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
February 13, 2018

Directors participating: Mary Beaumont; Joseph Camargo; Seong-Min Eom (DOBI); Sandi Kelly (Horizon); Thomas Pownall (Aetna); Tony Taliaferro (AmeriHealth).

Others participating: Ellen DeRosa, Executive Director; Chanell McDevitt, Deputy Executive Director; Christine Machnowsky, Deputy Executive Director; Eleanor Heck, Deputy Attorney General.

I. Call to Order

E. DeRosa called the meeting of the IHC Board to order at 10:00 A.M. She announced that notice of the meeting had been posted at the Department of Banking and Insurance ("DOBI"), on the DOBI website, at the Office of the Secretary of State, submitted to the State House Press Corps, and published in three newspapers of general circulation 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. Introductions

E. DeRosa welcomed J. Camargo to the Board meeting as a Director, noting that he actually has a long history with the Board, having been a periodic attendee over the years. She also announced that Brendan Peppard left the DOBI in January, and that Seong-Min Eom, the DOBI's Chief Life and Health Actuary, would be serving as the Commissioner's designee for this meeting.

III. Review of Minutes – *January 9, 2018*

T. Taliaferro made a motion, seconded by T. Pownall, to approve the minutes of the meeting of January 9, 2018. By roll call vote, the motion carried, with J. Camargo abstaining.

IV. Report of Staff – *Expense Report, Audit; Readoption of the IHC Program Rules*

Expense Report

E. DeRosa presented the expense report for February, with expenses totaling $10,931.37, primarily for salaries and fringe to be paid to the SEH Program, and to reimburse R. Lenox for expenses related to parking and her CPA license. She noted that a transfer of $11,000 from the Board's Money Market account to its checking account would be necessary to pay these expenses.

E. DeRosa briefly explained for the benefit of J. Camargo that most staff and office related expenses are shared evenly between the IHC and Small Employer Health Benefits (SEH) Program, with the IHC Board paying or reimbursing its half to the SEH Board, and the SEH Board in turn submitting payments to the DOBI.

M. Beaumont made a motion, seconded by S. Eom, to approve payment of the expenses reported, and transfer of $11,000 from the Board's Money Market account to its checking account to do so. By roll call vote, the motion carried.

E. DeRosa reported that WithumSmith+Brown (WSB) completed its FY2017 audit of the IHC Program, and met with the Operations & Audit Committee (OAC) to summarize and answer any questions the

OAC might have. She said that WSB stated it had no issues to raise and that the operations were very clean, and the OAC had no questions regarding the audit. She noted that staff provided WSB with the management representation letter, so a final audit report should be released shortly, after which the reconciliation will be performed. She further explained that when the final audit report is issued, it will be posted on the IHC Board's website, and shared with the Board.

Sunsetting of the IHC Program Rules – Readoption Proposal
E. DeRosa reminded the Board that the regulations for the IHC Program will sunset in accordance with the Administrative Procedures Act in May. She stated that since the January 2018 meeting, several bills were signed by then-governor Christie. She discussed language in the policy forms that would need to be revised to address the newest legislation.

- Newborn coverage (P.L. 2017, c. 361), effective January 16, 2018 for policies issued or renewed on or after that date. Essentially, the law extends newborn coverage from 31 to 60 days following birth without payment of a separate premium. E. DeRosa noted that the extension of coverage – like the original law – is for treatment of illness, injury and congenital defect, not routine well-child care or immunizations.
- Human breast milk donation coverage (P.L. 2017, c. 309), effective January 1, 2019 for policies issued or renewed on or after that date, or following the licensing of at least one facility able to store and process the donations in New Jersey, whichever comes later. E. DeRosa noted that the Department of Health will have the licensing duty. The language is available for carriers to use when needed on or after January 1, 2019.
- Contraceptive coverage mandate (P.L. 2017, c. 241), effective February 15, 2018 for policies issued or renewed on or after that date. E. DeRosa explained that the mandate requires coverage of a broader array of prescribed contraceptives, not just oral contraceptives, warranting movement of the coverage out of the prescription drug benefit and to its own provision, particularly because of very specific coverage standards: initial coverage is for a three-month period, and additional coverage is for six-months, unless the plan year ends in less than six months, in which case, the coverage can be limited to December 31. She noted that, generally, the coverage is considered preventive, and so not subject to cost-sharing, but that there is a provision for applying cost-sharing if the prescription is used for reasons other than birth control.
- Mammography performed with digital tomosynthesis (P.L. 2017, c. 305), effective August 1, 2018 for policies issued or renewed on or after that date. E. DeRosa explained that this is sometimes referred to as 3D mammography, and like other mammography, is used both as a screening tool and diagnostic tool primarily for imaging dense breast tissue, but under the mandate can be used without regard to the density of tissue involved. She noted that when used as a screening tool, no cost-sharing should apply, while cost-sharing can apply when used as a diagnostic tool.

E. DeRosa discussed an additional change requested by a carrier that is intended to help explain the accumulation of costs towards the deductible and MOOP for tiered high deductible health plans. She noted that the language is rather lengthy because of the differing permutations between tiers, and single and other-than-single coverage.

