FINAL
MINUTES OF THE MEETING OF THE
NEW JERSEY INDIVIDUAL HEALTH COVERAGE PROGRAM BOARD
HELD TELEPHONICALLY PURSUANT TO EXECUTIVE ORDER 103 (MURPHY)
April 13, 2021

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; Rosaria Lenox, Managing Financial Officer; 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.

E. DeRosa noted that, pursuant to P.L. 2020, c. 2, as a result of the public health state of emergency declared by Governor Murphy on March 9, 2020 through Executive Order 103, subsequently extended,[1] due to the COVID-19 pandemic, the IHC Board's regularly scheduled meeting was being held telephonically, and not at the Board's offices in Trenton. She stated that, in accordance with P.L. 2020 c. 11, electronic notice of the change in the meeting and the means by which the public could attend the meeting telephonically was posted on the Board's website, and issued electronically to all known interested parties.

E. DeRosa determined a quorum was present. She stated that voting would be by roll call.

Members of the public were asked to identify themselves; public attendees, if any, are identified at the end of these minutes.

II. Minutes – *March 9, 2021*

T. Taliaferro made a motion, seconded by T. Pownall, to approve the minutes of the meeting of March 9, 2021, without amendment. By roll call vote, the motion carried.

III. Report of Staff – *Expense Report; Enrollment Report; Financial Statements*

Expense Report

R. Lenox presented the expense report for April 2021, totaling $18,482.49, which amount includes $16,604.48 for salaries and shared expenses, $859.20 for WithumSmith+Brown (WSB) for FY20 audit costs, $903.84 for Admiral Consulting, which provides professional services related to the Great Plains accounting software, and $114.97 for legal notices in the newspapers related to the

[1] Executive Order 103 (Murphy) has been continuously extended multiple times since originally issued, the most recent extension occurring on March 17, 2021, pursuant to Executive Order 231 (Murphy).

IHC Board's recent rule proposal. R. Lenox explained that the costs for Admiral Consulting will be split among the IHC Program, the Small Employer Health Benefits (SEH) Program, and the Medicare Supplement Under 50 (MSU50) Program, but that the contract is between Admiral Consulting and the IHC Program, so the IHC Program will pay the full amount, and then obtain reimbursement from the SEH and MSU50 Programs. She stated that the Board can approve an internal transfer by the DOBI fiscal office of the amount due from the IHC Board's DOBI account to the SEH Board's DOBI account for the salaries and shared expenses. R. Lenox further explained that no transfer of funds to the IHC Board's Checking Account with Wells Fargo is needed to pay the remaining expense because in March, WSB was paid from the IHC Board's Money Market Account rather than its Checking Account, albeit inadvertently.

S. Kelly made a motion, seconded by C. Picklo, to approve the payment of the expenses related to salaries via a transfer by the DOBI of $16,604.48 from the IHC Board's account to the SEH Board's account within the DOBI, and the payment of the remaining expenses reported for April via the IHC Board's Wells Fargo Checking account. By roll call vote, the motion carried.

Enrollment Report
E. DeRosa presented the 4QCY2020 enrollment report, noting that the decline over the course of the year was much less relative to recent prior years, which was positive. She stated that the report has been posted on the IHC Board's webpages.

Financial Statements for the period ended December 31, 2020
R. Lenox presented the financial statements (previously reviewed by the Operations and Audit Committee), and provided a high-level discussion, among other things, noting that cash-on-hand totaled $311,128.79 at the close of December, and that, of the Board's budgeted amount for FY2021, totaling $305,030.80, the Board had $161,945.87 remaining after expenses were paid through December 31, 2020, suggesting the Board will likely end the fiscal year favorable to its budget. She presented and discussed the following for 2QFY2021:

- Statement of Financial Position
- Statement of Activities and Changes in Net Assets
- Statement of Cash Flows
- Comparison of Budget to Actual Expenditures

IV. Reinsurance Payment Parameters

E. DeRosa stated that, by statute, the Board is required to make recommendations for the upcoming benefit year's reinsurance payment parameters by April 30th in the current year. E. DeRosa explained that she discussed the requirement with the Commissioner of the Department of Banking and Insurance (DOBI) and P. Gennace about the need for the Board to delay making recommendations on the payment parameters due to the enactment on March 11th of the federal American Rescue Plan Act (ARPA), and continuing issuance of implementation guidance by the federal government, all of which will have an impact upon the dynamics of the individual market.[2]

[2] NB: among other things, the ARPA temporarily alters eligibility criteria for certain subsidies, allowing individuals with income above 400% FPL to obtain subsidy for the purchase of individual health plans (if eligible), and increases the subsidies for which individuals under 400% of FPL may be eligible when purchasing an individual health plan (possibly increasing choices for such consumers) through calendar years 2021 and 2022. ARPA also deems certain individuals eligible for unemployment to be eligible for cost-share reduction subsidies (through the end of December 2021), while also allowing some COBRA-eligible individuals,

She noted it had been surmised there would be no harm in waiting slightly longer to have the benefit of additional information from the federal government. She acknowledged that the carriers would need to know the payment parameters soon in order to file rates for 2022, but noted that the date for filing rates for 2022 had not yet been determined.

E. DeRosa reminded the Board that it had maintained the same parameters for 2020 as for 2019, because there was no additional information available from one year to the next for the Board to consider. She further explained that the Board recommended revised reinsurance payment parameters for the current benefit year, with the payment parameters for 2021 including an attachment point of $35,000; coinsurance at 50%, and a reinsurance cap at $245,000.

