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
May 10, 2011

Directors present in person: Darrel Farkus (Oxford); Sandi Kelly (Horizon); Christine Stearns (*arrived at 10:15*); Neil Sullivan (DOBI); Mary Taylor (Aetna Health, Inc).

Directors present by phone: Tony Taliaferro (AmeriHealth).

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 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, and the Office of the Secretary of State in accordance with the Open Public Meetings Act. A quorum was present.

II. Minutes – *March 8, 2011 (Open Session)*

S. Kelly made a motion, seconded by N. Sullivan, to approve the Open Session minutes of the meeting of March 8, 2011, with amendments. The motion carried.

III. Elections

E. DeRosa reported that only the incumbents were nominated for each of the three seats up for election, and each nominee had received all of the votes submitted by mail. She noted that there were no eligible IHC members present at the meeting who had not already submitted a vote by mail, so additional voting opportunities were unnecessary; consequently: Horizon would continue as the director representing health service corporations; Aetna Health Inc. would continue as the director representing health maintenance organizations; and Oxford/United would continue to represent foreign health insurance companies authorized to do business in New Jersey.

IV. Staff Report

Expense Report and Transfer of Funds

R. Lenox presented the May Expense Report, with expenses totaling $53,579.03, which included: $18,258.74 for Navigant's services on the fee schedule project thus far; $3,808.51 for Withum Smith + Brown for loss audits for 2003/2004, 2005/2006 and 2007/2008; and, the remainder for staff salaries and benefits.

M. Taylor made a motion, seconded by D. Farkus, to approve the May Expense Report. The motion carried.

R. Lenox then requested approval for the transfer of $53,600 from administrative funds in the Wells Fargo Money Market account to the IHC Board's checking account for the payment of operating expenses.

M. Taylor made a motion, seconded by T. Taliaferro, to approve the electronic transfer of $53,600 from the IHC Board's Wells Fargo Money Market account to the checking account with Wells Fargo for purposes of paying operating expenses. The motion carried.

Readoption of N.J.A.C. 11:20 with amendments
E. DeRosa reported that the comment period had closed with respect to the readoption of N.J.A.C. 11:20, and no comments had been received either in writing or at the hearing. She stated that, given the lack of comments and no need to make any further changes to the readoption as it was proposed, the IHC Board could vote to adopt the readoption with amendments and the adoption could be forwarded directly to the Office of Administrative Law (rather than to Governor's Counsel) to make the May 12th deadline for the June 6, 2011 *New Jersey Register* publication. E. DeRosa also explained that the Administrative Procedure Act had recently been amended to provide that agency rules remain effective for seven years, instead of five, so the readoption of N.J.A.C. 11:20 with amendments will not sunset until June 6 of 2018.

S. Kelly made a motion, seconded by D. Farkus, to adopt, without changes, the readoption with amendments to N.J.A.C. 11:20. The motion carried.

Good-faith Marketing Reports for Basic & Essential (B&E) Plans
E. DeRosa stated that May 1 was the due date for Basic & Essential Plan annual good-faith marketing reports, and that all carriers except AmeriHealth had submitted the required documentation, and staff recommended that the Board find all carriers that submitted documentation to have marketed in good faith during 2010.

D. Farkus recused himself from any action taken by the Board on this matter regarding Oxford Health Plans and/or Oxford Health Insurance because of the interest of his employer and its affiliates in the outcome of the Board's actions.

M. Taylor recused herself from any action taken by the Board on this matter regarding Aetna Health Inc. and/or Aetna Life Insurance Co., because of the interest of her employer and its affiliates in the outcome of the Board's actions.

S. Kelly recused herself from any action taken by the Board on this matter regarding Horizon Blue Cross and Blue Shield New Jersey and/or Horizon Healthcare because of the interest of her employer and its affiliates in the outcome of the Board's actions.

N. Sullivan made a motion, seconded by C. Stearns, to find that Aetna, Celtic, CIGNA, HealthNet, Inc., Horizon and Oxford marketed the B&E plan in good faith during CY2010. The motion carried.

Good Faith Marketing of IHC Standard Plans by Carriers offering SEH Plans

E. DeRosa reported that May 1 also was the deadline for submission of documentation proving good faith marketing of individual standard plans by carriers offering plans in the small employer market. She noted that only those carriers offering coverage in the small employer market are required to submit a report, so not all carriers offering individual plans submitted a report (i.e., Celtic); however, one carrier (AmeriHealth) required to submit a report had not done so. She stated that all of the reports that had been submitted initially were technically deficient, but each deficiency could be readily corrected, so staff recommended the Board find the carriers to be compliant upon submission of missing information. She noted that Horizon had already submitted the missing information requested.

