FINAL
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
September 16, 2015

Members participating: Herbert Ames; Gary Cupo; Patrick Gillespie (Cigna); Margaret Koller; Lisa Levine (United/Oxford); Avnee Parekh/Brendan Peppard (DOBI); Nicholas Peterson (Horizon); Ryan Petrizzi (AmeriHealth); Thomas Pownall (Aetna Health Inc.); Dutch Vanderhoof.

Others participating: Ellen DeRosa, Executive Director; Chanell McDevitt, Deputy Executive Director; Rosaria Lenox, Program Accountant; Eleanor Heck and Ryan Schaffer, Deputy Attorneys General.

I. Call to Order

E. DeRosa called the meeting to order at 10:05 A.M. She announced that notice of the meeting was provided to two newspapers of general circulation and the State House Press Corps, and posted at the Department of Banking and Insurance ("DOBI"), on the DOBI website, and at the Office of the Secretary of State in accordance with the Open Public Meetings Act. Following a roll call, she determined there was a quorum present, and stated that all votes would be by roll call because some of the Board members were participating by phone.

II. Public Comment

There were no public comments.

III. Minutes – *June 17, 2015*

P. Gillespie made a motion, seconded by T. Pownall, to approve the minutes of June 17, 2015. By roll call vote, the motion carried.

IV. Staff Report

Expense Report – September

R. Lenox presented the September expenses, totaling $830, primarily for services from the Division of Law, and one public notice. She noted that the Board would need to transfer $900 from its Wells Fargo Money Market account to pay for the expenses.

D. Vanderhoof made a motion, seconded by P. Gillespie, to approve the September expense report, and the transfer $900 from the Board's Wells Fargo Money Market account to the Board's Wells Fargo Checking account to pay the September expenses. By roll call vote, the motion carried.

Draft Rule Proposal – Policy Forms

E. DeRosa explained the proposed amendments in the draft presented to the Board, noting that some of the proposed amendments were necessitated by changes or clarifications in federal regulations, while some were requested by carriers, or made common sense for practical administration of the policies. She noted the following:

- CMS revised its rules regarding pediatric dental and pediatric vision coverage, specifying that coverage under either set of services should end at the end of the month in which a young adult becomes 19 years old (not upon the person's birthdate), requiring the policy forms for the standard plans to be revised accordingly.
- The draft revises the maximum out-of-pocket (MOOP) single person limit, which, per federal law, increases for 2016 to $6850.
- The draft includes a proposal to permit carriers to provide coverage for telemedicine/e-visits/virtual visits (and remove the exclusion of telephone conferences), at the suggestion of three different carriers. E. DeRosa noted that she drafted text allowing carriers to have language mentioning the service option even if it is only an enhanced benefit (i.e., there is no cost-sharing), as well as variable text to permit carriers to have cost-sharing for the visits, should the carrier choose to offer the plan that way. She explained that cost-sharing would be subject to the co-payment permitted for a PCP visit.
- The draft includes variable text regarding the grace period and reinstatement provisions to accommodate differences in administration of the policies offered through the SHOP, and those offered outside of the SHOP. She explained that, because of SHOP administrative issues, coverage under small employer plans offered through the SHOP will terminate as of the paid-to date if no payments are received by the end of the grace period (meaning, termination occurs just prior to the start of the grace period); whereas, the standard plans offered to small employers normally terminate as of the end of the grace period if required payment is not received.
- The draft includes revisions to the participation calculation. E. DeRosa explained that the SHOP currently uses a calculation method that differs significantly from the calculation method used outside the SHOP, but that, as of 2016, the SHOP will use a more typical calculation, consistent with what New Jersey has been doing for non-SHOP standard plans. She further explained that, in addition to altering the calculation, the SHOP also provides credit for anyone covered under an individual plan, which the draft proposal would include.
- The draft includes a proposal to add variable text by which carriers may end coverage for dependents aging-out as of the end of the month, rather than upon the dependent's birthdate, in order to reduce forced gaps between coverage for young adults. She explained that carriers would not be required to change their business rules to end coverage at the end of the month, but believed some would want to do so.
- The draft includes specific examples of covered habilitative devices, including walkers, wheelchairs, and hearing aids. She explained that the services are already covered by the standard plans, and thus, no new benefit is created, but that CMS is specifically trying to

verify that plans cover both habilitative services and devices, so adding the examples will make verification easier for them, and result in fewer questions and red flags from them.

- The draft adds language establishing that court orders requiring coverage of a dependent create a triggering event, with the coverage effective date for the person to be covered established by the terms of the court order, or the court order's effective date if its terms do not specify otherwise. E. DeRosa explained that, as a triggering event, there is a 60-day period within which a person may make a plan choice, which may result in backdating of coverage effective dates in some instances.
- The draft includes a proposed relocation and revision of language regarding the explanation of the plan when offered as a high deductible health plan (HDHP) that can be combined with a health savings account. E. DeRosa explained that the federal government had revised its explanation of how the accumulation of expenses should be administered for other-than-single-person HDHPs. The proposed revised language assures that the MOOP for other-than-single-person coverage applies on a per covered person basis, with the allowable costs for all covered persons accumulating towards the family MOOP (meaning that individuals can come into full benefit even if the family MOOP is not met). After some discussion, it was agreed that further clarifications were needed to assure that it was clear that there was a change in administration of the MOOP, but not the deductible for HDHPs.
- The draft makes prior approval for fertility treatment variable rather than mandatory. E. DeRosa further explained that the draft proposal also includes a proposed rider that would be used by carriers to assure compliance with New Jersey's infertility treatment mandate in 2016 when the definition of small employer is scheduled to include employers with up to 100 full-time employees. She noted that carriers would have to add the rider to any standards plans sold to employers with 51 to 100 employees, but that carriers could choose to simply offer the rider to employers with 1 to 50 employees. She also explained that the draft includes variable text to accommodate religious employers (of any group size), allowing certain procedures to be excluded from coverage. It was noted that the draft is consistent with DOBI Bulletin 2002-09, regarding administration of infertility benefits.

