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
April 20, 2016

Members participating: Herbert Ames; Mary Beaumont; Gary Cupo; Patrick Gillespie (Cigna); Margaret Koller; Lisa Levine (United/Oxford); Brendan Peppard (DOBI); Nicholas Peterson (Horizon); Thomas Pownall (Aetna Inc.); Tony Taliaferro (AmeriHealth); 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 10:02 A.M. She announced that notice of the meeting was provided to three 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 – *March 16, 2016*

T. Pownall made a motion, seconded by M. Beaumont, to approve the minutes of March 16, 2016. By roll call, the motion carried.

IV. Staff Report

Vacancy due to Resignation

E. DeRosa announced that Matthew Malat had taken a position with another organization that does not represent small employers, and so had resigned from his seat. She explained that a request for nominations of candidates to fill the vacancy had recently been sent out to members of the SEH Program, and she encouraged members to respond by May 13th.

Readoption of N.J.A.C. 11:21, with proposed amendments and proposed repeals

E. DeRosa explained to the Board that N.J.A.C. 11:21, which includes a combination of the Board's rules and DOBI rules implementing N.J.S.A. 17B:27A-17 et seq., and regulating the SEH market, will expire August 18, 2016 if a proposal to readopt the chapter is not submitted prior to that date. She further explained that the rules will be extended (as they currently exist)

for an additional 6 months if properly proposed for readoption prior to their expiration date, but noted that it would be prudent to try to propose and adopt the proposal as expeditiously as possible so that carriers will have updated policy forms to use in 2017. She stated that the Board could use its expedited rulemaking process if necessary, but that it is not preferable if there is ample time to use the standard rulemaking process, and because the DOBI cannot use the process, which could make the proposal and adoption process more confusing for regulated entities and other interested parties. She explained that the DOBI also is in the process of proposing readoption of its portion of the chapter with amendments and repeals.[1]

The Board considered whether and how the Board might want to propose amendments addressing the following definitions and provisions:

- N.J.A.C. 11:21-7.13 and definition of "allowed charge" at N.J.A.C. 11:21-1.2: The regulation and the corresponding definition require carriers to reimburse certain out-of-network expenses at the 80th percentile of the PHCS or at billed charges, whichever is less. The Board acknowledged that, because the PHCS data has been unavailable since 2010, some carriers are unable to purchase it, while carriers that have the data are using increasingly outdated and incomplete data for out-of-network services. Board members suggested that carriers could use other methodologies, if they explain the methodology in the policy forms, and provide a way for consumers to obtain more information about reimbursement, in order to be as transparent as possible, which was always a deficit of the PHCS data. The Board recalled that the nature of the plans offered in 1993 precipitated a need for a specific reimbursement methodology in order to standardize benefits, but that the plans offered in more recent years are vastly different. Current plans use networks with negotiated rates and hold harmless provisions; only about 25% of the employer purchasing small employer plans elect plans with out-of-network benefits, and the majority of services are rendered by network providers with the voluntary use of out-of-network providers far less frequent than network providers. Thus, the Board believes the need for a single, market-wide methodology is now unnecessary. 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. Additionally, it was noted that the voluntary out of network utilization that occurs tends to be associated with specialist services. The Board agreed the regulation and definition should be eliminated.
- Definitions of "eligible employee," "employee" the two-prong definition of "small employer" at N.J.A.C. 11:21-1.2: The Board commented on the current two-prong calculation for determining small employer versus large employer status and which persons are included for each calculation. There was general agreement that the use of two differing definitions and procedures for determining small employer is confusing and administratively difficult, and there was a strong preference to reconcile the terms and procedures. Board members noted the conflicts that arise with the different definitions and procedures, and the implications with respect to compliance with various federal laws in addition to the ACA, all of which rely on definitions and procedures established by federal regulation. It was agreed that the SEH Board's Legal Committee should

[1] The following subchapters of N.J.A.C. 11:21 are under the purview of the SEH Board: 1, 2, 3, 4, 7, 8, 10, 17, 18, 20, and 23. The following subchapters of N.J.A.C. 11:21 are under the purview of the DOBI: 6, 7A, 9, 11, 13, 15, 16, and 23. The following subchapters are currently reserved: 3A, 5, 12, 14, and 22.

consider the potential impact of using only the federal definitions and counting methods. Any change to the definitions will require a review of the participation requirements at N.J.A.C. 11:21-7.5.

- N.J.A.C. 11:21-2.13: This regulation establishes penalties for certain errors. Board staff noted that the Board has never employed the provision, and that alternate methods of penalizing carriers have been used instead. The Board agreed the regulation can be eliminated.