D. Farkus recused himself from any action taken by the Board on this matter regarding Oxford Health Plans and/or Oxford Health Insurance because of the interest of his employer and its affiliates in the outcome of the Board's actions.

M. Taylor recused herself from any action taken by the Board on this matter regarding Aetna Health Inc. and/or Aetna Life Insurance Co., because of the interest of her employer and its affiliates in the outcome of the Board's actions.

S. Kelly recused herself from any action taken by the Board on this matter regarding Horizon Blue Cross and Blue Shield New Jersey and/or Horizon Healthcare because of the interest of her employer and its affiliates in the outcome of the Board's actions.

C. Stearns made a motion, seconded by N. Sullivan, to find that Horizon, as well as Aetna, CIGNA and Oxford upon submission of information previously requested by staff, marketed the standard individual health benefits plans in good faith during CY2010. The motion carried.

T. Taliaferro noted that AmeriHealth would submit the documentation required for both good faith marketing reports shortly.

B&E Rider Filing

T. Taliaferro recused himself from any action taken by the Board on this matter regarding AmeriHealth HMO and/or AmeriHealth Insurance because of the interest of his employer and its affiliates in the outcome of the Board's actions.

E. DeRosa reported that AmeriHealth HMO submitted two riders for its B&E Plan, one to replace its existing basic rider and the other to replace its existing preferred rider, to do the following: eliminate the benefit limits for out of hospital diagnostics and wellness services (basic and preferred riders); set the copay for physician visits at $30 (basic and preferred riders); set the $700 limit for physician visits to apply to specialist visits only (basic rider), or eliminate the limit entirely (preferred rider); add coverage for prosthetics, durable medical equipment, chemotherapy, hospice, home health, and services in multiple alternate treatment settings, and coverage at 50% for prescriptions (preferred rider). She recommended finding the filing complete.

M. Taylor made a motion, seconded by D. Farkus, to find the AmeriHealth rider filing to be complete. The motion carried.

Appeal of the Individual Insurance Mandate
E. Heck reported that the suits filed in the Florida and Virginia federal district courts challenging the constitutionality of the federal individual insurance mandate set forth in the federal Patient Protection and Affordable Care Act (PPACA) had been appealed to their respective federal circuit courts. She said the hearing for the appeal in Virginia is scheduled for June 1st.

Financial Disclosures
E. DeRosa reminded Board members that they need to file their financial disclosure statements by May 15th. It was noted that a disclosure needs to be filed only once, regardless of the number of boards or commissions on which a person may sit. E. DeRosa told the Board that the State Ethics Commission requires training once every three years, and that both boards would be scheduled for training in the near future. She noted that, while no date had yet been set, the trainer had agreed to try to use a date already scheduled for a board meeting.

V. Operations & Audit Committee (OAC)

NJ Protect Audit
E. DeRosa explained that Withum Smith + Brown (WSB) would be performing the audit on NJ Protect for the 2010 period of its operations, and had met with the OAC on May 3rd for the kick-off meeting for the audit. She stated that WSB would begin field work on May 16th and that a final audit report is due to the U.S. Department of Health and Human Services (HHS) by June 30th. She explained that WSB would look at the IHC Program for some portion of the administrative aspect of NJ Protect, but would be going to Horizon to review premiums, claims, provider contracts, correspondence files, etc.

Final Assessments and reconciliations
R. Lenox reported that the audits for Guardian's losses were completed, and thus, she had been able to reconcile the 2003/2004 and 2005/2006 loss audits. She explained that, between the time of the original assessments and the reconciliations, the Board had reduced the de minimis amount below which a carrier would not be invoiced an assessment (and the amount reallocated across other carriers), from $20 to $10, and that the reduction had an impact on several carriers. She further explained that both the OAC and the Technical Advisory Committee (TAC) had looked at the issue, and recommended using the $20 de minimis amount, because it was what was in effect at the time the original assessments were performed. She noted that all carriers were receiving refunds because of a slight reduction in the amount of the reimbursable losses, and that the choice of de minimis amount did not change that, although the amount to be received was altered, as well as the explanation that would be required for purposes of the several carriers effected. R. Lenox also explained that, for the 2005/2006 period, there had been an interim reconciliation because of the Humana challenge regarding Medicare Part D premium, which results in the spreadsheet showing two billings with some refunds prior to this final reconciliation. She also reminded the Board that, because the 2005/2006 period was the final

period in which Guardian sought reimbursement, interest has been calculated for refund to Guardian based on the audited loss amount.

M. Taylor made a motion, seconded by C. Stearns, to: issue the final assessment for the 2003/2004 calculation period subject to a $20 de minimus amount and issue a refund to carriers totaling $43,171.51, including $20,297.38 in interest; and, issue refunds to carriers based upon the final assessment for the 2005/2006 calculation period, totaling $182,842.97, including interest of $10,889.58; and, issue payment to Guardian of the audited loss amount of $309,944, plus interest of $6,557.14, but less the portion of the audit fees of $9,292.17 owed by Guardian in accordance with IHC Program rules. The motion carried.

