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
September 10, 2019

Directors participating: Joseph Camargo; Philip Gennace (DOBI); Sandi Kelly (Horizon); Robert Morrow (United); Colleen Picklo; Thomas Pownall (Aetna); Tony Taliaferro (AmeriHealth).

Others participating: Ellen DeRosa, Executive Director; Chanell McDevitt, 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. Review of Minutes – August 13, 2019

S. Kelly made a motion, seconded by T. Pownall, to approve the minutes of the meeting of August 13, 2019, without amendment. By roll call vote, the motion carried.

III. Report of Staff – *Expense Report; Draft Amendments to the Standard Plans*

Expense Report

E. DeRosa presented the expense report for September 2019 with expenses totaling $11,120.04 for the Board's share of staff salaries, payable to the Small Employer Health Benefits Program. E. DeRosa stated that a transfer of $11,000.00 from the IHC Board's Wells Fargo Money Market account to its checking account would be necessary to pay the expense.

T. Pownall made a motion, seconded by C. Picklo, to approve payment of the expense reported, and the 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.

Second Draft of Proposed Amendments to the Standard Plans

E. DeRosa reminded Board members that she had invited them to share any additional comments and concerns with her regarding amendments to the standard plans discussed at the August meeting – a majority of which are being made to align with New Jersey's mental health parity law (P.L. 2019, c. 58) – and noted that she received no additional comments, but found additional areas where she thought some language changes would be prudent for clarity. She highlighted the following new and existing draft changes:

- Removal of the separate section in the schedule pages discussing treatment of autism and other developmental disabilities with physical therapy (PT), speech therapy (ST), and occupational therapy (OT), and substitution of references to the separate paragraph with simple statements in the schedule for PT, ST, and OT that there are no limits for these services with respect to treatment of autism and other developmental disabilities.
- Revision of the definition of "Mental Illness" to reflect Chapter 58 terminology by substituting the term Mental Health Condition, and inclusion of a reference to the Diagnostic and Statistical Manual 5 (DSM-5) throughout the forms, including, for example, in the definition of "Developmental Disability or Developmentally Disabled."
- Addition of a definition of "Same Terms and Conditions" to address the application of both quantitative and non-quantitative limitations to promote equitable treatment of Mental Health Conditions relative to other covered conditions.
- Revision to the definition of "Generic Drug" to add variable text that would permit carriers to make a distinction in benefits between generic drugs and authorized generic drugs as designated by the Federal Food and Drug Administration (FDA), which are not considered to be generic drugs by the FDA, but rather, a manufacturer's additional version of the manufacturer's own brand drug.
- Additions and revisions to the Triggering Events to better reflect all of the conditions triggering Special Enrollment Periods under federal law; however, E. DeRosa noted not all details of proving eligibility are included because certain proofs are required by and determinations are made by the Marketplace rather than by the carriers.
- Removal of the effective date regarding the coverage of human breast milk because the effective date has now passed; E. DeRosa noted that there are still no facilities in New Jersey that can address the supply issue.
- Removal of the section regarding coverage of a 96-hour supply of prescription drugs when a drug is otherwise subject to prior authorization; E. DeRosa noted there was never a formal mandate to provide this coverage, and that changes in technology mitigated any need that may have existed for it.
- Removal of prior authorization for therapy services for other developmental disabilities.
- Addition of variable text to permit carriers to cover immunizations administered in a pharmacy setting; it was noted that the manner in which carriers pay for the coverage need not change – a carrier could still pay the costs under the medical benefit, or pay for it as a pharmacy benefit, so long as the carrier is consistent, and applies no charge to the consumer for preventive services.
- Removal of coverage for autologous bone marrow transplant (ABMT) with high dose chemotherapy for treatment of breast cancer, notwithstanding the statutory mandate, because the treatment is not considered an appropriate protocol, and is not FDA-approved.
- Revision of grace period language to clarify that premiums must be paid without specific reference as to the party responsible for payments.

After further discussion, it was acknowledged that the Board should review the draft text for the following:

- Coverage of immunizations administered at a pharmacy
- Coverage of Legend drug vitamins
- Transplant benefits

- Third-party payment of premiums; the Board asked that the Legal Committee review this issue

IV. Report of the Operations and Audit Committee (OAC) – *Distribution of Interest; End-of-Year Financials*

Distribution of Interest
E. DeRosa stated that, because of the discussions at the August meeting on the issue of distribution of the interest earned on the loss and administrative assessments from July 2017 through January 2018 (arising from the manner in which the New Jersey Treasury posts to its accounts), R. Lenox developed a list of the carriers that would be effected by a change in the *de minimis* from $50 to $10 and $5. The variation of carriers across the spectrum of *de minimis* options was small, with approximately half of the money owed to non-members (for whom a credit against future administrative assessments could not occur), and fewer than 10 carriers are due sums between $5 and $50.

It was explained that OAC members did not believe most carriers would want to receive such nominal amounts – and staff's experience with carriers receiving small amounts supports that position – because carriers often do not know how to account for the funds. It was also explained that the OAC members thought it reasonable for all companies owed a *de minimis* amount to forego the sum so that all are treated alike, whether a member or non-member. Several Board members thought it appropriate to provide carriers with a choice.

S. Kelly made a motion, seconded by T. Pownall, requiring staff to ask each of the carriers to whom interest was owed of less than $50 but more than $10 whether the carrier preferred to forego the interest or receive the interest owed by check, or, if the carrier is a member of the IHC Program, as a credit against future assessments. By roll call vote, the motion carried.

End-of-Year Financial Statements
E. DeRosa briefly presented the end-of-year financial statements, including the following:

- Management's Discussion and Analysis
- Statement of Financial Position
- Statement of Activities and Changes in Net Assets
- Statement of Cash Flow
- Comparison of Budget to Expenditures, which shows a favorable balance

She noted that reconciliation of the assessment will be prepared following completion of the annual program audit.

V. Annual (Organizational) Meeting

E. DeRosa stated that, because this is the Annual meeting of the Board, the Board needs to re-organize itself through election of a Chair and Vice Chair, and it needs to reconstitute its standing committees. She reminded Board members that election of someone as Chair and Vice Chair is a personal election, not a company selection.

T. Taliaferro made a motion, seconded by J. Camargo, to nominate and elect S. Kelly as Chair of the Board. S. Kelly accepted the nomination, and upon no other nominations being moved, by roll call vote, the motion carried.

S. Kelly made a motion, seconded by T. Taliaferro, to nominate and elect T. Pownall as Vice Chair of the Board. T. Pownall accepted the nomination, and upon no other nominations being moved, by roll call vote, the motion carried.

E. DeRosa outlined the current representation on the Board's standing committees, which is as follows:

- Legal Committee: Aetna, DOBI, Horizon
- Technical Advisory Committee: AmeriHealth, DOBI, Horizon
- Marketing Committee: Horizon, United
- Operations & Audit Committee: C. Picklo, DOBI, United

J. Camargo asked to join the Marketing Committee, which has a vacancy.

S. Kelly made a motion, seconded by C. Picklo, to reconstitute the standing committees with their current representation, except that J. Camargo be added to the Marketing Committee. By roll call vote, the motion carried.

VI. Close of meeting

S. Kelly made a motion, seconded by C. Picklo, to adjourn the meeting. By roll call vote, the motion carried.

[The meeting ended at 11:35 A.M.]