FINAL
MINUTES OF THE 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
December 18, 2019

Members participating: Herb Ames; Robert Benkert (Oxford); Natalie Bernardi (Cigna); Gary Cupo; Laura Gunn; Margaret Koller; Taylor Kopelan (Horizon); Thomas Pownall (Aetna); Tony Taliaferro (AmeriHealth).

Others participating: Ellen DeRosa, Executive Director; Chanell McDevitt, Deputy Executive Director; Rosaria Lenox, Financial Manager; Jeff Posta, Deputy Attorney General.

I. Call to Order

E. DeRosa called the meeting to order at 10:00 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 Comments

There was no public present.

III. Review of Minutes of November 20, 2019

T. Pownall made a motion, seconded by L. Gunn, to approve the minutes of the meeting of November 20, 2019, without amendment. By roll call vote, the motion carried.

IV. Report of Staff – *Expense Report, Rule Proposal*

Expense Report

R. Lenox presented the Expense Report for December, totaling $9443, for expenses related to WithumSmith+Brown audit costs for FY2019, and Division of Law Q1FY20 charges. She stated the Board would need to transfer $9,400 from the Board's Money Market Account to its Checking Account.

G. Cupo made a motion, seconded by H. Ames, to approve payment of the expenses, and transfer of $9,400 from the SEH Board's Wells Fargo Money Market Account to the Board's Wells Fargo Checking Account. By a roll call vote, the motion carried.

Rule Proposal, policy form amendments

E. DeRosa explained that, subsequent to the Board's vote to approve the proposal, she had received a question for clarification regarding the triggering event related to Individual Coverage Heath

Reimbursement Accounts (ICHRAs) and Qualified Small Employer Health Reimbursement Accounts (QSERHAs). She stated she concluded that there is no triggering event with respect to enrollment in group coverage based on an employer's offer of an ICHRA or QSEHRA, because the employee is expected to use the funds in the ICHRA or QSEHRA to purchase an individual policy (meaning that the offer of the ICHRA or QSERHA creates a triggering event in the individual market). She referred the Board to a CMS presentation regarding ICHRAs and QSEHRAs that she included in the Board's meeting materials. E. DeRosa stated she deleted the statement in the SEH triggering events referencing the individual coverage HRA and QSEHRA (highlighted in the meeting materials), and that she had done so prior to sending the proposal for approval by the Governor's Office. She asked that the Board ratify the change to the proposal.

T. Taliaferro made a motion, seconded by L. Gunn, to approve the change to the proposed amendments to the policy forms by removal of language that would establish a triggering event for enrollment in a group health plan upon the offering of an ICHRA or QSEHRA, which is otherwise inconsistent with federal law. By roll call vote, the motion carried.

E. DeRosa noted that the proposal has not yet received all the approvals necessary for publication by the Office of Administrative Law. She reminded members that most of the proposed changes to the policy forms are based on laws already in effect (for example, all of those addressing mental health parity), and that carriers should be administering the policies consistent with the law pursuant to the Compliance with Law provision of the policy forms already. She noted that those amendments that are not based on statute (for example, the option to cover immunizations through either the pharmacy or the medical benefits, or the requirement to cover a 96-hour supply of medication when a prescription is subject to prior approval) will not become effective before the Board adopts them, so carriers must continue to administer the policies as is until such time. She stated the Board may establish an operative date for some period of time (four to six months) after adoption before requiring all plan documents to be have complying language (upon issue and/or renewal), but that can be discussed at a later meeting.

V. Public Comments

There was no public present.

VI. Close of Meeting

G. Cupo made a motion, seconded by M. Koller, to close the meeting. By roll call vote, the motion carried.

[The meeting adjourned at 10:17 A.M.]