A discussion ensued regarding the definition of hospital confinement indemnity coverage, which E. DeRosa reminded Board members they had requested staff to research more before deciding whether and how to update the definition. She stated that after going through the minutes, the proposal, the adoption, and related records from when the definition was first promulgated, nothing clearly explained the Board's process for developing the formula in the definition, but that, based on what was recorded, the $250 benefit probably represented the typical benefit payable at that time. She explained that a response to a comment in the original adoption stated that the overriding principle was that the benefit not be so comprehensive as to compete with the standard health benefits plans, and to avoid having consumers

lulled into thinking that they have purchased a plan that will pay adequately for catastrophic events, or is a reasonable replacement for comprehensive coverage.

S. Kelly stated that Horizon has concerns about increasing the $250 benefit, and with the loss of the individual mandate is very reluctant to raise the benefit to $500. She suggested two alternatives: (1) raise the benefit to $300, and add an index that allows the benefit to increase over time (such as the CPI-U); or (2) increase the $250 benefit based on the increase in the CPI since 1993, which would probably put it at around $400.

E. DeRosa noted that UNUM has suggested increasing the benefit to $750, and has offered additional alternatives, but she stated that there is no requirement to make a change, if the Board prefers not to do so. She noted that the hospital confinement indemnity plans are meant to be sold as supplemental plans, but that monitoring is difficult, particularly because people could cancel comprehensive plans after purchasing supplemental plans, and not report the cancellation.

After further discussion, the Board agreed that the issue should be reviewed by the Technical Advisory Committee, and the DOBI indicated it would like to have a sensitivity test done with respect to increases in standard plan premium and the supplemental plan benefit, plus potential distribution of enrollment.

[S. Eom left the meeting at 11:15 A.M.]

E. DeRosa reminded carriers that she had asked if other Board members were aware of any additional suggested changes, and that so far, she has only received the suggestion regarding the tiered high deductible health plans, plus certain language changes discussed during the January meeting. She discussed several of the changes to N.J.A.C. 11:20 previously discussed in January, including:

- Elimination of the definitions of "community rated," (HIPAA) "enrollment date," and "federally qualified HMO," because these terms have no applicability to the rules at this time
- Modification of the definition of "group health benefits plan" to be consistent with the definition in ERISA
- Removal of references to loss reimbursements because there is no longer a loss reimbursement program
- Removal of references to policy form filings because policy forms are not required to be filed
- Removal of the references to specific deductible and MOOP amounts because these are controlled by DOBI's minimum standards rules at N.J.A.C. 11:22-5, with addition of an exception for bronze and catastrophic plans
- Modification of the process set forth in the plan of operation for the election of Board members so that it would be more reflective of technological changes and current practices embraced by the Board
- Movement from a two-year to an annual assessment cycle, now that the loss reimbursement mechanism is shuttered and there is no need to use a two-year cycle.
- Updates to the good faith marketing standards for purposes of clarification of the standards

S. Kelly made a motion, seconded by M. Beaumont, to approve the proposal of the readoption of N.J.A.C. 11:21 and its appendices, with amendments as discussed. By roll call vote, the motion carried.

E. DeRosa explained that the proposal would be put into a format suitable for the Office of Administrative Law (OAL), and the preamble added (which includes the summary and impact statements required for rule proposals), and then follow the usual process of approvals prior to being submitted to OAL. She stated she assumed the Board would follow the rulemaking procedures of the Administrative Procedures Act. She said that the Board would have to hold a hearing because it is making changes to its

policy forms, and that the DOBI would have to hold a hearing because the Board is making changes to its Plan of Operation, over which the DOBI has ultimate approval. She indicated the two hearings would probably be held simultaneously.

V. Administrative Update – Rulemaking

E. Heck informed the Board that the SEH Program had recently won an appeal in Spine Society v. NJ SEH Program Board, in which the Superior Court, Appellate Division, upheld the SEH Board's use of the expedited rulemaking procedure set forth at N.J.S.A. 17B:27A-51, in a strong and definitive published opinion in support of the Board. She reminded Board members that N.J.S.A. 17B:27A-16.1, the IHC Board's expedited rulemaking statute, is identical to the SEH Board's expedited rulemaking statute, and had also been subject to challenge in 2002, with the IHC Board prevailing on that issue in an opinion that was published (although the Board did not prevail on other issues in that case). She noted that the 2002 opinion did not specifically address the definition of "action," focusing more on the expedited rulemaking procedure itself, while in Spine Society, the challengers contended that the SEH Board's 2016 readoption with amendments of N.J.A.C. 11:21 did not fall within the statutory definition of "action" and therefore, the expedited rulemaking procedure was not appropriate. E. Heck explained that the court disagreed with the challengers, reasoning that the readoption was in fact an "action" as defined by the statute, and the expedited rulemaking was appropriate. She noted that, because the two statutes are identical, the holding in Spine Society also benefits the IHC Board.

VI. Close of meeting

T. Pownall made a motion, seconded by M. Beaumont, to adjourn the meeting. By roll call vote, the motion carried.

[The meeting ended at 11:47 A.M.]