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 4, 2010

Directors present by phone: Darrel Farkus (Oxford); Sandi Kelly (Horizon); Christine Stearns; Tony Taliaferro (AmeriHealth); Mary Taylor (Aetna Health, Inc.); Lisa Yourman.

Directors present in person: Neil Sullivan (DOBI)

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

I. Call to Order

E. DeRosa called the meeting to order at 11:00 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. She noted that all votes would be by roll call because the meeting was being held via teleconference.

II. Minutes – *September 7, 2010 (Open Session)*

M. Taylor made a motion to approve the Open Session minutes of the September 7, 2010 meeting, with amendments. L. Yourman seconded the motion. By roll call vote, the motion carried unanimously.

III. Staff Report

Expense Report and Transfer of Funds

R. Lenox presented the October Expense Report, with expenses totaling $14,073.57, primarily for staff salaries and fringe benefits, and the services of Withum, Smith+Brown (WSB) related to loss audits.

L. Yourman made a motion, seconded by T. Taliaferro, to approve the October Expense Report. By roll call vote, the motion carried unanimously.

R. Lenox requested approval for the transfer of $16,000 from the Board's money market funds to the Board's checking account to cover the payment of the October expenses.

L. Yourman made a motion, seconded by M. Taylor, to approve the electronic transfer of $16,000 from the money market account to the checking account for purposes of paying the October expenses. By a roll call vote, the motion carried unanimously.

Rule Proposals amending standard policy forms and the specimen B&E form to comply with PPACA and several state laws

E. DeRosa reported that she had received no comments to the proposals either at the public hearing held on September 15 or in writing, so the adoptions of the rules would be without change from the proposals.

There was extensive discussion regarding the adoption notices. Several Board members expressed continuing concern about whether annual limits on preventive care services provided out-of-network are permissible for any plans regulated by the IHC Board, with carrier representatives acknowledging that opinions varied among the departments of each company. It was noted that the legal departments of multiple carriers took conservative positions, suggesting that preventive services must not be limited out-of-network because preventive services are an "essential benefit," while other departments within the same companies wished to continue marketing the products with limits on such services. However, several company representatives indicated their companies took the position that limits on preventive services out-of-network are permissible absent specific guidance from the federal agencies to the contrary.

N. Sullivan stated that, thus far, HHS appears to be distinguishing in- and out-of-network requirements with respect to preventive services, which are mandatory essential benefits, by allowing plans to satisfy the federal requirements on preventive services on an in-network basis only (in accordance with federal interim final regulations specific to preventive services and cost sharing issued on or about July 9, 2010); he noted that plans may either not offer preventive services out-of-network, or may apply cost-sharing to such services out-of-network. He suggested that the federal interim final regulations regarding lifetime and annual limits (issued on or about June 18, 2010), when read together with the later preventive services rules, indicate that HHS intends to permit out-of-network annual limits for preventive services, even though the June 18th interim final regulations do not explicitly state that the annual limits apply solely in-network (when both in- and out-of-network benefits are available). N. Sullivan clarified that essential benefits may not be subject to *lifetime* limits starting with the first policy year after September 23, 2010.

E. DeRosa clarified that the Board's rule proposal had eliminated any limits on preventive services in-network preventive services, but had not removed any limitations that currently existed for out-of-network, nor had any variable language been proposed for the out-of-network benefits. She suggested that carriers could provide a more generous out-of-network benefit administratively, if necessary or preferred.

M. Taylor made a motion, seconded by D. Farkus, to approve the notice of adoption of the proposed amendments to Plans A/50 through D and the B&E Specimen as drafted. By roll call, the motion carried, with T. Taliaferro and L. Yourman abstaining.

