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
July 21, 2010

Members present: Thomas Collins; Gary Cupo; Darrel Farkus (United/Oxford); Joyce Gralha (Horizon); Alan Maesaka (Aetna); Christine Stearns; James Stenger; Neil Sullivan and Neil Vance (DOBI – *sitting at different times throughout the meeting*); Tony Taliaferro (AmeriHealth); Dutch Vanderhoof.

Others participating: Ellen DeRosa, Executive Director; DAG Vicki Mangiaracina (DLPS); DAG Zoe McLaughlin; Chanell McDevitt, Deputy Executive Director.

I. Call to Order

E. DeRosa called the meeting to order at 10:05 A.M. She 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. She determined a quorum was present.

II. Public Comments

There were no public comments.

III. Minutes – *May 19, 2010*

T. Taliaferro made a motion to approve the open session minutes for May 19, 2010, which was seconded by T. Collins. The motion carried unanimously.

IV. Report of Staff

Expense Report

E. DeRosa provided information about the expense report for July, which included expenses totaling $5,923.75, primarily for legal services.

G. Cupo made a motion, seconded by J. Gralha, to approve the expenses on the July 2010 expense report. The motion carried unanimously.

Transfer of Funds

E. DeRosa reported that R. Lenox had requested an authorization to transfer $6,000 from the Administrative funds held in the Wachovia Money Market Account to the Board's checking account, in order to pay the expenses approved by the Board.

D. Vanderhoof made a motion authorizing the transfer of $6,000 from the Wachovia Money market Fund to the Board's Wachovia checking account for the purpose of paying operating expenses. A. Maesaka seconded the motion, which carried unanimously.

There was brief discussion whether the Board should authorize staff to make transfers and payments up to a certain dollar threshold without obtaining approval from the Board, but E. DeRosa reminded Board members that staff had put this process in place to provide a strong internal control.

NJ Protect

E. DeRosa provided a synopsis of the State's efforts to implement a high risk pool program in a guaranteed issue environment consistent with the federal Patient Protection and Affordable Care Act (PPACA, Public Law 111-148). She explained that the proposed program would be under the auspices of the Individual Health Coverage (IHC) Board, and that the U.S. Department of Health and Human Services (HHS) had agreed that eligibility could be based on an individual being: 1) a U.S. citizen, national or an alien lawfully present in the U.S.; 2) uninsured for at least 6 months; and, 3) having a preexisting condition without that person having to prove that she or he had been declined coverage, since New Jersey is a guaranteed issue state. E. DeRosa stated that the IHC Board was partnering with Horizon Blue Cross and Blue Shield of New Jersey, but that neither the contract between HHS and the IHC Board nor the contract between the IHC Board and Horizon has yet been signed. She said she believed contracts would be signed soon, and that the program, called NJ Protect, would be operational shortly thereafter. She noted information would be available on the DOBI website.

Coinsurance Credit

E. DeRosa reported that the DOBI has quarterly meetings with the Life and Health Advisory Board (LHAB), composed primarily of brokers, and that she had attended the most recent meeting, at which there was discussion regarding the plan withdrawals in the SEH market being implemented by Aetna and Horizon. She stated that some of the brokers were concerned about the financial hardship many employees will have because there is no requirement that they be credited under the replacement policy for the coinsurance amounts already satisfied under the policy being discontinued. She reported the LHAB was suggesting that, under the current withdrawal scenarios, credit be provided for coinsurance requirements satisfied in a plan (calendar) year when a policy is replaced, in order to avoid significant disruptions from the plan withdrawals. E. DeRosa said that the SEH Board had faced this issue in 2004 when it changed all of its plans from the coinsured charge limit concept to the maximum out-of-pocket (MOOP) concept, without considering the disruption the transition would cause (that is, policies were replaced consistent with DOBI rules on discontinuance and replacement which requires credit for the deductible but not coinsurance). She said the IHC Board faced a similar situation in 2006 when it moved to the MOOP, but having learned from the public outcry created by the SEH transition, required credit of both the deductible and coinsurance amounts satisfied when the IHC transition occurred.

