Affiliated Physicians & Employers Master Trust

a NJ self-insured MEWA

Members Health Plan New Jersey (MHPNJ) - FAQ's Regarding Assessment August 2021

1. **How is the assessment calculated? Do you have an estimate of what the assessment will be?**
   The assessment is calculated based on a few factors. The factors are, the time (1/1/2020 through July 31, 2021) for which the deficiency occurred, the amount of the liability (7.5% of health care fees billed in this period) and the amount of total health care fees each employer was billed during this time. The assessment amount due from each employer is on a pro-rata basis of the total as per the MEWA Regulatory Statute.

   Examples:
   - Employer A paid $50,000 in Health Care Fees (premiums) from 1/1/20 through 7/31/2021
     The Assessment percentage for all employers is 7.5%. Employer A would pay $3,750 Assessment.
   - Employer B paid $100,000 in Health Care Fees (premiums) from 1/1/20 through 12/31/2020
     The Assessment percentage for all employers is 7.5%. Employer B would pay $7,500 Assessment

2. **Is there a maximum percentage that can be assessed?**
   No, the assessment is based on the total liabilities of the plan and calculated on a pro rata basis.

3. **What assurances do plan members have that the assessment number is accurate?**
   The Trust has evaluated its current and expected liabilities for medical claims as well as Plan expenses to provide the best projection for an accurate assessment amount.

4. **If the assessment is deemed incorrect, how will adjustments be made and communicated?**
   If medical claims and Plan expenses exceed the projected assessment amount, the Plan will need to do an additional assessment of the employers. If the medical claims and plan expenses are less than the assessment amount, then employers will be issued a refund in the same proportion as the assessment. The Trust will continue to communicate with the employers and brokers of any changes or revisions to the assessment.

5. **Can an employer collect the Assessment money from their employees?**
   We would advise the employer to consult with their legal counsel as the Employer signed the Health Plan Participation Request Contract.

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6. **What documents/Information did an Employer or Employee receive regarding the ability for the plan to do an Assessment?**
   At time of Enrollment an Employer is required to complete and sign a Health Plan Participation Request Contract which includes a Statement of Contingent Liability in Section 10. Information is also included in the Plans Underwriting Guidelines and well as the Summary Plan Documents.

   Click Here for Health Plan Participation Request Contract Form
   Click Here For a Copy of Underwriting Guidelines
   Click Here to Download a Copy of your Summary Plan Document

7. **Once the assessment is communicated, can there be any additional assessment once all claims run out through the system? And if so, when?**
   Yes, in the event the Trust exceeds the projected liabilities or continues to have a shortfall, the Trust can do an additional assessment to the employer groups. The timing of communication will be dependent on the need.

8. **What happens if employers do not pay the assessment?**
   The Trust is legally required to pursue payment of an assessment from its membership and will take all necessary legal actions required to collect, including bringing suit against the employers through the Bankruptcy court.

9. **What if the plan fails to collect a high percentage of the assessments? How would that affect the plan and the plan members?**
   The Trust is legally required to pursue payment from its membership and will take all necessary legal action to collect. In the event the Plan has a short fall due to non-payment the Trust will first pursue legal action against those employers and if unable to collect at that time the Trust can pursue an additional assessment from the remaining members.

10. **Are claims being denied and, if so, which type(s) of claims? What recourse does a plan member have if an eligible claim gets denied? What advice would you give to brokers who have clients in this situation?**
    Claims are not being denied, however medical claims are being put on hold while the Trust collects the assessment. Prescription claims will continue to be paid until funds are exhausted. It is important to note that until the employer termination date with the Plan (no later than December 31, 2021) the Trust cannot guarantee that medical or prescription claims for enrolled

members will continue to be paid until we have collected the full assessment necessary to run out the program.

11. **Are prescription claims handled differently than medical claims?**
Prescription Claims are processed at point of sale for enrolled members; therefore, the Trust is funding Prescription claims first.

12. **What role, if any, will Aetna play in this "wind down" process?**
The Trust is working with Aetna to process and manage the processing of both medical and Rx claims. As the Third Party Administrator (TPA) for the Trust, Aetna is responsible for the adjudication of claims, and network management and member services through run out period of the Plan.

13. **Can Aetna come after the member for any assessments due?**
Aetna is not responsible for the assessment, billing, or collection of the Trust employers. The assessment is a managed by the Trust.

14. **If the plan collects a large percentage of the assessments, does the Chapter 11 process need to continue or can it be withdrawn to reduce the administrative costs to members?**
The Chapter 11 will not be withdrawn as the Plan is now in liquidation and will utilize the Chapter 11 process to provide an orderly process during wind down and through the run-out period.

15. **If the NJ Legislature does follow through with passage of a "Relief Bill," would members who already paid the assessment be refunded?**
In the event funding comes into the Trust from either the Legislative efforts or the American Rescue Plan Funds, the Trust will pay all its liabilities and evaluate what if any of the assessment dollars are used and needed to fulfill the liability. If there are funds remaining, the employers will receive a refund.

16. **For those active clients who have direct debit, the notice states the Trust will be collecting the assessment that way. However, if a client is no longer active with the Plan, can he or she still draw direct debit?**
The assessment will be collected via ACH if you are still enrolled with the Plan and have elected ACH for payment on or about August 15, 2021. If you are no longer enrolled with the Plan, your payment will be due no later than September 15, 2021. The Plan will work with Employers to

provide payment plan options, including our credit card payment option and written extensions for payment.

17. **What contractual obligations (if any) do brokers have regarding their clients and the assessment?**
    The Health Plan Participation/Request Contract is between the Trust and the employer (client). The Broker has no obligation, however, Brokers have agreed under their contract with the Trust that they would educate and provide their clients with the information on the type of plan including and not limited to the Contingent Liability Provision on the contract.

18. **What type of protections do brokers have relative to Errors and Omissions coverage regarding a fiduciary role to the Trust?**
    Brokers should reach out to their individual E & O carriers for details on their coverages and fiduciary responsibilities.

19. **How does filling a bankruptcy claim against the Trust affect Brokers or General Agents?**
    Filing a proof of claim with the Bankruptcy Court provides the Brokers and General Agents the best opportunity to be paid in the event there are funds remaining after claims and other liabilities have been paid.