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
January 16, 2013

Members present: Gary Cupo; Darrel Farkus (Oxford); Patrick Gillespie (CIGNA); Joyce Gralha (Horizon); Margaret Koller; Mary Ellen Peppard; Thomas Pownall (Aetna Health Inc.); Christine Stearns *(arrived at 10:15 A.M., departed at 12:10 P.M.)*; Dutch Vanderhoof.

Members participating by phone: Neil Sullivan (DOBI)

Others participating: Ellen DeRosa, Executive Director; Chanell McDevitt, Deputy Executive Director; Rosaria Lenox, Program Accountant; DAG Eleanor Heck (DLPS).

I. Call to Order

E. DeRosa called the meeting to order at 10:05 A.M. E. DeRosa announced that notice of the meeting had been published in two newspapers 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. M. Koller chaired the meeting.

II. Public Comments

There were no public comments.

III. Staff Report

Minutes – November 21, 2012

D. Farkus made a motion, seconded by G. Cupo, to approve the draft minutes from the open session of the November 21, 2012 meeting, with amendments. The motion carried.

J. Gralha made a motion, seconded by D. Vanderhoof, to accept the draft minutes from the executive session of the November 21, 2012 meeting. The motion carried.

Expense Report and Transfer of Funds
R. Lenox presented the January expense report, with expenses totaling $12,088.60, primarily for WithumSmith+Brown (WSB) audit costs, and the Division of Law. She requested that the Board approve the expenses, and also requested that the Board approve a transfer of $12,100 from the Board's Money Market fund to the Board's checking account to pay the January expenses.

T. Pownall made a motion, seconded by P. Gillespie, to approve the January expense report, and the transfer of funds from the Board's Wells Fargo Money Market account to the Board's Wells Fargo checking account to pay expenses. The motion carried.

R. Lenox explained that the Board needed to transfer funds into its DOBI account in order to cover salaries and fringe for staff, and requested that the Board approve transfer of $25,000 from its Money Market account at Wells Fargo.

D. Vanderhoof made a motion, seconded by J. Gralha, to authorize the transfer of $25,000 of the SEH Board's funds from its Money Market account at Well Fargo Bank to the Board's funds held by the Department of Banking and Insurance to fund salaries and fringe. The motion carried.

Rule Proposal – Summary of Benefits and Coverage (SBC)
E. DeRosa reminded the Board that it had proposed amendments to its policy forms (in Exhibits A, F, G and HH of the appendix to N.J.A.C. 11:21) to include a provision addressing the obligation of empoyers to provide Summary of Benefits and Coverage (SBC). She reported that a hearing had been held on January 8, 2013, and the comment period had now closed, with no verbal or written comments received. She recommended the Board adopt the proposal without change.

D. Vanderhoof made a motion, seconded by D. Farkus, to adopt the proposed amendments to Exhibits A, F, G and HH of the appendix to N.J.A.C. 11:21, without change, to incorporate a provision regarding distribution of the SBCs. The motion carried.

Financial Statements for Fiscal Year 2013, First Quarter (Q1FY13)
R. Lenox presented the financial statements for Q1FY13, including the Statement of Net Assets, the Statement of Changes in Net Assets, the Statement of Cash Flows, and the Comparison of Budget to Actual Expenditures, noting that the Board's expenses are currently running about $3700 under budget. She explained that the Finance and Audit Committee did not meet because no members of the committee had comments or questions about the financial statements that were sent to them in advance of the meeting date, and there were no other issues to discuss.

Election for a Small Employer Representative
E. DeRosa reminded the Board that John Harmon, elected in September 2012 to the Board as a person representing minority small employers, resigned from his position, and the Board will be holding another election for the position. She explained that staff sent out solicitations for nominations, received one nomination (for Herbert Ames), and that absentee ballots had been sent out with a return date of February 13th.

Preventive Care Inquiry – PSA test
E. DeRosa reported she received an inquiry as to why the policies no longer cover screening tests for prostate cancer (PSA tests), with the inquirer noting that the New Jersey Legislature had passed a resolution for PSA tests to be covered. She noted that the United States Preventive Services Task Force (USPSTF) made a final recommendation in 2012 *against* routine screening for prostate cancer, making the PSA test a "D" category service. E. DeRosa also explained that

the resolution (Joint Resolution 10) urges Congress to ask the USPSTF to change its recommendation on prostate cancer screening. After discussion, the Board suggested a response to the inquiry explaining the history and recommendation of the USPSTF, and the impact of requiring coverage of a service not already mandated and included within the benchmark plan (i.e., the U.S. Department of Health and Human Services has proposed, at 45 C.F.R. 155.170 *(Federal Register of November 26, 2011),* that States pay the premium associated with the benefit).

IV. Ad Hoc Committee – Gender Affirmation

E. DeRosa reported that the ad hoc committee had met again after reviewing more specific information regarding prevalence and incidence of transgender status, treatment being sought, and costs. She reported that the committee noted that benefits for gender reassignment continue not to be covered through federal programs, including Medicaid, nor New Jersey's State Health Benefits Plan, and again considered the possibility that the State would become financially liable for such services if the exclusion was removed, because the services were not included in New Jersey's essential health benefits (EHB) benchmark plan. She stated that the committee ultimately recommended against removing the exclusion for such services from the standard plans. E. DeRosa said the committee recommended the SEH Board issue a bulletin to carriers affirming that administration of benefits should be nondiscriminatory, affirming the position stated by the federal Centers for Medicare and Medicaid (CMS).

