plan and indicated that it is included in the fulfillment kit, but that Cigna did not provide any additional fulfillment kit information, such as rates.

Board members suggested that staff request additional information and explanation from Oxford and Cigna either to clarify what is included in the fulfillment kits (which can be considered marketing), or to provide additional specific marketing information before taking any final action with respect to those two companies.

[T. Pownall recused himself from action or discussion by the Board with respect to Aetna because of the interest of his employer in the outcome of such action.]

B. Peppard made a motion, seconded by L. Levine, to find that Aetna marketed IHC plans in good faith for calendar year 2015. By roll call vote, the motion carried.

S. Kelly made a motion, seconded by B. Peppard, to find that Health Republic marketed IHC plans in good faith for calendar year 2015. By roll call vote, the motion carried.

[T. Taliaferro recused himself from action or discussion by the Board with respect to AmeriHealth because of the interest of his employer in the outcome of such action.]

B. Peppard made a motion, seconded by T. Pownall, to find that AmeriHealth marketed IHC plans in good faith for calendar year 2015. By roll call vote, the motion carried.

[S. Kelly recused herself from action or discussion by the Board with respect to Horizon because of the interest of her employer in the outcome of such action.]

T. Taliaferro made a motion, seconded by B. Peppard, to find that Horizon marketed IHC plans in good faith for calendar year 2015. By roll call vote, the motion carried.

IV. Report of the Operations and Audit Committee (OAC)

R. Lenox reported that the OAC met to discuss the IHC Program's quarterly financial statements for the quarter ended March 31, 2016 (3Q), and went on to explain the Statement of Net Assets, the Statement of Changes in Net Assets, the Statement of Changes in Assets & Liabilities, the Statement of Cash Flows, and the Comparison of Budget to Actual. She noted that year-to-date

expenses totaled $179,544.19, leaving a balances of $169,425.81, suggesting a favorable balance at the close of fiscal year 2016.

V. Changes to the IHC Program Rules and Policy Forms

E. DeRosa discussed the changes included in the most recent draft proposal distributed to Board members, which included topics discussed by the Board at its May meeting, and additional points related to housekeeping. She noted that changes are only proposed for those rules in the subchapter under the purview of the Board, not the DOBI. She highlighted the following:

- In subchapter 1, deletion of the definition of Basic & Essential (B&E) plan (and deleting the term throughout the rules and forms), because such plans no longer can be sold; amendment of the definition of eligible person to match a change already made in the policy forms with respect to Medicare-covered individuals; deletion of the term "initial enrollment period," "NAIC," and "preexisting condition" because they are not used in the rules at this time; amendment of the definition of special enrollment period to clarify that it includes up to 60 days preceding a loss of coverage; and amendment of the definition of triggering event to match the policy forms by referencing the date of a court order.
- In subchapter 2, amendment of the Board's voting requirements that currently require 5 affirmative votes for certain actions, to require a majority of the Board for such actions; addition of email addresses for contact information; deletion of the good faith marketing requirement related to sale of the B&E plans.
- In subchapter 12, amendments to language regarding annual enrollment dates and effective dates to recognize changes in operation at the federal level; amendments to the provisions specifying triggering events to reflect the changes discussed in the definitions, and to clarify that carriers may request proof of the occurrence of a triggering event resulting in a special enrollment period.
- In subchapter 17, amendments to the required enrollment reports to provide carriers an additional 15 days to submit reports, and to remove the reporting forms from the appendix to the rules in favor of a general description in the rules and a reference to finding the forms online at the IHC Program's website. It was noted that these changes would more accurately reflect current operations, including significant revisions of the forms to address the changes in the plans offered in the IHC market.
- In subchapter 19, amendments to the rules regarding petitions for rulemaking to bring the rules in line with changes in state law
- In subchapter 24, various amendments reflecting changes in the definitions (e.g., triggering event and special enrollment period); deletion of N.J.A.C. 11:20-24.5, which requires carriers to reimburse certain out-of-network expenses at the 80th percentile of the PHCS or at billed charges, whichever is less; amendment of IHC standard plan good faith marketing requirements to clarify that marketing should be outbound, and consumer-oriented.
- Revisions to the standard plans to address relevant issues noted above, as well as:
    - Dedication of space for language option taglines (used to let consumers know how to obtain help in other languages).

- Deletion of dollar limits on preventive services to comply with the final federal rules addressing lifetime and annual limits (2017 Payment and Benefits Parameters).
- Amendment to the allowed charges definition to require carriers offering plans with out-of-network benefits a space to explain how reimbursement will be determined for out-of-network services, and to explain how a covered person may obtain specific information. It was noted that no change would be required for plans having no voluntary out-of-network benefits (which is the vast majority of IHC plans).
- Amendment to the Covered Charges with Special Limitation section to merge it with the Covered Charges section, because special limitations no longer really exist in the IHC plans under the ACA.
- Amendments to the definition of developmental disabilities to remove age limits to be consistent with MHPAEA, and to update language to comply with the federal law commonly referred to as Rosa's Law.
- Revisions to the Continuation of Care provisions to assure compliance with the final federal 2017 Benefit and Payment Parameter rules, by adding a continuity of care requirement when a physician states it is medically necessary and accepts the negotiated rate for the continuity of care period.
- Addition of a "split-fill" pharmacy option with respect to specialty pharmacy that would allow members to fill only a portion of a new prescription (two weeks or 15 days) until the member's tolerance to the medication can be determined. It was noted that if carriers elected this option, it would allow members to save money in the event they are unable to tolerate a medication and must change drugs before the end of the prescription cycle.
- Revision to the dental services provision to remove the "hidden" pre-existing condition language that is objectionable to the U.S. Department of Labor, so that benefits for treatment of injuries to teeth are available during the 6 months following the effective date of coverage or following the date of the injury, whichever is later.
- Deletion of the current exclusion of benefits when covered services are being rendered with respect to gender reassignment. It was explained that this change would make the standard plans compliant with the rules proposed and expected to be adopted soon by the Office of Civil Rights.

The Board discussed proposal options, and whether action to propose the draft was required today. E. DeRosa suggested the Board could use its expedited rulemaking rather than the process established through the Administrative Procedure Act (ACA), but provide commenters a period of time to comment exceeding the minimum 20 days required using the expedited process. She explained that this would reduce the proposal and adoption process by 6 weeks, helping the Board and carriers more readily meet deadlines for the 2017 open enrollment period, but could still provide interested parties a greater period of time to submit comments; she reminded Board members that a hearing would also be required during the proposal process because of changing being proposed to the policy forms.

Board members expressed a need to discuss some of the changes with their companies. It was agreed that the Board would try to have an additional meeting before its July 12th meeting in order to take action on the proposal.

T. Taliaferro made a motion, and B. Peppard seconded, to move into Executive Session to discuss anticipated litigation and obtain legal advice, without the intent of taking any further action in open session. By roll call vote, the motion carried.

[The Board moved into Executive Session for approximately 30 minutes, starting at about 11:45 A.M.]

V. Close of meeting

The Board lost its quorum immediately after the close of the Executive Session, and could not take official action to end the Open Session meeting. No additional action occurred during the Open Session.

[All business ended at approximately 12:15 P.M.]