**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**
**July 13, 2010**

**Directors present:** Darrel Farkus (Oxford); Sandi Kelly (Horizon); Neil Sullivan (DOBI); Tony Taliaferro (AmeriHealth); Mary Taylor (Aetna Health Inc).

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

## I. Call to Order

E. DeRosa called the meeting to order at 10:03 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, and the Office of the Secretary of State in accordance with the Open Public Meetings Act. A quorum was present.

## II. Minutes – *May 11, 2010 Open Session*

**N. Sullivan made a motion to approve the Open Session minutes of the May 11, 2010 meeting, with amendments. M. Taylor seconded the motion. The motion carried, with D. Farkus abstaining.**

## III. Staff Report

*Expense Report*

R. Lenox presented the July Expense Report, with expenses totaling $26,411.37, which involved primarily salaries and benefits for staff, and the services of Withum, Smith+Brown (WSB) related to loss audits. R. Lenox also made a request for approval of the transfer of $26,000 from the Board's money market funds to the Board's checking account if the Board approved payment of the July expenses.

**S. Kelly made a motion to approve payment of the expenses on the July 2010 expense report and to approve the electronic transfer of $26,000 from the money market account to the checking account for purposes of paying the expenses. The motion was seconded by D. Farkus, and carried by a unanimous vote.**

*Rule Proposal – Changes to forms to comply with multiple laws*

E. DeRosa explained that the standard plan forms need to be amended to bring them into compliance with:

- Grace's Law (P.L. 2008, c. 126), requiring coverage of hearing aids for hearing-impaired children up to 15 years old;

- P.L. 2009, c. 115, which mandates coverage of certain treatments for autism and other developmental disabilities as well as coverage of New Jersey Early Intervention Services Family Cost Share (Autism mandate);
- DOBI's minimum standards rules at N.J.A.C. 11:22-5, which do not permit the application of copayments and coinsurance to apply to the same services, thus eliminating Plan B's unique hospital copayment design feature;
- The Patient Protection and Affordable Care Act (PPACA, Public Law 111-148 as amended by Public Law 111-152), which prohibits cost-sharing requirements for preventive care, prohibits application of a preexisting condition period to children under 19 years old, and requires coverage of dependent children up to 26 years old;
- DOBI's rule prohibiting war exclusions, which is not a new rule, but one that previous form amendments have not addressed.

In addition, she explained that some changes had to be made to try to have certain requirements interact in an orderly manner, such as coverage of child dependents under PPACA and New Jersey's requirements concerning continued dependent coverage for incapacitated children.

E. DeRosa walked the Board through the amendments to the form for Plans A/50 through D. She clarified the following issues:

- PPACA does not seem to prohibit limits on out-of-network benefits. PPACA clearly prohibits in-network annual limits for those items that are essential.
- The $36,000 limit for applied behavioral analysis in the treatment of autism applies to individual standard plans because the federal law on mental health parity (which would otherwise prevent the benefit limitation) only applies to the group market.
- The armed forces restriction on dependent coverage will be removed because the PPACA requirement to cover children to age 26 does not allow for consideration of the child's dependency status (or occupation).
- The forms will continue to establish standards with respect to children who qualify as dependents under the standard plans but who would not be considered dependents under federal law (i.e., the grandparent provision, and children of only one domestic or civil union partner) that differ from the PPACA standards.
- Children who continue to be covered due to meeting the incapacitated requirements will be covered regardless of marital status up to age 26, but at age 26 years and older, marital status will be considered.
- Because the federal and state statutory changes will be effective prior to the form amendments being adopted, carriers will have to comply by operation of law provisions initially, and then a compliance rider which would be operative not later than 90 days after the Board adopts the proposed changes.
- The Basic & Essential (B&E) plan has many internal limits but because the federal law does not seem to eliminate internal limits, there is no need to alter these in the B&E Plan. The B&E Plan will comply with the PPACA requirements for preexisting conditions prohibitions for children, coverage of

children to age 26, and removal of the war exclusion pursuant to DOBI rules, but otherwise, the statutory benefits remain unchanged; neither Grace's Law nor the Autism Mandate are included in the B&E Plan.

**S. Kelly made a motion, seconded by D. Farkus, to propose amendments to the policy forms as presented and further discussed, using the IHC Board's expedited rulemaking authority. The motion carried by a unanimous vote.**

## IV. Report of the Technical Advisory Committee (TAC) and Operations and Audit Committee (OAC)

R. Lenox reported that TAC met twice, once to review the loss assessment reconciliations for the 1993, 1994 and 1995 loss calculation periods, and again to review the B&E Plan reports for the first quarter of 2010. She noted that the OAC had also reviewed the reconciliations, and information regarding the loss audits.

