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
November 20, 2013

Members present: Charles Cerniglia (Oxford); Gary Cupo; Pat Gillespie (CIGNA); Joyce Gralha (Horizon); Margaret Koller; Mary Ellen Peppard; Thomas Pownall (Aetna Health Inc.); Christine Stearns; Neil Sullivan (DOBI); Tony Taliaferro (AmeriHealth); Dutch Vanderhoof.

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

I. Call to Order

E. DeRosa called the meeting to order at 10:10 A.M. E. DeRosa announced that notice of the meeting was provided to three newspapers and the State House Press Corps, 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. Minutes – *September 18, 2013*

P. Gillespie made a motion, seconded by G. Cupo, to approve the minutes of September 18, 2013, with amendments. The motion carried, with D. Vanderhoof abstaining.

IV. Staff Report

Expense Report

R. Lenox presented the expense report, with expenses totaling $9,711.85 for the audit services of WithumSmith+Brown with respect to the SEH Program's fiscal year 2013. R. Lenox recommended to the Board that, if they approve payment of the expense, they also approve a transfer of $9,700.00 from the Board's Money Market account to its checking account.

P. Gillespie made a motion, seconded by C. Stearns, to approve payment of the expenses totaling $9,711.85, and the transfer of $9,700 from the Board's Wells Fargo Money Market account to its checking account in order to pay the expense as approved. By roll call vote, the motion carried.

Optional benefits riders
E. DeRosa reported that optional benefits riders had been filed by two carriers.

T. Pownall recused himself from the discussion about, and any action to be taken upon, the optional benefit riders submitted by Aetna Health, because of the interest of his employer in the outcome of the action.

E. DeRosa explained that Aetna Health submitted four riders that enhance the prescription drug benefit on the 2014 POS plan, POS-HSA plan, HMO plan and HMO-HSA plan, with the riders varying somewhat based on the specific plan being amended. She explained that Aetna Health submitted three additional riders, to do the following: (1) one rider would amend the HMO and HMO-HSA plans to add adult vision coverage, benefits for E-visits, and open access provisions; (2) one rider would amend the POS and POS-HSA plans to add unlimited benefits for out-of-network preventive services, adult vision coverage, benefits for E-visits, and open access provisions; and, (3) one rider that amends the HMO and HMO-HSA plans to add tiered network provisions, along with adding benefits for adult vision coverage, E-visits and open access options. She recommended finding all of the riders complete.

P. Gillespie made a motion, seconded by G. Cupo, to find each of the filings complete. The motion carried.

C. Cerniglia recused himself from the discussion about, and any action to be taken upon, the optional benefit riders submitted by Oxford Health Insurance and Oxford Health Plan, because of the interest of his employer in the outcome of the action.

E. DeRosa explained that Oxford Insurance Company submitted three separate riders that would amend the 2014 insurance plans: (1) one would allow cost-share to accumulate on either a plan year or calendar year basis; (2) one would add benefits for health aids for insureds over the age of 15 (subject to a maximum of $5,000 per year every 24 months); and, (3) one that would provide restorative services at different cost-share levels based on classification as major or minor within the pediatric dental coverage. She stated that Oxford Health Plan submitted one rider for its HMO plans that would also provide restorative services at different cost-share levels for pediatric dental, based on whether the restorative service is considered major or minor. She recommended that the Board find all of the riders complete.

D. Vanderhoof made a motion, seconded by P. Gillespie, to find the riders complete. The motion carried.

V. Rule Proposal – *Policy Forms and Subchapters 1, 3, 4, 6, 7 and 17*

E. DeRosa discussed the draft rule proposal. She noted the following within the proposal:

- Several definitions within subchapter 1 would be deleted, including: church plan, creditable coverage, government plan and preexisting condition exclusion. Because of the prohibition of preexisting condition limitations, the concept of creditable coverage is no longer applicable, and several of the terms proposed for deletion were included specifically because of the creditable coverage standards. In addition, the terms

"federally-qualified HMO" and "nonstandard plan" would be deleted because they are no longer relevant.

- Several terms would be amended or added to subchapter 1, including:
    - Carrier coinsurance, a new term that would be used to clarify when a coinsurance percentage is meant to be paid by the carrier, as opposed to the consumer.
    - Employee open enrollment period, a new term identifying the annual time period designated by a small employer during which employees may enroll (or change) coverage subsequent to the lapse of the initial enrollment period.
    - Employer open enrollment period, a new term identifying the annual time period during which employers may enroll in small employer plans despite not meeting minimum participation or contribution requirements.
    - Employee, a new term that is consistent with the federally-specified concept of employee.
    - Eligible employee, an existing term that would be amended to exclude sole proprietors, partners and independent contractors. The term would no longer include such persons because the federal law considers them to be individuals, not employees.
    - Late enrollee, an existing term that would be amended to mean an employee or dependent that did not enroll when initially eligible under a small employer plan, without further reference to preexisting condition limitations.
    - Maximum out-of-pocket (MOOP), an existing term that would be amended to require accumulation of cost-sharing for prescription coverage towards satisfaction of the MOOP.
    - Network MOOP, an existing term that would be amended to require accumulation of all cost-sharing towards any in-network MOOP.
    - Small employer, an existing term that would be amended to provide two qualifying standards, the first being similar to that in current use in New Jersey, except that an employer may have one eligible employee rather than a minimum of two (and the standard is applicable only to purchases made outside the SHOP), while the second is the standard established under federal law (and is applicable to purchases made both inside and outside the SHOP).

