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
November 12, 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 – October 8, 2019

T. Pownall made a motion, seconded by R. Morrow, to approve the minutes of the meeting of October 8, 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 November 2019 with expenses totaling $10,794.46 for the Board's share of staff salaries, and newspaper notices regarding the Board's scheduled CY2020 meeting dates. She stated that a transfer of $10,800.00 from the IHC Board's Wells Fargo Money Market account to its checking account would be necessary to pay the expenses.

S. Kelly made a motion, seconded by J. Camargo, to approve payment of the expenses reported, and the transfer of $10,800 from the Board's Wells Fargo Money Market account to its checking account to do so. By roll call vote, the motion carried.

Fourth Draft of Amendments to the IHC Policy Forms

E. DeRosa reported that the SEH Board voted at its October meeting to propose changes to its policy forms. She noted that the proposed amendments to the IHC and SEH policy forms are substantially similar, although a few points differ. E. DeRosa discussed each of the draft changes to the IHC policy forms the Board must consider, reminding Board members that a majority of the changes are being made to comply with P.L. 2019, c. 58 (Chapter 58), regarding mental health and substance use treatment parity. The following draft amendments were highlighted:

- Replacement of the term "mental illness" with "mental health condition" throughout, including a definition of the term that aligns with Chapter 58, which includes reliance on the Diagnostic and Statistical Manual, 5th edition (DSM-5).
- Amendment of the definition of developmental disability/developmentally disabled to recognize that there is no longer a distinction between developmental disabilities and neurodevelopmental disorders. She noted that neurodevelopmental disorders are addressed in the DSM-5.
- Addition of variable text to the definition of Generic Drugs to explain the concept of "authorized generic drug" – which is a designation by the FDA of a manufacturer's own brand alternative – and which carriers may classify as other than a generic drug for purposes of cost-sharing under the terms of the policy; carriers may elect whether to incorporate the variable text. E. DeRosa noted this proposed change was not made in the SEH forms, because the SEH forms do not include a definition of generic drug.
- Addition of a definition of "Same Terms and Conditions" applicable only to the treatment of Mental Health Conditions and Substance Use Disorder, to align with Chapter 58, which clarifies that the term addresses both quantitative and non-quantitative limits.
- Updating of the triggering events to align more closely with federal law, in particular with respect to amendments to federal rules effective as of August 2019 as well as June 2019 that address opportunities for enrollment when individuals become eligible for Individual Coverage Health Reimbursement Arrangements or Qualified Small Employer Health Reimbursement Arrangements.
- Removal of the compliance date with respect to coverage of donated human breast milk, because the date has passed.
- Removal of the requirement to provide a 96-hour prescription drug supply when prior authorization is required for a drug and had not yet been obtained, because it is generally agreed that the provision is unnecessary in the current technological environment. She noted that other than the standard plans text, no statute or regulation required carriers to cover such 96-hour supply.
- Revisions to clarify that coverage of physical, occupational and speech therapies to treat autism or other developmental disabilities is not addressed under the therapy services provision, but rather, is addressed under the specific provision regarding coverage of treatments for autism and other developmental disabilities.
- Revisions to the autism and other developmental disabilities provision to remove all visit limits and to clarify that pre-authorization for services is not required.
- Revisions to transplant services to:
    - Simplify the list of transplants while continuing to cover medically necessary transplants
    - Specifically remove autologous bone marrow transplants for treatment of breast cancer from coverage under the policies, because it is no longer an approved FDA protocol
    - Add language regarding coverage of hemopoietic stem cell transplants
- Removal of the exclusion of coverage of nicotine dependence treatment based on Chapter 58.
- Addition of variable text to permit carriers to cover immunizations administered at a pharmacy through either the medical benefits or pharmacy benefits of the plan. It was noted that there should be no difference in cost to the consumer.

- Removal of the stated exclusion of vitamins other than Legend Drug Vitamins, but maintenance of the second general vitamin exclusion (that never specifically addressed Legend Drug Vitamins) with an amendment to clarify that certain vitamins are covered as preventive care.
- Revision of premium payment language to make sentence construction passive and eliminate any reference to the premium payor.
- Amendments to the effective date of a voluntary termination request by the covered person to better align with the request made.

T. Taliaferro made a motion, seconded by C. Picklo, to propose the amendments to the policy forms as presented. By roll call vote, the motion carried, with R. Morrow abstaining.

E. DeRosa stated that, given the Board's vote to propose, she would immediately begin the process of seeking the additional approvals necessary to file the proposal with the Office of Administrative Law. She noted that many of the amendments are in effect through other laws already, so carriers should be complying with them already – for example, Chapter 58; P.L. 2017, c. 28 (regarding substance abuse disorder treatment); and, the federal rules regarding triggering events. She explained that some amendments will not be in effect until the Board ultimately votes to adopt the amendments – for example, the option to cover immunizations under either the medical benefit or the pharmacy benefit, and removal of the 96-hour prescription drug requirement.

IV. Close of Meeting

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

[The meeting ended at 10:45 A.M.]