Upon request, R. Lenox reminded the Board that at least some portion of refunds for the 1997/1998, 1999/2000 and 2001/2002 calculation periods remain outstanding because the audits of Time Insurance Company remain incomplete. E. DeRosa explained that Time submitted more materials somewhat recently, and that Deloitte & Touche sought some clarifications or additional information, to which Time has not yet responded. She stated that she believes the process is moving along at this point.

R. Lenox added that reconciliation and refunds for the 2007/2008 calculation period are still outstanding, because the audit of Celtic Life Insurance Company is not quite complete, but should be shortly.

VI. Technical Advisory Committee (TAC) – *B&E Reports and Benefits Review*

S. Kelly reported that TAC had reviewed the B&E reports, and agrees that there is no clear indication that the B&E plans are causing adverse selection against the standard plans. She noted that, beginning with the next set of quarterly reports, the Board will no longer require carriers to submit data regarding B&E purchasers' prior coverage, if any, but will continue to require submission of premium and claim data.

S. Kelly reported that TAC discussed the issue of whether to remove the limits on the B&E wellness benefit, or continue to seek a waiver for it from HHS. E. DeRosa noted that the issue had arisen because wellness promotion is consistent with Governor Christie's initiatives for health care. She noted that only Horizon had actual numbers pricing out the cost of removing the limits, and had indicated it was likely to be less than a 1% increase in premium for them, which both AmeriHealth and DOBI's representatives on TAC considered a reasonable assumption for most carriers. S. Kelly noted, however, that there was some slight concern about increased utilization if the limit is removed, for such things as "Executive Physicals," but did not have actual data. E. DeRosa explained that AmeriHealth had not tried to cost out the benefit separately because AmeriHealth essentially has no limit on its B&E wellness benefits already, since both of its riders remove the limit, and purchasers virtually always buy AmeriHealth's B&E plans with riders. It was pointed out that Oxford also has a rider that removes the limit for wellness benefits. E. DeRosa stated that concerns from callers about limits on the B&E plans almost always were with the diagnostic caps, not the caps on preventive services. She also noted that during the TAC meeting, when concerns were raised about slowing growth in the B&E plans because of rate increases, Neil Vance (of the DOBI) indicated that the growth in the B&E plans

already is slowing, and stated he believes this is due to market saturation as well as the change in the federal law allowing a child to remain on a parent's coverage until age 26.

C. Stearns expressed concern about any unnecessary increase in the premiums for B&E plans, and suggested that all of the carriers on the Board try to review claims to see if members are exceeding the cap for preventive services, and if so, by how much. There was debate whether a review of the claims would provide much information. The Board agreed to refer the question back to TAC for further review.

VII. Legal Committee – *Buying Up Outside of the Open Enrollment Period*

E DeRosa reminded the Board that it had asked the Legal Committee to consider whether the Board could further restrict when people who have already purchased an individual plan may purchase richer plans, in order to close an unintended loophole in the rules at N.J.A.C. 11:20-12, whereby an individual may terminate their existing coverage, be uninsured for a day or two, and then submit an application for new, richer coverage, often with the same company, and the carrier must issue the new, richer plan. She reported that the Legal Committee had agreed that the Board has the authority to revise its rules to further define when coverage must be guaranteed issue, and recommended revising the rules to not permit purchase of richer benefit plans within 31 days following a termination, except during a designated open enrollment period. E. DeRosa explained that staff had drafted an amendment to the rules to accomplish this suggestion, and then the Legal Committee met again to review the draft. She stated that the Legal Committee recommended that the Board propose the draft amendments.

The Board discussion of the draft raised the question of whether there were some contradictions or lack of clarity between certain existing provisions as well as the new draft with respect to the question of an individual's ability to purchase the same plan from a different carrier offered at a greater premium than the plan under which the person is currently covered. The Board recognized that this would be a rare circumstance, but could occur because of network issues (e.g., an individual's health care practitioner leaves the network of the carrier by whom the individual is insured, but remains available in another carrier's network). Board members acknowledged that the problem results from the Board's traditional use of price as a proxy for richness of benefit, which is rather imprecise. After discussing how to rework the rules and exceptions, the Board requested that the Legal Committee consider the rules again in an effort to clarify the Board's intent to close the currently-existing buy-up loophole while maintaining the right of individuals to move freely among carriers so long as purchasing the same plan or one of lesser actuarial value.

VII. Close of Meeting

M. Taylor made a motion, seconded by D. Farkus, to close the meeting of the Board. The motion carried.

[The meeting adjourned at 11:55 A.M.]