- N.J.A.C. 11:21-3.1: The regulation includes a requirement that a carrier offer at least one plan statewide if the carrier is offering network-based plans on other than a state-wide basis. E. DeRosa noted that in recent years, an insurance carrier was authorized to do business in New Jersey and that authority was limited to certain counties, making it impossible for the carrier to comply with the rule as written, and precluding the carrier from entering the SEH market. She suggested the rule be revised to require carriers to offer at least one plan throughout the carrier's approved service area, but not require a carrier to offer an indemnity plan statewide unless the carrier has authority to do so. Although some concern was expressed that other carriers might be inclined to try to limit their offerings as well, it was also noted that existing carriers would have to give up their existing licenses and seek the limited license in order to do so, which is onerous, and unattractive for purposes of the large group market and other types of health insurance a carrier might want to offer. The Board agreed the regulation should be amended, as suggested.

- Optional benefit riders: The regulations address riders in multiple sections including N.J.A.C. 11:21-3.2 and the disclosure requirement at N.J.A.C. 11:21-17.4. E. DeRosa stated that under the ACA all small employer plans must cover all of the Essential Health Benefits and it is not permissible to have a plan that does not satisfy that minimum requirement. Thus, the opportunity for decreasing riders ceased to exist. It was also noted that, from the federal perspective, optional riders that increase benefits create a new plan for which a new plan number is generated, with all of the attendant certification, rating and disclosure requirements becoming applicable as for any other plan.

- N.J.A.C. 11:21-7.10: This regulation addresses a prohibition with respect to tie-in sales However, since a carrier is required to have reasonable assurances that a purchaser will obtain pediatric dental coverage when the carrier offers plans without such coverage embedded in its plans, amendment to N.J.A.C. 11:21-7.10 to address the required pediatric dental coverage is necessary.

- N.J.A.C. 11:21-8: The regulation requires carriers to annually file notices of nonmember status. It was agreed that the requirement is outdated and unnecessary, because the Board knows who is and is not an SEH Program member. Board staff noted that the requirement is an unnecessary reporting requirement for carriers, but is also burdensome for staff. The Board agreed it would be appropriate to repeal the regulation.

- 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, and ambulatory service centers when services are obtained out-of-network under plans having out-of-network benefits, to comply with the final federal rules addressing lifetime and annual limits.
- Amendments to the definition of developmental disability 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.
- Changing the term "primary care physician" to "primary care provider" throughout.
- 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 full prescription is taken.
- 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 currently proposed by the Office of Civil Rights, which are expected to be adopted in the near future. There was some discussion whether this change might create a requirement for the state to defray costs. It was noted that this change does not create a new benefit or remove medical necessity standards; rather, it eliminates exclusion of benefits for otherwise covered services based solely on treatment of a particular condition. It was further noted that this change would not result in a need to defray costs because the change would be made to conform with federal law regarding nondiscrimination.

E. DeRosa suggested that Board members let her know as soon as possible if they want to suggest other changes to the regulations or policy forms so that these can be considered by the Board, and possibly included as part of the proposal. It was agreed that staff would try to get a draft of the proposal addressing the above revisions to the Board prior to the Board's scheduled meeting in May.

V. Loss Ratio Report for CY2014

A. Parekh noted that there are significant differences in the data for 2014 relative to the several years preceding it, but that this was expected because 2014 was the first year that the requirements of the ACA were more fully operational. She highlighted the following:

- Premiums for the market at the end of 2014 were around $2.83B, a decrease from the $3.20B recorded for the end of 2013, which represented a decrease of 11.4%
- The 2014 average loss ratio for the market was 84.7% (before any refunds) compared to 82.8% in 2013; however, the 2014 increase in the loss ratio also occurred at the time the loss ratio formula changed to take into account the federal reinsurance, risk corridor and risk adjustment programs, and ACA-related taxes and fees, so there is no straightforward explanation for the increase in the loss ratio
- Refunds for the standard market totaled $5.9 million for 2014, and were paid out among four companies. Oxford Health Insurance paid the vast majority of the refunds at $5.7M, while Health Republic and CIGNA HealthCare paid $114,000 and $64,000, respectively, and Oxford Health Plan paid $26,000 for its purchasing alliance.
- The non-standard plan market is virtually non-existent now; no carrier collected premiums in 2014; Horizon paid a small amount of run-out claims; Aetna Life released its remaining reserves and paid a final refund on its business
- Oxford Health Plans had the only remaining purchasing alliance business, which was in run-out status until June 2014.

A. Parekh stated that the report would be posted online, as is customary, at http://www.nj.gov/dobi/division_insurance/ihcseh/ihchistrate.html.

VI. Public Comment

There were no public comments.

VII. Close of Meeting

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

[The meeting adjourned at 12:06 P.M.]