FINAL

MEETING OF THE NEW JERSEY UNDER 50 MEDICARE SUPPLEMENT PROGRAM BOARD

September 19, 2017

Board Members:

Present – Aetna (HMO) – Tom Kowalczyk (Chair)
Present – UHC (Med Supp writer) – Steve Kane (Vice Chair)
Present – Horizon (Contracting Carrier) – Jackie Duddy
Present – Transamerica (Med Supp writer) – Crystal Wyland
Present – Public Rep – Ron Ouellette
Present – Public Rep – Pat Walsh
Present – DOBI Rep – Brendan Peppard
Vacant – AHIP Rep

Others Present:
Fran Cancro, Division of Aging, DHS
Ellen DeRosa, Executive Director, IHC/SEH Programs
Rosaria Lenox, Managing Financial Officer, IHC/SEH Programs
Chanell McDevitt, Deputy Ex. Dir., IHC/SEH Programs
Christine Machnowsky, Deputy Ex. Dir., IHC/SEH Programs

This meeting was held at 1:30 p.m. in the 5th floor conference room at the Department of Banking and Insurance. Some members participated by phone. Voting was by roll call.

Although not recorded, note that each carrier member and the DOBI had at least one actuarial representative at this meeting in addition to their designated representative.

I. Minutes of July 18, 2017

T. Kowalczyk made a motion, seconded by S. Kane, to accept the minutes of July 18, 2017, with amendments. By roll call vote, the motion carried.

II. Reimbursement to Horizon for CY2014 and CY2015 Losses

R. Lenox reported that there are a few companies that have not yet paid their assessments (for example, one is based in Houston, and its operations were effected by Hurricane Harvey), but that the amounts outstanding total just over $3,500. She suggested that the total amount collected in assessments thus far, combined with the accrued administrative funds currently held for the MSU50 Program at Wells Fargo, would be more than enough to reimburse Horizon for both its CY2014 and CY2015 losses (less Horizon's share of the loss assessments, which is $3,286,190.29 for CY2014 and $3,299,368.12 for CY2015). She noted that the late assessment payments will be deposited into the Wells Fargo account to reimburse that account.

T. Kowalczyk made a motion, seconded by B. Peppard, to transfer to the Small Employer Health Benefits Program's Wells Fargo Checking Account from the DOBI Treasury account $6,420,551.80 in assessments collected to date for the MSU50 Program's combined CY2014 and CY2015 audited losses, and then to issue from the Small Employer Health Benefits Program's Wells Fargo Checking Account reimbursements on behalf of the MSU50 Program to Horizon in the amount of $3,252,385.71 for CY2014 and $3,171,685.88 for CY2015, which constitute the total audited losses that exceed Horizon's share of the MSU50 Program's losses for each of those calendar years. By roll call vote, the motion carried.

E. DeRosa stated she would notify Director of Insurance Peter Hartt of the MSU50 Program's Governing Board's recommendation to transfer the funds and make payment to Horizon in full for CY2014 and CY2015.

III. CY2016 Loss Audit: Recommendation of the Evaluation Committee and the Audit Committee

C. McDevitt discussed the process regarding the engagement of an auditor for the CY2016 losses, noting that the Scope of Work for the audit of the losses of the MSU50 Program had been issued at the end of June to those accounting firms remaining on Treasury's cooperative agreement labeled T-2458 for a single audit, and received a single response of interest from WithumSmith+Brown (WSB). She explained that, because it was a single response and no comparison to other bidders was necessary, the Evaluation Committee modified its review to determine whether WSB met the requirements of the SOW and presented a reasonable cost estimate. She stated the Evaluation Committee recommended awarding the engagement to WSB. She further explained that the Audit Committee reviewed the recommendation of the Evaluation Committee, as well as WSB's proposal, and agreed with the Evaluation Committee, and accordingly, the Audit Committee also recommended awarding the engagement to WSB for the CY2016 audit. She noted that the Department of Treasury has since finalized its award of new contracts for cooperative agreement T-2458 in August 2017, and that the Governing Board may consider entering into multi-year engagements for auditing services going forward.

T. Kowalczyk made a motion, seconded by B. Peppard, to accept the recommendations of the Evaluation and Audit Committees and engage the services of WithumSmith+Brown to audit the CY2016 reported losses of the MSU50 Program, in accordance with the terms of T-2458 (issued in 2011), the SOW and WSB's response to the SOW. By roll call vote, the motion carried.

T. Kowalczyk asked what the loss review and audit process would be going forward, and R. Lenox explained that Horizon (as the contracting carrier) is required to report the net losses for a calendar year to the Board by April of the following year, with an audit commencing after that. She noted that for CY2017, the audit of net losses could be completed during the Summer of 2018, assuming a new audit contract is awarded no later than the Spring of 2018, with assessments approved and invoices issued within a few months after the audit is completed, and payment made after all invoiced amounts are paid, barring any extraordinary circumstances.