In response to questions, P. Gennace acknowledged the DOBI is again seeking input from an outside actuarial firm, and is specifically requesting additional information regarding ARPA before presenting the relevant actuarial information to the Board, and seeking a recommendation from the Board on the payment parameters for 2022.

V. COVID-19 Special Enrollment Period (SEP)

E. DeRosa explained that the recent news release from Governor Murphy regarding the extension of the COVID-19 SEP from May 1, 2021 through the end of the calendar year specifically mentioned that the State-Based Exchange (GetCovered NJ) would allow for uninsured individuals otherwise eligible for the individual market to apply for coverage through GetCovered NJ. She further explained that the DOBI has, as of April 12, 2021, released Bulletin 21-07, indicating that the COVID-19 SEP applies with respect to individual health benefits plans offered without subsidies outside of GetCovered NJ, as well as any individual health benefits plans offered through GetCovered NJ, until November 30, 2021. She noted that Bulletin 21-07 clarifies that individuals already covered must be given the opportunity to change plans if they wish to do so.

A Board member commented that an application submitted during November could be for either the open enrollment period, for which the effective date of coverage would be January 1, 2022, or for a December effective date if the applicant is submitting it as a COVID-19 SEP, and it was agreed that there would need to be a means for applicants to indicate the intended effective date.

VI. Rule Proposal/Draft Notice of Adoption

E. DeRosa reported that no one from the public attended the public hearing on the proposed amendments to the standard health benefits plan policy forms, but that timely written comments were received from the New Jersey Association of Health Plans. She summarized the comments and the draft responses:

- One comment objected to the proposed amendment to the Payment of Premiums-Grace Period provisions of the form, which removed text that could be interpreted to limit the entities from whom the carrier was required to accept premium payments on behalf of the insured/covered person. Specifically, the commenter stated that it objected to the removal of the term "you" from that provision – the term being defined in the policy forms as

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and individuals eligible for state-mandated continuation coverage the ability to continue coverage through their employer's plan for free for up to six months (April through September 30, 2021). In addition, a special open enrollment period is in effect through November 30, 2021 for enrollment in individual plans. These and other factors create more uncertainty regarding the composition/risks of those that will enroll and renew enrollment in the individual market in 2022.

meaning specifically the policyholder – in favor of more passive, and less proscriptive phraseology that would appear to require carriers to accept payments from third parties without limitation. The drafted response notes that the Board discussed the issues with the Grace Period provision during three separate Board meetings, and elected to revise the phraseology with the intention of clarifying that carriers should be accepting payments from parties in addition to the policyholder when required by law or otherwise appropriate (for example, from family members). The draft response notes that carriers are required to accept third party payments in particular situations pursuant to 45 C.F.R. 156.1250, and even prior to that rule, were obligated to accept payments from Medicaid when Medicaid determined it was in the best interest of the Medicaid program to pay premiums to maintain coverage for individuals under private insurance.

- One comment sought clarification whether the Board's interpretation of P.L. 2019, c. 361 specifically regarding coverage of contraceptives without cost-sharing: (1) would allow carriers to exclude certain contraceptive drugs, devices or products so long as coverage is provided for a therapeutic class for that drug, device or product; or (2) would still require carriers to cover all such items, subject to cost-sharing. The draft response noted that P.L. 2019, c. 361 requires coverage of <u>either</u> the requested contraceptive drug, device or product, <u>or</u> the therapeutic equivalent, and further, that the law requires coverage of such without cost-sharing. The draft response notes that the statute permits a closed formulary, but that New Jersey also has rules at N.J.A.C. 11:22-5 that prohibit closed formularies. The draft response suggests that, consequently, both the requested drugs, devices and products <u>and</u> their therapeutic equivalents must be covered, but that those required to be covered pursuant to P.L. 2019, c. 361 must be covered with no cost-sharing, while all other drugs, devices and products would still be covered under the terms of the prescription drug benefit.[3]

With respect to the third-party payment comment and response, one Board member suggested that some guardrails be introduced to make it clearer for carriers regarding which third party payments they must accept. There was some discussion of whether this should be in the policy forms or the rules, and E. DeRosa reminded the Board that it had previously discussed and rejected putting the standards in the policy forms. She also noted that the mention of 45 C.F.R. 156.1250 was meant to provide some standards for reference because it identifies specific circumstances in which third party payment must be accepted, and may allow some inferences of when third party payment need not be accepted.

With respect to the contraceptive issue, E. DeRosa noted that, because of prior statutory contraceptive mandates under New Jersey and federal law, the Board previously removed contraceptives from the prescription drug benefit provisions, and set them into their own provision. But she stated that the P.L. 2019, c. 361 mandate makes it necessary for some aspect of the contraceptive drug coverage to be "returned" to the prescription drug benefits when not otherwise covered pursuant to the contraceptive provisions. There was some agreement among the Board members that the carrier representatives should further discuss P.L. 2019, c. 361 and the comment raised within their companies to better understand how the benefits have been administered before taking action on the draft adoption.

[3] 42 U.S.C. 300gg-13(a)(4), addressing preventive services at no cost share, remains applicable.

The Board agreed to meet again on April 29 at 11:00 A.M. for the purpose of further discussing the comments and responses, and to possibly take action to adopt the proposal.

VII. 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 11:10 A.M.]

Identified Public Attendees:
No members of the public identified themselves as participating in the meeting.