There was agreement that the Board was not prepared to discuss changes to the definition of small employer size and count. It was acknowledged that there was a bill in Congress to revise the federal definition so small employer would be groups of 1 to 50 employees, but which would allow states to define small employer as larger groups, in a state's discretion. It was also acknowledged that most members of the SEH Board believed the bill has momentum, and will be signed by the President if passed out of Congress. It was acknowledged that if the bill was enacted, the SEH Board would not need to make a change with respect to small employer group size, and would not need to adopt the rider for treatment of infertility.

E. DeRosa explained that she believed it was reasonable for carriers to use the Compliance and Variability Rider to make the 2016 changes, and postpone re-issuing all new plans until 2017. She explained that the Board would need to use its expedited rulemaking authority, and would likely be in a position to adopt the proposed amendments at the October Board meeting.

P. Gillespie made a motion, seconded by R. Petrizzi, to approve the draft for proposal, with modifications as needed to clarify the language for the HDHP compatible with a Health Savings Account. By roll call vote, the motion carried.

V. Report of the Finance & Audit Committee (FAC)

R. Lenox reported that the FAC met to review and discuss the financials for the fiscal year ended June 30, 2015, as well as the Management's Discussion and Analysis (MDA), and had recommended presentation of all of the information to the Board. R. Lenox presented the MDA, noting the following:

- Total assests and liabilities increased by $148,790 from FY 2014 to FY2015 largely due to the receipt from carriers for the FY2016 administrative assessments during FY2015 (for the budgeted amount of $289,350).
- Total expenses increased by $1,118 from 2014 to 2015 primarily due to chargebacks from the Department for overhead.
- Nevertheless, total actual expenses were favorable as compared to budgeted expenses by about $71,000 primarily because of a decrease in salaries and fringe (based on a reduction in staff for FY2015).

She then briefly discussed the Statement of Net Assets, Statement of Changes in Net Assets, Statement of Cash Flows and the Comparison of Budget and Actual Expenditures. R. Lenox also stated that the auditors are expected to commence work on FY2015 in October.

VI. Annual Election of Officers; Reconstitution of Committees; Election of Small Employer Representative

Chair & Vice Chair

T. Pownall nominated T. Taliaferro and M. Koller to continue in their current positions as Chair and Vice Chair, respectively, for an additional year. There were no other nominations, and upon a roll call vote, T. Taliaferro and M. Koller were re-elected.

Standing Committees

The composition of the committees during the preceding 12 months has been as follows:

Finance & Audit Committee: AmeriHealth, Herbert Ames, DOBI, Horizon, Margaret Koller, and United

Legal Committee: Aetna, AmeriHealth, DOBI, Horizon, Dutch Vanderhoof

Marketing Committee: Gary Cupo, Horizon, Margaret Koller, United, Dutch Vanderhoof

United asked to be added to the Legal Committee, and AmeriHealth asked to be added to the Marketing Committee.

B. Peppard made a motion, seconded by H. Ames, to reconstitute the committees as is for another year, with the addition of United to the Legal Committee, and the addition of AmeriHealth to the Marketing Committee. By roll call vote, the motion carried.

Small Employer Representative

C. McDevitt reminded the Board that it was originally scheduled to hold a vote at its August meeting regarding a vacancy in its small employer representation, but that such vote did not take place because the meeting was cancelled. She stated that there were completed ballots received timely prior to the scheduled August meeting, and asked whether any eligible carrier wished to take the opportunity to vote in person at the current meeting. Upon determining that there were no other eligible carriers seeking to cast a ballot, she stated that, based upon the ballots previously received, Matt Malat was elected to serve as a small employer representative for the duration of the term vacated by Mary Ellen Peppard (ending 5/2017).

VII. Rates and marketing

Avnee Parekh stated that the DOBI had advised carriers that they are not permitted to send out or advertise their rates for renewal (or new business) until CMS gives the go-ahead, which the DOBI expects to be in the second week of October, but acknowledges could be later, and clarified that the opportunity to start sending out quotes and other advertising is tied to the event, not a specific date. She stated that the DOBI is holding carriers offering plans off the Marketplace to the same standard that applies to carriers offering plans on the Marketplace. It was noted that the shopping window for Healthcare.gov is expected to go live October 15th.

VIII. Public Comment

There were no public comments.

IX. Close of Meeting

B. Peppard made a motion, seconded by R. Petrizzi, to adjourn the meeting. By roll call vote, the motion carried.

[The meeting adjourned at 11:40 A.M.]