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
May 22, 2013

Members present: Herbert Ames; Gary Cupo; Darrel Farkus (Oxford); Joyce Gralha (Horizon); Wyatt Kasserman (AmeriHealth); Margaret Koller; Mary Ellen Peppard *(arrived at 10:55)*; Thomas Pownall (Aetna Health Inc.); Christine Stearns *(arrived at 10:35)*; Neil Vance (DOBI); Dutch Vanderhoof

Others participating: Ellen DeRosa, Executive Director; Chanell McDevitt, Deputy Executive Director; Rosaria Lenox, Program Accountant.

I. Call to Order

E. DeRosa called the meeting to order at 10:15 A.M. E. DeRosa announced that notice of the meeting was provided to three newspapers and the State House Press Corp, 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.

II. Public Comments

There were no public comments.

III. Staff Report

Minutes – April 29, 2013

D. Vanderhoof made a motion, seconded by D. Farkus, to approve the draft minutes from the open session of the April 29, 2013 meeting. The motion carried, with N. Vance abstaining.

Expense Report and Transfer of Funds

R. Lenox presented the May expense report, with expenses totaling $1,905.88, primarily for charges from the Division of Law, for legal services. She requested that the Board approve the expenses, and a transfer of $1,900 from the Board's Money Market fund to the Board's checking account to pay the May expenses.

D. Vanderhoof made a motion, seconded by J. Gralha, to approve the May 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 the expenses. The motion carried.

Rider Filings

W. Kasserman recused himself from discussion and any action that might be taken with respect to any riders submitted by AmeriHealth because of his company's interest in the outcome.

E. DeRosa explained that AmeriHealth submitted a rider to amend its EPO and POS plans to provide vision benefits for covered persons aged 19 and older. She recommended that the Board find the rider complete.

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

E. DeRosa noted that carriers can now submit their increasing riders through SERFF (the NAIC's System for Electronic Rate and Form Filing), just as they do their decreasing riders.

III. General Rule Amendments – Committee Discussions

E. DeRosa stated that there are a number of the Board rules, including definitions, that should be revised to avoid unnecessary inconsistencies and confusion with respect to implementation of federal laws starting in 2014. She suggested that the Board have its committees begin looking at the rules and making revisions. After general discussion, the Board agreed to allocate work among committees thus:

- Legal Committee → Subchapter 1 (general rules and definitions)
- Ad hoc (Application/Certifcation) Committee → Subchapter 6, and related exhibits
- Ad hoc (Program Compliance) Committee → Subchapter 7
- Marketing Committee →Subchapter 17 (fair marketing) and enrollment report forms

The Ad hoc (Application/Certification) includes: G. Cupo, D. Farkus, J. Gralha, H. Ames, and T. Taliaferro.

The Ad hoc (Program Compliance) Committee includes: T. Pownall, D. Farkus, J. Gralha, M. Koller, G. Cupo, T. Taliaferro, and the DOBI.

*[**Note:** the Roebling Building was evacuated from 10:40 until 10:55 due to a fire drill. During this time, the Board meeting was suspended, and no action or discussion occurred.]*

IV. Out-of-Network (OON) Reimbursement

E. DeRosa reminded Board members that the question of what methodology is to be used for reimbursement of OON services remains unresolved. She noted that the Board had intended to hold stakeholder meetings facilitated by Rutgers Center for State Health Policy – with or without the Individual Health Coverage (IHC) Board joining or in the audience – but nothing was finalized. She stated the IHC Board discussed the issue again, and was no longer certain that there would be any products for the IHC market with OON options. It was noted that whether or not the IHC market has any plans with OON features, the SEH market probably would, and even if the number is small, a reimbursement methodology would be needed.

Several Board members made additional suggestions regarding the draft white paper, specifically to include discussion of EPO products, and the anticipated impact. The Board acknowledged that it still wanted to have stakeholder meetings, but considered it prudent to wait until mid-summer before holding them. After further discussion, the Board concluded that it would like to:

- have multiple meeting options with the same topic, so that invitees unable to make one time/date may be able to make another time/date
- have meetings with mixed stakeholder groups
- assume about 2 hours for the meetings
- have documents issued prior to the meetings, so that people can have an opportunity for more thoughtful reaction
- include some presentation to set the stage
- not solicit written feedback

It was agreed to target the second or third week in July. M. Koller stated she would circulate invitee lists and a draft agenda for the Board's consideration, and look at space availability near the DOBI.

V. Process for Transitioning from Current to New Plans

Withdrawal and Notice
The Board discussed how the transition process should occur for moving business from the existing standard plans to the new plans in 2014. The Board agreed that it is impractical to try to distinguish between those actions taken by carriers that may be considered voluntary, and those that result as a matter of federal law. The Board agreed that the principal issue is to assure that employers receive adequate notice about what will be happening to their current coverage, and what options they will have going forward in 2014. It was agreed that neither the Board nor the DOBI are expecting carriers to make formal withdrawal filings, but also agreed that carriers should follow the plan withdrawal procedures for purposes of providing notifications to employers as well as producers.

The Board agreed to the following:

- In August or September, carriers will mail a letter from E. DeRosa to employers providing a general overview of what is happening in the market. The letter is intended to set the stage for the notices of nonrenewal that carriers will issue.
- To post the Board's notice on its website and issue (email) the notice to the interested parties list at about the same time as notices are first sent to employers.
- At 90 and 60 days prior to renewal, carriers will issue to employers notices of nonrenewal of the current plans and options for obtaining new coverage with the carrier, or through other means.

Forced Migration and Credits
The Board discussed whether carriers would be required to provide credits for cost-sharing already incurred when a group/employee/dependent moves from one plan to another in 2014 with respect to the maximum out-of-pocket limits (noting that credits for deductibles are already provided). The Board suggested that the ad hoc committee considering program compliance

consider the issue. It was acknowledged that requiring credits would be very consumer friendly, but some carriers questioned the impact such a credit would have on rating, given that whole blocks of business may be affected.

Early Renewals

E. DeRosa noted she has heard that some policyholders are seeking to purchase new plans prior to the expiration of their plan years, for the purpose of having a pre-2014 policy for a longer period of time. (For example, a policyholder with a March-to-March plan year terminates the current policy in November, and replaces it with the same plan but an effective date of November or December. The new, later effective date allows the policy to remain in place until the anniversary date in 2014.) A member of the audience asked whether maintaining a non-compliant group plan during 2014 violates the ACA "play or pay" standards (requiring employers to offer minimum essential coverage to employees or be subject to a penalty, and requiring individuals to have coverage under plans meeting certain standards or be subject to a penalty). It was noted that the "play or pay" requirements apply to employers with more than 50 full-time equivalent employees, so there would be an impact on only a small percentage of small employers, and such employers would have to evaluate their circumstances. The Board acknowledged that employers are not required to keep a policy for a full 12-month period (plan year). The Board did not determine whether it is necessary or appropriate to take a position on the practice.

VII. Public Comment

There was no public comment.

X. Close of Meeting

M. Koller made a motion, seconded by W. Kasserman, to adjourn the meeting. The motion carried.

[The meeting adjourned at 12:25 P.M.]