*Loss Assessment Reconciliation*

R. Lenox reported TAC reviewed reconciliation spreadsheets in May, and recommended changes, including revisions to calculations to address the effect of the 35% cap on liability. R. Lenox further explained that redistributions had been made for the assessed amounts of liquidated carriers, and other adjustments had been made based on late submissions, mergers of some carriers, and removal of premiums arising from federal employee health benefit plans. She stated that collections of assessments will be required prior to refunds being issued, and that staff intended to wait until the interest earned through June 2010 is posted before issuing any refunds. It was noted that the interest stated on the spreadsheets would be increased to reflect the actual interest that would be posted by the end of the fiscal year, but there would be no impact on the amounts to be assessed.

**M. Taylor made a motion, seconded by T. Taliaferro, to issue invoices based upon the loss assessment reconciliations for the 1993, 1994 and 1995 loss calculation periods. The motion carried by unanimous vote.**

*Loss Audits*

E. DeRosa provided an update on the status of the loss audits, stating that:

- the loss audits for Time for 1997-1998, 1999-2000 and 2001-2002 remain outstanding, and that Deloitte & Touche (1997-1998 and 1999-2000) recently asked another question of Time to which Time had not yet responded.
- Protective is still in litigation with the IHC with respect to the 1997-1998 loss audit of that company.
- the 1996 calculation period audits are complete, but the Board is still owed money by Protective (which is part of its litigation).
- UICI/AEGON's loss audits for 1997-1998 and 1999-2000 still require submission of a signed management representation letter.
- the loss audits of Guardian for the 2003-2004 and the 2005-2006 calculation periods are in progress.

- the loss audit of Celtic for the 2007-2008 calculation period is in progress.

*Basic & Essential Plans*
E. DeRosa reported that TAC reviewed the B&E quarterly reports from AmeriHealth, Oxford and Horizon, and recommended continued monitoring.

*Consulting Contract for Reimbursement of Out-of-Network Services*
E. DeRosa reminded the Board that TAC had made a recommendation for a contract award for consulting services regarding reimbursement methodologies, but that the Board had chosen to table action on the recommendation at the last meeting so that the Board could review the bids that were considered by the selection committee.

E. DeRosa noted that if the Board agrees to engage a consultant as recommended by TAC, it would be necessary to authorize an additional administrative assessment for $400,000, because the existing budget did not include costs of the consultant. R. Lenox stated that the assessment would be based upon the 2007-2008 Exhibit K's.

There was discussion indicating that the Board may not be able to take action on any consultant analyses prior to the demise of the Ingenix PHCS database.

**S. Kelly made a motion, seconded by N. Sullivan, to award a contract to Navigant Consulting as recommended by the TAC for purposes of providing services outlined in the Board's January 11, 2010 Request for Proposal. The motion carried by unanimous vote.**

**M. Taylor made a motion, seconded by T. Taliaferro, to issue invoices for an additional administrative assessment of $400,000 to assure the availability of funds to pay the expenses incurred pursuant to the consulting contract with Navigant. The motion carried by unanimous vote.**

R. Lenox stated she would bring the revised budget to the Board's September meeting.

## V. NJ Protect (Temporary High Risk Pool, also known as a Preexisting Condition Insurance Plan)

E. DeRosa provided the Board with a brief overview and update on New Jersey's activity with regard to establishment of a preexisting condition insurance plan (PCIP). She explained that the U.S. Department of Health and Human Services offered a contract authorizing NJ Protect as the PCIP in New Jersey, but that she had not yet signed the contract on behalf of the Board because no carrier had yet signed a contract with the Board to provide services for NJ Protect. She stated that there have been discussions with Oxford and Horizon, with both carriers making verbal commitments to participate, but nothing had been formalized yet. E. DeRosa explained that the federal government had contracted with GEHA (Government Employees Health Association) to act as a third party administrator for the federal PCIP in those states that have chosen not to establish their own plan.

Board members asked whether NJ Protect enrollment is to be counted as IHC enrollment and included for purposes of loss ratios. N. Sullivan explained that IHC staff and DOBI personnel had viewed the NJ Protect program as akin to a self-funded program, with carriers acting as third party administrators. He noted that NJ Protect is not a truly risk-based product, because the federal government pays for claims in excess of premiums. M. Taylor stated she views NJ Protect as an insured product, with the federal government providing a reinsurance mechanism. It was suggested that carriers participating in NJ Protect probably will not want to claim premiums received for it, so as to avoid having the product subject to state premium taxes. There was agreement that the issue should be discussed by TAC and/or the Operations and Audit Committee (OAC).

## VIII. Close of Meeting

**D. Farkus made a motion, seconded by N. Sullivan, to adjourn the meeting. The motion carried by a unanimous vote.**

*[The meeting adjourned at 12:07 P.M.]*