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 8, 2015

Directors participating: Sandi Kelly (Horizon); Lisa Levine (United/Oxford); Brendan Peppard (DOBI); Ryan Petrizzi (AmeriHealth); Thomas Pownall (Aetna).

Others participating: Ellen DeRosa, Executive Director; Chanell McDevitt, Deputy Executive Director; Rosaria Lenox, Program Accountant; and 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. E. DeRosa announced that notice of the meeting had been published in two newspapers of general circulation and posted at the Department of Banking and Insurance ("DOBI"), on the DOBI website, at the Office of the Secretary of State, and submitted to the State House Press Corps, 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. Minutes – *June 9, 2015*

T. Pownall made a motion, seconded by B. Peppard, to approve the minutes of the June 9, 2015 Board meeting. In voting by roll call, the motion carried.

III. Staff Report

Expense Report – September

R. Lenox presented the expense report for September, totaling $30,435.12, noting that the majority of it was payment to the Small Employer Health Benefits Program for the IHC Board's share of staff salaries and fringe, but that there were also expenses from the *Courier Post* for the notice required for the most recent rule proposal, and expenses from the Division of Law. She explained that the Board would need to transfer $30,000 from its Wells Fargo Money Market Account to its Checking account to pay for the operating expenses, should the Board approve them.

S. Kelly made a motion, seconded by T. Pownall, to approve the September expense report, and the transfer of $30,000 from the IHC Board's Wells Fargo Money Market account to its Wells Fargo Checking account for the purpose of paying the September operating expenses. In voting by roll call, the motion carried.

Policy Forms – Proposed Amendments Draft

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 is also the deductible for Catastrophic Plans), 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, 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. After discussion, the Board agreed the definition of e-visits should be revised to remove language that indicated the service may not be used for emergency or urgent treatments.
- 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. A question arose regarding bracketed language addressing child dependent qualifications, and E. DeRosa explained that New Jersey has a more expansive definition of dependent in the individual market than is used elsewhere. She reminded the Board that this is the IHC Program's "Rita Rondum" rule which has been in place for 20+ years (Rita Rondum being one of the initial public representatives on the IHC Board).
- 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 includes a revision to the definition of "eligible person" to be consistent with the federal law. E. DeRosa explained that New Jersey law has traditionally defined an eligible person as someone who is not eligible for Medicare, while the federal law limits eligibility to people not enrolled in Medicare, which is a different status. She noted that the HINT enrollment form for 2016 asks whether a person is <u>covered</u> by Medicare in order to be consistent with this change. She acknowledged that, while Medicare-eligible individuals have the right to purchase an IHC plan under federal law, doing so may prove

problematic for them because the IHC standard plans pay secondary to Medicare Part B, whether or not someone eligible for Medicare actually enrolls in Medicare. She pointed out that, in addition, people who do not sign-up for Medicare when first eligible incur waiting periods and surcharges when they actually become enrolled in Medicare.

- 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 still 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, in order to reduce the disincentive for families to cover multiple people under one HDHP. 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).
- The HMO standard policy form contains a draft amendment changing the term "PCP" to mean a "primary care provider" (rather than a primary care physician) to be consistent with New Jersey rules and the other policy forms.

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 could wait until it had adopted the changes to determine how long carriers could use the Compliance and Variability Rider for new business in 2016.

S. Kelly made a motion, seconded by R. Petrizzi, to approve the draft with changes as discussed for proposal. By roll call vote, the motion carried.

IV. Annual Election of Officers and Designation of Committees

Chair: T. Pownall nominated S. Kelly to serve as Chair for an additional year. There were no other nominations, and by roll call vote, S. Kelly was elected.

Vice Chair: S. Kelly nominated T. Pownall to serve as Vice Chair for an additional year. There were no other nominations, and by roll call vote, T. Pownall was elected.

The standing committees are composed of the Board members as follows:

- Technical Advisory Committee – AmeriHealth, DOBI, Horizon
- Legal Committee – Aetna, DOBI, Horizon
- Marketing Committee – Horizon, Oxford
- Operations & Audit Committee – Aetna, DOBI, Oxford

It was noted that Christine Stearns previously participated on the Marketing Committee, and that with her resignation, there is a vacancy. AmeriHealth volunteered to fill the position.

S. Kelly made a motion, seconded by B. Peppard, to reconstitute the standing committees as they currently exist, with the addition of AmeriHealth as a participant on the Marketing Committee. By roll call vote, the motion carried.

V. Reports of the Operation and Audit Committee (OAC) – *End of Fiscal Year 2015 Financials and Management's Discussion and Analysis (MDA)*

R. Lenox presented the MDA, noting the following:

- The IHC Program's assets and liabilities increased from the prior fiscal year primarily due to an increase in Accounts Receivable and deferred income related to the 2016-2017 administrative assessments
- The Program continues to have restricted cash and restricted net assets related to the 1997/1998 and 1999/2000 calculation periods.
- The FY2014 audit was completed and an unqualified opinion was issued by Withum Smith+Brown
- The IHC Program continued to operate NJ Protect (a pre-existing condition plan program) in accordance with the contract with the U.S. Department of Health and Human Services, receiving $30,500,000 to cover claims incurred, and transferring an equivalent sum to the issuing carriers.

R. Lenox also discussed the June 30, 2015 financial statements for the IHC Program, including the Statement of Net Assets, the Statement of Changes in Net Assets, the Statement of Changes in Assets and Liabilities for the Loss Assessment Fund, the Statement of Cash Flows, and the Comparison of Budget and Actual Expenditures. She noted that the Program ended the fiscal year in a favorable position by $67,562.33.

VI. Individual Plan Effective Dates Outside of the Marketplace

E. DeRosa reminded the Board members that carriers need to continue to work towards accommodating effective dates to avoid gaps in coverage between policies when such gaps are not the result of inaction or inattention on the part of the covered person. She noted that there continue to be issues with gaps occurring when prior coverage terminates due to exhaustion of a COBRA election, aging-out, or group coverage ending, and that such gaps are not necessary outside of the Marketplace. She referred members to the advisory letter previously sent to carriers, dated 9/15/14, and included in their Board packets.

VII. Close of Meeting

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

[The meeting adjourned at 11:31 A.M.]