MINUTES OF THE OPEN SESSION MEETING OF THE
NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM BOARD
AT THE OFFICES OF THE
NEW JERSEY DEPARTMENT OF BANKING AND INSURANCE
TRENTON, NEW JERSEY
April 16, 2014

Members present: Herbert Ames; Charles Cerniglia (Oxford); Gary Cupo; Margaret Koller; Mary Ellen Peppard *(arrived at 10:20)*; Nicholas Peterson (Horizon); Thomas Pownall (Aetna Health Inc.); Gale Simon (DOBI); Christine Stearns *(arrived at 10:15)*; Dutch Vanderhoof *(arrived at 10:20)*.

Others participating: Ellen DeRosa, Executive Director; Chanell McDevitt, Deputy Executive Director; Rosaria Lenox, Program Accountant.

I. Call to Order

E. DeRosa called the meeting to order at 10:10 A.M. E. DeRosa announced that notice of the meeting was provided to three newspapers and the State House Press Corps, and posted at the Department of Banking and Insurance ("DOBI"), the DOBI website, and the Office of the Secretary of State in accordance with the Open Public Meetings Act. A quorum was present.

II. Change in Board Membership

E. DeRosa acknowledged that Gale Simon, Assistant Commissioner of Enforcement & Consumer Assistance, will be serving as the designee of the Commissioner of the Department of Banking and Insurance.

E. DeRosa also announced that Dr. Niranjan Rao resigned as a representative of physicians. She reminded Board members that the position is appointed by the Governor, with consent of the Senate.

III. Public Comment

There were no public comments.

IV. Minutes – *March 19, 2014*

D. Vanderhoof made a motion, seconded by T. Pownall, to approve the minutes of March 19, 2014. The motion carried.

V. Staff Report

Expense Report

R. Lenox presented the expense report for April, with expenses totaling $3592.44, for charges attributable to the Division of Law and to Admiral Consulting Group, which provides support for the accounting software. She recommended a transfer of funds totaling $3,600 from the Board's Wells Fargo Money Market Account to pay these expenses.

G. Cupo made a motion, seconded by D. Vanderhoof, to approve the payment of the expenses on the April expense report, and to approve the transfer of funds from the Board's Wells Fargo Money Market Account to its Wells Fargo Checking Account for the purpose of paying the expenses approved. The motion carried.

Reconciliation of Administrative Expense Assessments for Fiscal Years 2012 and 2013
R. Lenox reported that the Board had collected all monies due to it as part of the reconciliation process ($13,969.61), and recommended now transferring $47,500 from the Board's funds with the DOBI to the Board's Wells Fargo Checking Account so that staff may issue refunds to those carriers to which funds are due under the reconciliation. R. Lenox also suggested that it would be prudent to transfer $150,000 from the Board's funds with the DOBI to the Board's Wells Fargo Money Market Account to earn interest on the assessment funds collected with respect to the fiscal year 2015 budget.

T. Pownall made a motion, seconded by C. Stearns, to approve the transfer of $47,500 from the Board funds with the DOBI to the Board's Wells Fargo Checking Account for the purpose of refunding carriers in accordance with the 2012 and 2013 final administrative reconciliations, and to transfer $150,000 from the Board's funds with the DOBI to the Board's Wells Fargo Money Market Account for the purpose of earning interest on the assessment funds collected for 2015.

Quarterly Enrollment Reports
E. DeRosa stated that the Board needs to consider updating its form for quarterly enrollment reporting form, and presented draft revisions to the Board. She noted that the existing form would need to remain in effect to capture pre-2014 plans. She further explained that new forms are needed for plans newly offered beginning in 2014, to capture some of the different plan designs, including capturing information specifically for EPO products separately from PPO/POS products, and HMO POS separately from HMO products, as well as actuarial value groupings, and the number of plans sold that are HSA-compatible. Because it was suggested that carriers report the number of employees and dependents covered (as well as employers), if carriers are able to do so, carriers on the Board were given the task of checking when carriers not already able to report this information could reasonably expect to do so.

SEH Buyer's Guide and FAQs
E. DeRosa stated that a revised version of the SEH Buyer's Guide had been posted to the Board's website, along with revised Frequently Asked Questions. She noted a few of the topics about which she is often receiving questions:

- There is an (inaccurate) assumption that when an employer that is ineligible for small employer coverage hires an employee, the employer will automatically become eligible to purchase small employer coverage. She explained that the assumption is inaccurate because the determination of small employer eligibility has been and continues to be based on size of the employer on business days in the preceding calendar year in accordance with HIPAA.
- There is an (inaccurate) assumption that independent contractors being dropped from small employer groups are eligible for a continuation election. She explained that the

assumption is inaccurate because these covered lives do not incur a qualifying event that would create a right to a continuation election (they are not being laid off or having their hours reduced below benefit eligibility); their option is to seek coverage through the IHC market (with or without subsidy).

- It continues to be an open question whether owners of a C-corporation are also employees for purposes of determining eligibility of the small employer to purchase small employer coverage because of lack of federal guidance. She explained that CMS acknowledged that its prior guidance suggesting that such owners are also employees for this purpose was premature.

The question arose as to what the SEH Board's position is regarding Professional Employee Organizations (PEO, a.k.a., employee leasing companies). It was pointed out that federal Department of Labor rules classify the PEO as the employer of leased employees. She noted that the application for insurance has questions on it that address the involvement of a PEO.

E. DeRosa stated that she has received some inquiries about the reasonableness of carrier requests for information and documentation, and thus far, the requests have seemed reasonable. She pointed out that reference to *bona fide* employees generally means *paid* employees, and to the extent minimum wage applies, the pay should have to be at least minimum wage.