Significant discussion followed regarding: whether a credit should be limited to scenarios in which the employer replaces the withdrawn plan by a plan with the same carrier; disadvantages to some employers and employees resulting from use of a calendar year as the benefit year; the underlying reasons for withdrawals; and, pricing for replacement plans when a carrier withdraws existing plans. There was some agreement that carriers probably did not price their replacement products with the intent to obtain a windfall assuming a significant lack of claims. There was

some concern about the administrative costs involved with a coinsurance credit. The question arose whether there should also be reductions in benefits, such as visit limits, when such benefits were already used under the discontinued plan. It was noted that the intention is to be consumer friendly. The question arose whether an employer's subgroups that move to a replacement plan even though their specific existing plan was not withdrawn should be given the credit, in the event that credits are limited to situations of forced conversions. This led to the question of how the withdrawal/replacement issue interacts with the new participation rules.

The Board decided to table action on the matter, so that representatives could discuss the questions within their companies. The principle for discussion was that credit would be provided for allowed charges paid year-to-date towards both the deductible and coinsurance when an employer covered by a withdrawn plan replaces that plan with another plan through the same carrier, but that carriers should consider the issue of subgroups also being moved to the replacement plan, and how to operationalize the process retroactively (given that Aetna is beginning its withdrawals on August 1, 2010), and implementation in general. E. DeRosa agreed to send an email to everyone re-capping the issues.

The Board agreed to meet again on August 11, 2010 in order to resolve the issues as quickly as possible. Representatives of carriers agreed to return recommendations to E. DeRosa by August 4, so that she could send them out collectively for consideration prior to the August 11 meeting. It was also agreed that the decisions of the August 11 meeting would be put into a bulletin for quick distribution, so that brokers and employers would know as soon as possible what the options would be.

[The Board took a break from 12:00 until 12:10 P.M.]

Optional Benefit Riders
E. DeRosa reported that two carriers had each filed an optional benefit rider.

T. Taliaferro recused himself from discussion and action regarding a rider filed by AmeriHealth HMO because of the interest of his employer in the outcome of the issue.

E. DeRosa reported that AmeriHealth had filed a rider to add to the HMO schedule pages coverage for hearing aids up to $1,000 every 24 months for each hearing impaired ear for members 15 years old and younger. She recommended finding the filing complete.

G. Cupo made a motion, seconded by D. Vanderhoof, to find the AmeriHealth HMO rider to be complete. The motion carried unanimously.

D. Farkus recused himself from discussion and action regarding a rider filed by Oxford Health Plans because of the interest of his employer in the outcome of the issue.

E. DeRosa reported that Oxford had filed a rider amending standard plans B through E PPO and POS to provide coverage for hearing aids up to $5,000 every 24 months for each hearing impaired ear for members regardless of age. She recommended finding the filing complete.

G. Cupo made a motion, seconded by D. Vanderhoof, to find the Oxford PPO and POS plans B through E rider to be complete. The motion carried unanimously.

Counting to 75% Participation
E. DeRosa noted that since the Board's last meeting, she received information suggesting that carriers and/or brokers did not understand the change to the interpretation of the participation rules the Board had actually agreed upon. She stated that the only change the Board made was to permit carriers not to count towards participation those eligible employees covered by another small employer plan of the same employer issued by another carrier. She said some carriers are not counting eligible employees who make other valid waivers, and some carriers are saying that 75% of the eligible employees must be with that carrier, but neither position is accurate. She stated that the "primary" carrier concept does not mean that a carrier is the "sole" carrier. She distributed illustrations of how the count should be done, including examples in which an employer may have more than one carrier, each of which must acknowledge 75% participation has been met by the group.

Annual Employer Certification
E. DeRosa stated she believes a change to the employer certification that shows when employees are covered by other carriers along with the carrier names would be helpful to the participation issue, and it could be made a part of the impending policy form changes. There was discussion whether the additional information was data that the Board would want carriers to review, but no decision was made on that issue. There was brief discussion as to whether there should be more explanation about employer affiliation in the certification, but it was agreed that a reference to the SEH website for more information would be adequate. There was discussion about references to independent contractors, who are permitted to be covered under SEH law, even though such coverage creates significant problems under labor laws. E. DeRosa explained that the SEH Buyer's Guide cautions employers about covering independent contractors, but nevertheless, other forms indicate it is an option because of the SEH statutes.