The Board discussed roll-out of the plan amendments. E. DeRosa suggested carriers could use a rider to make the changes, rather than re-issuing contracts. She stated she would send out a bulletin with rider language included for both Plans A/50 through D and the B&E Specimen. She noted that, if a carrier had developed its own B&E specimen, the carrier would need to refile it to show how it was complying with the amendments. E. DeRosa reminded carriers that the

Compliance with Law provision of the contracts apply, so carriers should be complying administratively with certain amendments already, but can wait until renewal to send out the riders updating the contracts. The Board agreed that carriers must begin issuing the riders upon renewal and to new business no later than February 1, 2011. E. DeRosa indicated the actual adoption would be published in the *New Jersey Register* November 1, if the notices of adoption are filed with the Office of Administrative Law by October 7th.

Readoption of IHC Program Rules
E. DeRosa explained that N.J.A.C. 11:20 expires December 7, 2010, so a readoption will be necessary to prevent the rules – including those adopted by the Board in this meeting – from expiring. She stated she would provide the Board with a draft readoption at the November meeting. She said it appears the readoption may require only a few changes to the Board's rules.

IV. Report of the Operations and Audit Committee (OAC)

R. Lenox reported that the OAC met to discuss whether to apply late fees to certain carriers that had failed to pay timely their assessments resulting from the reconciliations for 1993, 1994 and 1995. She noted that the OAC had agreed not to invoice for less than $2.00 total, but had recommended adding an amount of less than $2.00 to an already existing late fee for a carrier (Phoenix Life Insurance Company) that had indicated it would mail its assessment plus late fee on a specific date, but did not put the check into the mail until several days later. R. Lenox reported that, with the late charges calculated according to the OAC's recommendation, the late fees totaled $24,586.48, and that seven carriers were subject to the late fees.

M. Taylor made a motion, seconded by L. Yourman, to invoice the late fees in accordance with the recommendations of the OAC. By a roll call vote, the motion carried unanimously.

V. B&E Plan Waiver from Annual Limits Application

E. DeRosa stated she had several discussions with HHS regarding whether the IHC Program could apply for the waiver from compliance with the June 18, 2010 federal interim final regulations (regarding annual limits) with respect to the B&E Plan on behalf of all carriers offering the B&E Plan, and has received oral guidance that such a filing will be accepted. She said HHS has stated that the waiver will apply retroactively to September 23, 2010. E. DeRosa reported that HHS is working on specific guidelines for a waiver filing that would be made by a State, and noted that the requirements would be similar to the requirements for employer/employee plans or carriers seeking a waiver.

She noted, however, that the IHC Program waiver would be limited to the benefits for out-of-hospital diagnostic services ($500 total), the physician visits ($700 total) and the therapy services ($600 total), as set forth in the New Jersey statutes, and that if a carrier wanted to seek a waiver with respect to other benefits that it may offer with limitations not in compliance with the federal regulations (i.e., prescription benefits via a rider), the carrier would have to do so separately.

E. DeRosa stated that if a carrier wants to eliminate the impermissible limit and make other changes (for instance, increase cost-sharing for that benefit), that would require a plan withdrawal notice procedure. E. DeRosa noted the following:

- Prescription drug benefits are considered essential benefits, and thus, the rules regarding annual limits will apply.
- Carriers can stop selling the withdrawn product upon receipt of notice of approval of the withdrawal.
- Carriers must provide members with the withdrawal notice at least 90 days prior to the member's renewal/anniversary date.
- Carriers can change the rates because of benefit changes resulting from the federal law.

[L. Yourman left the call at 12:45 P.M.]

VI. Executive Session

M. Taylor made a motion, seconded by D. Farkus, to move into Executive Session for the purpose of obtaining advice from counsel, and to discuss executive session minutes. By roll call vote, the motion carried unanimously.

[The Board was in Executive Session from 12:45 P.M. until 12:50 P.M.]

VII. Consultant Contract for Rating Methodology

E. DeRosa reported there was discussion with Navigant regarding a concern with an appendix included in the Navigant bid. She said it appeared Navigant's counsel understood the issues, and would be speaking with others at Navigant. E. DeRosa stated that a follow-up phone call was scheduled for October 5, 2010.

VIII. Close of Meeting

M. Taylor made a motion, seconded by D. Farkus, to close the meeting of the Board. By roll call vote, the motion carried unanimously.

[The meeting adjourned at 12:55 P.M.]