D. Vanderhoof made a motion, seconded by P. Gillespie, to accept the recommendation of the ad hoc committee to maintain the exclusion and issue a bulletin regarding nondiscrimination in benefits administration. ***However, it was suggested that the Board postpone action on the matter pending discussion in Executive Session.***

V. Out-of-Network Reimbursement Methodology – White Paper and Stakeholder Meeting

E. DeRosa noted that the previously-distributed second draft of a white paper had been revised based on comments from Board members following the November meeting. She noted that one of the primary suggestions was to leave the percentage of the Medicare Resource-based Relative Value Scale (RBRVS) undetermined, so that it could be discussed at the stakeholder meeting without preconception. She explained that the IHC Board, however, had a different perspective, and considered it more prudent to have a percentage of RBRVS presented in the white paper to avoid the inference that stakeholders may propose a percentage. The SEH Board discussed the pros and cons of presenting a specific percentage of RBRVS, with several members agreeing that they would like to present a floor as a starting point for discussion, and generally agreeing that 150% of RBRVS is a reasonable starting point given trends in the large group market, so long as the rationale can be articulated well, while some Board members had concerns about presenting 150% and receiving too much negative input.

Several Board members who sit on both the SEH and IHC Boards confirmed that the IHC Board is anxious to propose 150% of RBRVS without waiting on the SEH Board's stakeholder meeting, if only to see what the reaction may be. The SEH Board decided it would be best to hold the stakeholder meeting (with or without the IHC Board members in attendance) as had

been decided at the November meeting (with M. Koller and Rutgers Center for State Policy facilitating and moderating).

There was discussion as to whether carriers might be permitted to have a menu of acceptable percentages of the RBRVS (a range), or even a menu of Board-specified reimbursement methodologies (Medicare's RBRVS, FAIR Health, etc.) among which each customer (employer) could choose. There was a suggestion that alternate reimbursement options be offered only as riders in an effort to maintain a base of standardized plans. It was noted, however, that carriers may not be willing to offer the richer choices due to adverse selection concerns. It was argued that even if choice is provided, when pricing is shown, most purchasers are likely to choose the lower cost plan, despite the potential for increased out-of-pocket costs for insureds. It was acknowledged that having the option might address some public criticisms, but it was also noted that it would create other issues that would need to be resolved.

The Board referred the question of whether to include alternate reimbursement options to the Ad Hoc Committee. In the meantime, the Board suggested that the white paper include some comparisons of reimbursement methods (RBRVS and FAIR Health) for 5 procedures most commonly reimbursed out-of-network, to provide a base of reference. The Board asked that the revised draft be reviewed again by the Ad Hoc Committee.

VI. Amendment of SEH Plans to Comply with Essential Health Benefits Standards

E. DeRosa explained that the current federal timeframes for certifying qualified health plans (QHP) for purposes of the health insurance exchange (Exchange) assume submission of the QHP applications starting in April. She said that QHPs for small employers will need to be built on SEH standard plans, and stated that, if the Board used its expedited rulemaking authority, it could propose and adopt amendments to the standard plans to make them compliant with federal EHB requirements in time for carriers to submit QHP applications in April. E. DeRosa noted that, because New Jersey's small employer health law remains in place (that is, carriers may only offer what the SEH Board designates), the plans offered inside and outside of an Exchange should be standard plans. She discussed the draft proposed amendments to the SEH standard plans that she believes need to be made to bring the standard plans into compliance with EHB requirements:

- The upper limits for the deductible and maximum out-of-pocket limits are revised to reflect the federal regulations for employer plans.
- The references to and definition of dependent are modified to de-link spouse and children (so that employers can permit employees to cover children without necessarily covering spouses)
- Dollar limits are removed for hearing aids
- The cost-sharing for prescription coverage must apply towards the maximum out-of-pocket limit
- All references to preexisting conditions and related limitation periods are removed
- The waiting period is reduced to no more than 90 days
- A pediatric (through age 18) vision benefit based on the Federal Employees Dental and Vision Plan is added
- A pediatric (through age 18) dental benefit based on New Jersey's FamilyCare Part A (CHIP) dental program is added

E. DeRosa asked that carriers review the draft and provide her with comments by February 1. She noted that Medicaid's dental director, Dr. Stanley, is reviewing the dental benefit to make sure it is appropriately explained in the form, and that she expected some changes to the dental benefit language would be forthcoming.

The question arose whether New Jersey should and may institute a specified open enrollment period for late enrollees, since the late enrollee preexisting condition period must be eliminated. It was agreed this is something that needs to be looked at more closely, and might be something to pursue legislatively if it is unclear that the Board can institute it under the current law.

There was discussion of what must be offered in the Exchange (at least one Gold and one Silver plan), and whether a carrier may satisfy the requirement to offer at least three plans by only offering plans within or only offering plans outside of the Exchange. It was agreed that this is an issue that also needs to be considered more closely.

VII. Public Comment

There was no public comment.

VIII. Executive Session

T. Pownall made a motion, seconded by M. Koller, to table the pending motion regarding gender affirmation while the Board moves into executive session to obtain legal advice from counsel regarding the gender affirmation issue, which could result in one or more actions by the Board when the Board reconvenes in Open Session. The motion carried.

[The Board was in Executive session from 12:25 until 12:33 P.M.]

IX. Gender Affirmation

D. Vanderhoof moved to revive his earlier motion, seconded by P. Gillespie, to accept the recommendation of the ad hoc committee to maintain the exclusion for sex reassignment surgery and issue a bulletin regarding nondiscrimination in benefits administration. The motion carried.

X. Close of Meeting

D. Vanderhoof made a motion, seconded by J. Gralha, to adjourn the meeting. The motion carried.

[The meeting adjourned at 12:35 P.M.]