There was some discussion among Board members regarding the definitions of "employee," "eligible employee," and "small employer." The following points were noted:

- The federal law does not allow sole proprietors, partners, or immediate family to be counted as employees for purposes of determining whether an employer is a small employer, but the law does not prevent sole proprietors, partners or immediate family from being covered under a small employer's plan if there is at least one common law employee.
- The two-part definition of small employer, when used outside of the SHOP, is an either/or standard – meaning that the employer can meet one standard or the other and be

considered a small employer for purposes of coverage under a small employer plan offered outside of the SHOP.

- The first part of the small employer definition maintains the existing union exception, while the second part has no such exception.
- An eligible employee is still someone who works 25 hours per week for purposes of non-SHOP plans, while the SHOP counts full-time equivalents based on a 30-hour work week; accordingly, it is possible that an employer who does not qualify as a small employer under the first part of the small employer definition may qualify as a small employer under the second part of the definition, and thus, be eligible to purchase a small employer plan both on and off the SHOP.
- There is no longer a requirement that the majority of a small employer's employees work in New Jersey; however, a carrier offering a network-based plan may restrict coverage to employees who live, work, or reside within the carrier's service area.

E. DeRosa described other proposed changes to the rules, highlighting the following:

- Subchapter 3, which describes the plan designs, included most of the changes presented to the Board in April to bring the plans into alignment with the federal essential health benefits standards. The changes would include the removal of Plan A, and specification of cost-sharing defined as ranges consistent with New Jersey's minimum standards rules (N.J.A.C. 11:22-5).
- Subchapter 4, which essentially matches the plan designs with policy forms, would be amended primarily to remove references to Plan A.
- Subchapter 6, which requires carriers to use a standard application and employer certification form, would be amended to remove references to the forms in the appendix of the chapter, and instead, would describe the content of the forms and direct readers to the forms published on the SEH Board's website. The forms would be removed from the appendix.
- Subchapter 7, which sets forth standards for program compliance, would have some significant amendments, including:
    - Addition of new rules that would explain how to determine whether an employer is a small employer, using the 2-part small employer definition outside of the SHOP, and counting of full-time equivalent employees when it is necessary to use the second part of the definition. It was noted that employer size would only be evaluated annually.
    - Amendments requiring carriers to offer three standard plans from among Plans B, C, D or E, which means that carriers that used Plan A to meet the three-plan requirement would have to replace it with another plan.
    - Amendments clarifying that late enrollees may not be subjected to a preexisting condition limitation period, but will be required to wait until the employee open enrollment period.
    - Removal of the option to cover retirees and part-timer employees, and removal of the option to include independent contractors.

- Amendments clarifying that employees covered under TriCare count towards the participation requirement (since it is an employer group health plan).
- Amendments stating that the 75% participation requirement and the 10% contribution requirement do not apply during the employer open enrollment period.
- Addition of new rules requiring that every small employer group have an employee open enrollment period of at least 30 days, during which late enrollees may enroll, and current enrollees may change plans, if options exist.
- Addition of new rules setting forth special enrollment periods arising due to triggering events, some of which already existed as a result of older federal law (HIPAA), but which had not been included in Board rules, and some of which result from newer federal legal requirements.
- Amendments to the timing of quarterly enrollment reports, and removal of one requirement that carriers had been unsuccessful in capturing.
- Amendments to the permissible rate classification factors to: remove gender as a factor, allow for single year age bands (rather than prescribed 5-year bands), establish limitations on child rates, limit territorial rating to six counties, and remove the four-tier rate structure.

There was brief discussion about the forms, and general discussion among the Board members, during which the following points were noted:

- The description of the method of how to determine whether a small employer meets the participation requirements is included in the policy forms. The methodology would differ based on whether the employer is purchasing a plan inside or outside the SHOP. The methodology outside of the SHOP provides two ways for employers to meet eligibility, while the methodology for purchases inside the SHOP follows the federal rules (and provides one route to meet eligibility).
- Foster children would be added to the definition of dependent within the forms.
- The forms would also include added language regarding coverage of clinical trials.
- The forms would include language permitting an exclusion of contraceptive coverage as a preventive service for certain employers.
- Dependents under 31 electing to become covered or continue coverage under a small employer plan should be rated based on their age starting in in 2014, and such individuals could be added only during defined open or special enrollment periods.

It was agreed that Board members would have several days to digest the information discussed, provide comments to E. DeRosa on November 25, and that the Board would meet again, by conference call, on November 27, at 10:00 A.M. with the intent of taking action on the proposal. E. DeRosa explained that, if the Board accepts the proposal on November 27, 2013, the proposal will be proposed using the Board's expedited rulemaking authority, with the comment period ending on December 17, 2013, prior to the Board's regularly scheduled meeting on December 18, 2013 which would permit the Board to adopt the proposal during the December 18, 2013 meeting.

T. Taliaferro stated that Darrel Farkus had retired from Oxford, and that C. Cerniglia will be filling Oxford/United's seat on the SEH Board. T. Taliaferro noted D. Farkus' long participation and significant contribution on both the IHC and SEH Boards and indicated a desire to have some function for D. Farkus at some point in the near future, if possible. Other Board members agreed.

VI. Public Comment

There was no public comment.

VII. Close of Meeting

D. Vanderhoof made a motion, seconded by G. Cupo, to adjourn the meeting. The motion carried.

[The meeting adjourned at 12:00 NOON.]