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 9, 2017

Directors participating: Mary Beaumont; Sandi Kelly (Horizon); Ulysses Lee (United/Oxford); Brendan Peppard (DOBI); Tom 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 newpapers of general circulation 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. Review of Minutes – *April 20, 2017*

T. Taliaferro made a motion, seconded by B. Peppard, to approve the minutes of the meeting of April 20, 2017, as amended. By roll call vote, the motion carried.

III. Report of Staff – *Expense Report*

R. Lenox presented the expense report for May, totaling $13,002.72, primarily related to expenses for salaries and fringe, and the final costs of the audit by WithumSmith+Brown for FY2016. R. Lenox explained that the Board would need to transfer $13,000 from its Money Market account to pay the operating expenses if approved.

S. Kelly made a motion, seconded by M. Beaumont, to approve payment of the expenses reported, and the transfer of $13,000 from the Board's Wells Fargo Money Market account to its Wells Fargo checking account to pay the operating expenses. By roll call vote, the motion carried.

IV. Federal Market Stabilization Rules

Guaranteed Availability

E. DeRosa reminded Board members that the federal "market stabilization rules" were proposed in February and adopted in April, and that the Board had asked to discuss whether any changes to New Jersey rules were necessary as a result. It was noted that the federal rules reinterpreted guaranteed availability under the federal law to permit carriers (within a company) to require overdue payments accrued during a grace period (owed to any carrier within a company) to be

paid before a new policy is issued by any carrier within that company. E. DeRosa stated that CMS intends to discourage people from "riding" the grace period, noting that there appears to be a significant number of people who buy policies, but fail to pay premiums during the final three months of the plan year, then buy a new policy (whether from the same or another carrier) during open enrollment. E. DeRosa stated that CMS made clear, however, that this reinterpretation of the federal law applies only to the extent that State law doesn't require a different result, and pointed out that New Jersey's guaranteed issue provision pre-dates those of the federal law, and is worded differently. She noted also that New Jersey's statutory language regarding grace periods for individual policies provides that individuals have coverage for 31 days, but creates no claims liability beyond that, not even for those policies in which an individual receives APTC and consequently has a 90-day grace period. There was some discussion as to whether the Board could interpret the various New Jersey laws differently, and whether there may be an option to treat policies sold on and off the Marketplace differently. It was agreed that carriers needed some time to discuss the issues internally. The Board decided to discuss the issue again at its June meeting, and in the interim, to have the Legal Committee consider the question.

Open Enrollment Period

E. DeRosa asked whether the Board wanted to use the exact same period of time for its open enrollment period off-Marketplace as specified by CMS. She noted in particular that CMS' open enrollment period runs from November 1 through December 15, with all policies intended to be effective as of January 1, but that, with respect to off-Marketplace policies, carriers have the ability to accept applications as late as December 31, and issue coverage effective on January 1. Some Board members expressed concern about having a different end date to the open enrollment period for policies sold off-Marketplace both with respect to operations and potential for adverse selection. It was agreed that carriers would discuss the matter internally, and provide E. DeRosa with more information by May 30th.

Special Enrollment Periods (SEP)

E. DeRosa explained that CMS said carriers reported there is a distinctly different risk profile between the group of people who purchased coverage through a SEP and the group that purchased during the annual open enrollment period, prompting CMS to alter its SEP rules, including requiring 100% verification of the triggering event prior to issuance of coverage. She noted that the new requirement for verification will not have an impact for coverage offered off-Marketplace, because carriers were always permitted to require verification of triggering events off-Marketplace.

She explained additional changes to the SEP that apply both on- and off-Marketplace:

1. In order to qualify for a SEP due to marriage, one of the spouses must have been covered under minimum essential coverage for at least one day during the 60-day period immediately preceding the marriage. She noted that a minor change to the policy forms will need to be made to address this.
2. Similarly, in order to qualify for a SEP due to relocation, the individuals seeking coverage had to have had coverage prior to the move. E. DeRosa noted that was already within New Jersey's policy forms, so no change was needed.

S. Kelly stated that the Market Stabilization regulations also include a new restriction with respect to adding dependents to coverage via a SEP, requiring that the dependent be added to the

existing policy of the policyholder, or be placed on a policy of the dependent's own, but effectively eliminating the option for the entire family to select another (richer) policy prior to the annual open enrollment period. E. DeRosa noted that this regulation appears to address only Marketplace plans, but suggested further review of whether the restricted could be applied to off-Marketplace plans was warranted.

Actuarial Value; Network Adequacy
E. DeRosa said CMS had altered the actuarial value parameters for the metal levels, but there was nothing for the Board to do in this regard. E. DeRosa noted that CMS indicated that States (with rare exception) would have sole oversight of network adequacy issues, but that also requires no specific Board action.

V. Financial Disclosures

E. DeRosa reminded Board members that annual financial disclosures are required to be filed with the State Ethics Commission by May 15th. She noted that the State Ethics Commission is not accepting training dates that are older, so filers may have to sit through the online training. She also reminded Board members that if they are sitting on both boards, they only need to file once annually.

VI. Close of meeting

S. Kelly made a motion, seconded by U. Lee, to adjourn the meeting. By roll call vote, the motion carried.

[The meeting ended at 11:05 A.M.]