E. DeRosa also pointed out that the SEH website now includes a terrific calculator for employers.

Participation Standard Waiver
E. DeRosa stated that another company submitted a filing seeking waiver of the standard participation requirement.

[N. Peterson recused himself from discussion and any potential action to be taken on the filing submitted by Horizon because of the interest of his employer in the outcome of any such discussion and action.]

E. DeRosa explained that Horizon proposed to accept whatever participation level the employer presented under the special circumstances outlined in Bulletin 14-SEH-01. She noted that the waiver request is substantially similar to that filed by Oxford, and recommended approval of it.

D. Vanderhoof made a motion, seconded by T. Pownall, to approve the requested waiver. The motion carried.

Draft proposed amendments to policy forms
E. DeRosa explained that a few more changes to the policy forms are appropriate to assure compliance with P.L. 2013, c. 196 (revising the existing mammography benefit somewhat), and to make the definition of small employer in the policy forms consistent with the definition contained in the rules currently. She noted that she believes carriers could use the compliance and variability rider to comply with the changes if they prefer not to reissue contracts. She stated that the mammography changes will take effect as of 5/1/2014 (applying to new business as of that date, and to business as it renews on and after that date).

C. Stearns made a motion, seconded by T. Pownall, approving the proposed policy form amendments, as drafted, and use of the expedited rulemaking procedure. The motion carried.

VI. DOBI Loss Ratio and Refund Report for 2012

Avnee Parekh presented the 2012 Loss Ratio and Refund report to the SEH Board. She noted that: the report is public information; it will be posted on the SEH website shortly; and, it is based on calendar year 2012 data filed in reports that were due in August of 2013. A. Parekh highlighted the following:

- Total premium for 2012 was about $3.22 billion, basically equal to the premium for 2011, but down from almost $3.4 billion in 2010.
- Average enrollment declined from 717,000 to 687,000.
- The loss ratio for the market (before refunds) was 81.4%.
- CIGNA Healthcare, Horizon Healthcare, Oxford Health Insurance and Oxford Health Plans paid refunds for their standard plans (including Purchasing Alliance business for Oxford Health Plan). CIGNA's loss ratio was very low (27%), but its data is volatile due to very small enrollment numbers.
- The total refunds were about $34 million for the standard plan market.
- The average loss ratio for the non-standard market was 93.9% (before refunds). Aetna Life and Horizon Healthcare paid refunds on their nonstandard business, totaling about $363,000. MEWA business was not included in any of the statistics for the nonstandard market.
- Average premiums in 2012 were $390 per person per month, which represented a 4.3% increase over the prior year; there is an assumption that this lower increase in premiums is due in large part to employers continuing to shift more cost to employees, and greater penetration of closed network products.

VII. Finance & Audit Committee (FAC) Report

R. Lenox presented the financial statements for the 2nd quarter (ending December 31, 2013) of fiscal year 2014, including the Statement of Net Assets, Statement of Changes in Net Assets, Statement of Cash Flows, and Comparison of Actual Expense to Budget. She noted that the Board is running under budget thus far, although she expects that the cost of fringe benefits will be over budget for FY2014. She reported that the FAC had agreed to accept estimations of Legal expenses on quarterly reports (with appropriate adjustments when actual expenses are known), in order to speed up the process of preparing and reviewing quarterly financial statements.

VIII. Out-of-Network Reimbursement Methodology

The Board acknowledged that the data it has is dated, and determined that it would like to collect more recent data on utilization patterns of out-of-network benefits. The Board determined it would follow the track of the IHC Board in requesting that carriers sitting on the Board provide data from calendar year 2012 and 2013 individual and group claims regarding payment to

providers outside of the network, excluding payments made for in-plan exceptions and emergency services. The Board determined it would establish an ad hoc committee to analyze the data collected, probably at its May meeting, with the expectation that the data would not be available until June. There was some discussion about stakeholder meetings, but agreement that such meetings would not occur until after the data has been collected and analyzed.

IX. Public Comment

A member of the pubic asked whether carriers would accept a husband-wife formed C-corporation (with no other employees) as a small employer and provide small employer coverage to the couple given the current lack of federal governance to the contrary. Various Board members acknowledged that it was not clear how carriers may decide to address these situations.

A member of the public suggested being cautious in relying on the minimum wage to prove that someone is an employee, because not everyone is required to be paid at the prevailing minimum wage. He suggested referencing the Fair Labor Standards Act.

A member of the public asked whether instructions would be forthcoming with respect to the revised Employer Certification form, noting that there is confusion about how to complete it, particularly with respect to Part B (using the federal definition of small employer). He stated that some carriers are requiring that there be at least one employee working 30 hours/wk even though the form (and rules) do not specify it. In addition, there are questions as to who counts in terms of meeting participation. E. DeRosa suggested this may be something for the Legal Committee to consider, and she requested that commenter (and other interested parties) submit details of scenarios.

A member of the public indicated that there are some carriers that are not handling requests from new businesses correctly. He stated that federal law only requires a new employer to provide employment numbers based on a *reasonable expectation* of the business' needs for the calendar year, but that some carriers are refusing to consider such employers. E. DeRosa confirmed that the federal law establishes the reasonable expectation standard so that newly-established businesses have an opportunity to qualify for small employer coverage, and that the standard has been in existence for many years (the standard having been established by HIPAA, not the ACA).

X. Close of Meeting

G. Cupo made a motion, seconded by T. Pownall, to adjourn the meeting. The motion carried.

[The meeting adjourned at 12:05 P.M.]