FINAL
MINUTES OF THE MEETING OF THE
NEW JERSEY INDIVIDUAL HEALTH COVERAGE PROGRAM BOARD
AT THE OFFICES OF THE
NEW JERSEY DEPARTMENT OF BANKING AND INSURANCE
TRENTON, NEW JERSEY
October 14, 2014

Directors participating: Sandi Kelly (Horizon); Lisa Levine (United); Thomas Pownall (Aetna); Gale Simon (DOBI); Tony Taliaferro (AmeriHealth).

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

I. Call to Order

E. DeRosa called the Annual Meeting of the IHC Board to order at 10:05 A.M. She announced that notice of the meeting had been published in two newspapers of general circulation and posted at the Department of Banking and Insurance ("DOBI"), the DOBI website, the Office of the Secretary of State and submitted to the State House Press Corps, in accordance with the Open Public Meetings Act. A quorum was present. She stated that voting would be by roll call because many of the directors were participating by phone.

II. Minutes – *September 9, 2014*

G. Simon made a motion, seconded by L. Levine, to approve the minutes of the September 9, 2014 meeting, with amendments. In voting by roll call, the motion carried.

III. Staff Report

Expense Report and Transfer of Funds

E. DeRosa stated that the Board has expenses totaling $10,646.91 on the October 2014 expense report, for the IHC Board's portion of salaries and fringe. She indicated that the Board will need to transfer $10,000 from its Wells Fargo Money Market fund to its Wells Fargo Checking account, if the Board approved payment of its operating expenses on the October expense report.

S. Kelly made a motion, seconded by T. Pownall, to approve the October expense report, and to approve the transfer of $10,000 from the Board's Wells Fargo Money Market Account, to the Board's Wells Fargo Checking account, to pay the approved operating expenses. In voting by roll call, the motion carried.

IV. Draft Revisions to the Standard Plans

E. DeRosa discussed the proposed amendments, additions and deletions to the text of Exhibit A in the Appendix to N.J.A.C. 11:20, which sets forth the content for Plans A/50, B, C, and D. She also explained that, following approval by the Board, substantially similar changes would be made to Exhibit B (containing the contents of the HMO Plan). She further explained that some

changes would also be made to the rules at N.J.A.C. 11:20 to keep the rules and the policy forms in alignment.

E. DeRosa highlighted the following:

- The Maximum Out-of-Pocket (MOOP) amount will become $6,600, consistent with the maximum permitted under federal law. In addition, she noted the insertion of a reference to the federal rules implementing changes in the MOOP, so that the standard plans will remain consistent with this cost-sharing amount without requiring regulatory action by the Board in the future.
- In the tiered plan option, a clarification was made demonstrating that the emergency room copay requirement cannot be different between Tier 1 and Tier 2 for medical emergencies. The Board did not endorse this amendment.
- Removal of the 30-visit limit for therapy services for autism. E. DeRosa noted that this change is due to the Mental Health Parity and Addiction Equity Act (MHPAEA), and rules implementing that federal law, which permit limitations only to the extent that two-thirds of treatments for medical conditions are subject to such limits. She explained that, although therapy services are subject to visit limits regardless of whether for physical or mental health treatment, the two-thirds standard of MHPAEA is not met.
- Deletion of the definition of anniversary date, because the term no longer has purpose in the standard plans.
- Amendment of the definition of "open enrollment period" to replace reference to a date-certain with an indication that the open enrollment period will be designated annually.
- Upon the request of a hospice organization, correction to the names of the accrediting bodies for hospice organizations within the definition of "Hospice."
- Amendment of the definition of "renewal date" to clarify that January 1 will always be the renewal date of the policy.
- Upon the request of a carrier, addition of variable language that permits a carrier to require greater cost-sharing for use of the services of a primary care provider (PCP) who has not been selected as a covered person's specific PCP.
- Amendment to the Emergency Room Copayment requirement, making it a variable term, so as to clarify that carriers are permitted to omit the emergency room copayment when issuing plans as high deductible health plans (HDHP).
- Amendment to instructions contained in the Orally Administered Anti-Cancer Prescription Drug section to clarify that certain variable text applies when a plan is a managed care plan, and not just when a Preferred Provider Organization plan is involved.
- Amendments to the mammography benefit to match the most recent changes to New Jersey law, with which carriers should already be in compliance for purposes of administering their policies.
- Amendments to the provisions addressing Diagnosis and Treatment of Autism and Other Developmental Disabilities to clarify that visit limits still apply to treatment of developmental disabilities other than autism. In addition, the provision would be amended to remove reference to age 21 with respect to applied behavioral analysis

treatments for autism because the age 21 limit is not permissible pursuant to MHPAEA's two-thirds standard.

- Amendments to the pediatric vision benefit to be more consistent with the FedVIP plan, which New Jersey selected for purposes of compliance with the pediatric benefit requirement. The FedVIP includes a low vision benefit for vision aides, as well as an evaluation for low vision every 5 years.
- Deletion of a separate Grievance Procedure provision, because all of the carriers are putting their grievance and appeals procedures into the same section.
- Amendments to the Term of the Policy provisions, renaming it Renewal Privilege – Termination. The amendments clarify that all policies renew at the end of December annually, and that the covered person has the right to renew the policy annually upon the renewal date, subject to certain conditions. The amendments clarify the notice time period for terminations when: the carrier is ceasing to do business in the individual market (180 days advance notice); the carrier is ceasing to offer a specific plan to anyone (90 days advance notice); or, the Board terminates the standard plan (90 days advance notice). The section was also clarified by moving reference to catastrophic plans from the termination paragraph to the nonrenewal paragraph, where nonrenewal primarily occurs due to the actions, or a change in status, of a covered person, rather than actions of the carrier, or the Board.

E. DeRosa noted that, in addition to the changes discussed for all of the plans, she would also like approval to modify the HMO Plan to build in provisions for a high deductible health plan option that could be used with a health saving account, which had been requested by one or more carriers.

E. DeRosa stated that, if approved, the proposal would follow the Board's expedited rulemaking process, with a 20-day comment period from the date the proposal is filed with the Office of Administrative Law. She explained that once the forms are adopted, she will send out a bulletin with a rider for carriers to use with the 2014 policy forms in 2015, so that carriers will not have to reissue the existing block in its entirety.

T. Pownall made a motion, seconded by S. Kelly, as follows: to propose the amendments, additions and deletions as presented in Exhibit A for all of the standard plans, including the HMO Plan, but not including the suggested changes regarding emergency room copayments in the two-tier version of the standard plans; and, to propose amendments to the rules at N.J.A.C. 11:20 as necessary to assure that the rules and the policy forms are consistent and in alignment. In voting by roll call, the motion carried.

E. DeRosa noted that the HINT form had already been updated for purposes of 2014, but that additional revisions may be appropriate to make it more flexible for open enrollment and electronic notifications.

V. Close of Meeting

S. Kelly made a motion, seconded by L. Levine, to adjourn the meeting. In voting by roll call, the motion carried. *[The meeting adjourned at 10:55 A.M.]*