IV. Transition for CY2020

a) Guaranteed issue plan recommendation

The Board again discussed what recommendations to make for the MSU50 Program for CY2020. After discussion, there was a consensus to recommend that Plan D be available in 2020 for the MSU50 Program population. The following points were noted:

- Plan D is most similar to Plan C, but Plan G will be the most comprehensive plan in 2020.
- Plan G's extra benefit is coverage of the Medicare Part B excess, but it turns out that the additional claims covered are nominal on average, resulting in about $1 difference in premium between Plans G and D.
- Horizon does not offer Plan D currently, so when it becomes available in 2020 (as it must for those who are eligible for Medicare due to age), there would be less impact on existing pricing pools than if any other plan was chosen to substitute for Plan C for the MSU50 Program population (as well as the 50-64 population).
- Using Plan D would align with MACRA[1], which suggests using Plan D.

One Board member recommended Plan G because of its broader coverage. However, because concern was expressed about the impact the MSU50 Program population might have on the rating pool for Plan G, and because it was acknowledged that the additional benefits are not widely used, the majority of Board members agreed to recommend Plan D.

b) Should current enrollees have an option to buy into Plan D in 2020?

The Board next discussed whether current enrollees should have an option to buy into Plan D in 2020. The Board did not reach a recommendation on this question. The following points were highlighted:

- When blocks of business close – which will be the situation for Plan C in 2020, although not immediately as of December 31, 2019 – experience for the block tends to trend negatively, and rates increase accordingly. However, the trend for this population may be less steep over time simply because both the under 50 and 50-64 populations come into the pool with poor health and increased service needs, which may not become significantly worse over time. Rates are likely to increase over time, but not dramatically just because it is a closed block.
- When MIPPA[2] was implemented, carriers allowed current enrollees (65 and older) to move into revised plans, subject to underwriting, and if carriers do that for implementation of MACRA they are likely to establish the same requirement, but this population could not meet underwriting standards applicable for the typical Medicare eligible population.
- The difference in premium between Plan C and Plan D should be relatively small.

The DOBI indicated it would like to consider the closed block issues more thoroughly.

[1] Medicare Access and CHIP Reauthorization Act of 2015 – which makes Plans C and F unavailable to newly eligible Medicare beneficiaries as of 2020.

[2] Medicare Improvements for Patients and Providers Act of 2008.

c) Should the open enrollment period be revised for plan years starting with 2020?

The Board then considered whether to provide an additional period of time for people to enroll in Plan D, beyond the six-month open enrollment standard that typically applies to individuals who become eligible for Medicare by reason of age. The Board coalesced around the concept of permitting people to have a longer open enrollment period following eligibility due to disability. The following points were made:

- Under current rules, if individuals do not enroll within the first 6 months of eligibility, they have no additional option until age 65.
- The six-month enrollment period is often inadequate for those who become eligible for Medicare due to disability. Because these individuals are younger and disabled/chronically ill, they are not only less aware about Medicare coverage and Medicare Supplement plans, they are less aware of resources available to educate them and help them navigate Medicare and related issues, while also having fragile health and often a fragile support system. They often do not realize they are eligible for a Medicare Supplement plan, or they do not realize the need for a Medicare Supplement plan until after the six-month window has closed.
- The individuals at issue are already disabled/chronically ill; consequently, they do not represent an increased risk just because the six-month window closes, unlike the more typical enrollee who seeks enrollment after the open enrollment period ends.
- Other markets have additional opportunities to enroll, whether through annual open enrollment periods, or special enrollment periods based on changes in circumstances.
- Individuals who elect Medicare Advantage enrollment have the opportunity to make some changes in their Medicare Advantage coverage from time to time, even when enrolled as a result of disability. Although more restrictive than regular Medicare combined with a Medicare Supplement plan, for people who think they want to make changes annually, Medicare Advantage would be the option to choose. However, it doesn't necessarily solve the problem for those who miss the initial six-month enrollment period for a Medicare Supplement plan.
- Having an annual open enrollment period is administratively burdensome for the contracting carrier. Extending the open enrollment period for each person from 6 months to 12 months would be much less burdensome, and easier to explain to Medicare beneficiaries.

d) Should the rating requirements for the MSU50 Program continue as currently constructed?

The Board considered the question of rating, and whether the rates offered to the MSU50 Program population should continue to be the same as the lowest rate offered for the same plan available to the 65 and older population, or whether another form of subsidization of the premiums for the MSU50 Program would be appropriate instead of or in addition to the community rate. No specific consensus was reached on the issue. The following points were made:

- Because Horizon has no Plan D offering now, when it offers in 2020, an inordinately large percentage of its pool will be the disabled population.
- Other States that require coverage of the disabled and community rate tend to allow a rate more commensurate with the risk.
- Changes to the rating standard may need a legislative change.

There was brief discussion regarding the contract, but it was suggested that details could probably be left to discussions between Horizon and staff.

E. DeRosa agreed to summarize the recommendations reached today, and present them to the Commissioner for possible further action.

B. Peppard made a motion, seconded by T. Kowalczyk, to adjourn the meeting. By roll call vote, the motion carried.

[The meeting adjourned at 2:45 P.M.]