Policy Form Changes
E. DeRosa discussed the changes proposed to be made to the policy forms, including the following:

- Addition of Exclusive Provider Option (EPO) schedule pages and language changes to accommodate an EPO type of standard plan offering;
- Removal of in-network cost-sharing for preventive care services in accordance with the PPACA (no change to the out-of-network benefit is required, and based on information received to date from HHS, it seems annual dollar limits on preventive services are still acceptable);
- Variable text addressing whether prescription drug cost-sharing helps to satisfy the MOOP (except in the case of designated High Deductible Health Plans, where such cost-sharing must be considered);
- Removal of the Plan B hospital copayment, as required by DOBI rules at N.J.A.C. 11:22-5, effective in September;
- Removal of language distinguishing between biologically-based and non-biologically-based mental illnesses for purposes of treatment benefits/services, because of the federal Mental Health Parity and Addiction Equity Act (MHPAEA)

- Addition of language to address the various benefits required by P.L. 2009, c. 115 (Autism Mandate), which requires coverage of certain services for autism and other developmental disabilities, as well as coverage of New Jersey Early Intervention Services Family Cost Share.
- Amendment to the paragraphs explaining participation requirements in accordance with the Board's most recent decision;
- Extension of the child dependent coverage to age 26, consistent with PPACA;
- Amendment of language distinguishing alcoholism from other forms of substance abuse treatment benefits, in accordance MHPAEA;
- Removal of preexisting condition limitation periods for children under 19 years old, in accordance with PPACA;
- Changes to be consistent with the DOBI rules on discontinuance and replacement at N.J.A.C. 11:2-13;
- Changes to be consistent with the DOBI rules regarding war exclusions
- Changes to address situations in which multiple laws interact, including:
    - A modification to the definition of developmentally disabled to accommodate both the Autism Mandate and PPACA
    - A modification to the incapacitated child provisions because of the interaction of PPACA on the insurance laws (thus removing consideration of the child's marital status until age 26, while retaining such consideration thereafter);
    - A modification to dependent/overage dependent child status because of the interaction of PPACA (dependent-to-age-26) and New Jersey's dependent-to-age-31 law.

E. DeRosa reminded Board members that the $36,000 annual cap for applied behavior analysis services for treatment of autism is not included under the standard small group plans (even though permitted by the Autism Mandate) because of the interaction of MHPAEA and New Jersey's definition of biologically-based mental illnesses, and the Board's decision to apply MHPAEA across all small employers.

E. DeRosa explained that she would like to use the Board's expedited rulemaking authority in proposing and adopting these rules, so that the rules can be implemented as soon as possible.

D. Vanderhoof made a motion, seconded by T. Collins, to propose the amendments, new rules and repeals set forth for the policy forms, certificates and pertinent related exhibits, including exhibits A, F, G, H, K, O, V, W, Y, HH and II. The motion carried unanimously.

Executive Session Minutes
E. DeRosa suggested deferring review of the prior executive session minutes until a subsequent meeting, in part because of an impending change in legal counsel.

Transfer of Deputy Attorney General
E. DeRosa announced that DAG V. Mangiaracina has been reassigned to the Health and Human Services section, where she will be working with the Division of Medical Assistance and Health Services (Medicaid). She stated that Zoe McLaughlin, who had sat in on the meeting today, may – or may not – be assigned to represent the SEH Board, but will, at the very least, serve as a

back-up for the SEH Board. E. DeRosa noted that V. Mangiaracina will also no longer be representing the IHC Board. Board members expressed gratitude to V. Mangiaracina for her work with the SEH Program.

V. Public Comments

There were no public comments.

VI. Close of Meeting

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

[The meeting adjourned at 1:05 P.M.]