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
May 10, 2016

Directors participating: Sandi Kelly (Horizon); Cheryle Lawson (Aetna); Lisa Levine (United/Oxford); Brendan Peppard (DOBI); Tony Taliaferro (AmeriHealth)

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

I. Call to Order

E. DeRosa called the meeting of the IHC Board to order at 10:02 A.M. E. DeRosa announced that notice of the meeting had been published in three 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 – *April 12, 2016*

B. Peppard made a motion, seconded by S. Kelly, to approve the minutes of the April 12, 2016 Board meeting. By roll call vote, the motion carried.

III. Staff Report

Expense Report/Transfer of Funds

R. Lenox presented the expense report for May, totaling $10,687.41, solely for the IHC Board's share of salaries and fringe, to be paid to the Small Employer Health Benefits (SEH) Program. She explained that the Board needs to transfer $11,000 from its Wells Fargo Money Market Account to its Wells Fargo checking account in order to pay the expenses, if approved.

S. Kelly made a motion, seconded by B. Peppard, to approve payment of the May expenses, and authorizing the transfer of $11,000 from the Board's Wells Fargo Money Market Account to the Board's Wells Fargo checking account to pay the approved expense. By roll call vote, the motion carried.

III. Report of the Operations and Audit Committee (OAC) and the Technical Advisory Committee (TAC)

S. Kelly reported that both the OAC and the TAC met separately to discuss the final administrative assessment for the 2014/2015 two year calculation period. She explained that the audit for the calculation period had been completed, allowing the reconciliation to be performed. She further explained that the original assessment for the calculation period was based on information from the Exhibit K's submitted for the 2011/2012 period, while the final assessment

is based on information from the Exhibit K's submitted for the more recent 2013/2014 period. She stated that the final assessment would result in a refund to carriers of $151,265.39, including interest of $1,289.73, while carriers would be invoiced for $5,631.37. S. Kelly stated that both the OAC and the TAC recommended the Board authorize staff to proceed with issuing the final assessment, and that it was suggested the Board approve the transfer of funds from Treasury to pay the refunds owed to carriers rather than wait for collections of the amounts due from the carriers, because the amount to be collected does not cover the amount that is to be refunded.

S. Kelly also noted that both the OAC and TAC discussed giving carriers who are owed a refund the option of applying refund amounts as credits against future year assessments in the event the amount owed to the carrier is "nominal." She explained that the committees discussed checks for small amounts because the final administrative assessment shows amounts due for as little as $.85. The Board has issued checks for small amounts in the past and had to follow-up with some carriers multiple times in order to get the carriers to cash the checks. S. Kelly stated that the OAC discussed the matter first, and recommended that "nominal" be amounts of $15 or less, while the TAC later suggested that "nominal" be an amount as great as $50.

S. Kelly made a motion, seconded by T. Taliaferro, to: approve the final administrative assessment for the 2014/2015 two year calculation period; authorize the transfer of $152,000 from the administrative fund in Treasury to the Board's Wells Fargo Checking Account for the purpose of issuing refunds to carriers to which refunds are due in accordance with the final administrative assessment for 2014/2015; authorize staff to issue payment of the refunds due, and collection of funds owed by carriers to the IHC Program in accordance with the final administrative assessment for the 2014/2015 calculation period; and, authorize staff to provide carriers to which refunds in the amount of $50 or less are owed the option to request that the refund be held as a credit on behalf of the carrier against any future amounts that may be assessed by the IHC Program against the carrier. By roll call vote, the motion carried.

IV. Discussion of Possible Amendments of IHC Rules

E. DeRosa explained that the SEH Program rules are scheduled to expire in August 2016 and as a result the SEH Board has been discussing various amendments to include in the proposal readoption. She explained that while the IHC Program rules are not yet expiring the Board may want to consider a rule proposal this year that would include some of the same amendments the SEH Board is considering. The Board went on to discuss the following possible amendments:

- Changing the Board's voting requirements that currently require 5 affirmative votes for certain actions, to require a majority of the Board for such actions.
- Deletion of N.J.A.C. 11:20-24.5, which requires carriers to reimburse certain out-of-network expenses at the 80th percentile of the PHCS or at billed charges, whichever is less. With the requirement deleted a carrier would designate the basis the carrier believes is appropriate just as carriers do in the large group market in New Jersey and in all markets in other states. This would also result in a change in the definition of "allowed charge" in the policy forms, and it was suggested that, if the standard were removed, carriers should be required to explain in the policy form what method for reimbursement would be used, and how consumers could obtain more specific information. It was noted that this would apply for the voluntary use of out-of-network services only, not

emergency situations or situations in which the facility is in-network but one or more of the professional health care providers is not. It was agreed that the nature of the majority of plans offered in 1993 precipitated a need for a specific reimbursement methodology in order to standardize benefits, but that the current plans offered are very different: now all plans have a network with negotiated rates and hold-harmless provisions; there are very few plans offered that have out-of-network benefits, only a relatively small number of people purchase such plans, and an even smaller number elect to use out-of-network services even when they could, reducing the need for a single, market-wide methodology. It was also suggested that the opportunity to have a more appropriate methodology to reimburse out-of-network benefits could encourage carriers to offer more plans that feature out-of-network benefits. It was acknowledged that, because the PHCS has been unavailable since 2010, new carriers are unable to purchase it, while carriers that have the data are using increasingly outdated and incomplete data for out-of-network services. It was acknowledged that the known gaps in the PHCS data for carriers still able to access it have grown increasingly large, as updates to the various medical and facility coding systems continue to occur over time. The IHC Board favored allowing carriers to designate the basis for voluntary out of network reimbursement

- Revisions to the standard plans to address relevant issues noted above, as well as:
    - Dedication of space for language option taglines (used to let consumers know how to obtain help in other languages).
    - Deletion of dollar limits on preventive services to comply with the final federal rules addressing lifetime and annual limits.
    - Amendments to the definition of developmental disabilities to remove age limits to be consistent with MHPAEA, and to update language to comply with the federal law commonly referred to as Rosa's Law.
    - Revisions to the Continuation of Care provisions to assure compliance with the final federal 2017 Benefit and Payment Parameter rules, by adding a continuity of care requirement when a physician states it is medically necessary and accepts the negotiated rate for the continuity of care period.
    - Addition of a "split-fill" pharmacy option with respect to specialty pharmacy that would allow members to fill only a portion of a new prescription (two weeks or 15 days) until the member's tolerance to the medication can be determined. It was noted that if carriers elected this option, it would allow members to save money in the event they are unable to tolerate a medication and must change drugs before the end of the prescription cycle.
    - Revision to the dental services provision to remove the "hidden" pre-existing condition language that is objectionable to the U.S. Department of Labor, so that benefits for treatment of injuries to teeth are available during the 6 months following the effective date of coverage or following the date of the injury, whichever is later.
    - Deletion of the current exclusion of benefits when covered services are being rendered with respect to gender reassignment. It was explained that this change would make the standard plans compliant with the rules proposed and expected to be adopted soon by the Office of Civil Rights.

The Board asked E. DeRosa to begin drafting proposed amendments. E. DeRosa asked Board members to send her any other suggestions for amendments to the rule or the policy forms no later than June 7th.

V. Close of meeting

B. Peppard made a motion, seconded by L. Levine, to close the meeting. By roll call vote, the motions carried.

[The meeting ended at 10:50]