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
March 13, 2012

Directors present: Darrel Farkus (Oxford); Sandi Kelly (Horizon); Christine Stearns; Neil Sullivan (DOBI) (*Neil Vance substituted for Neil Sullivan from 12:00 until 1:20 P.M.*); Tony Taliaferro (AmeriHealth); Mary Taylor (Aetna Health Inc.)

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 10:08 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 – *January 10, 2012*

Minutes of the Open Session

T. Taliaferro made a motion, seconded by S. Kelly, to approve the open session minutes of January 10, 2012, with amendments. The motion carried.

Minutes of the Executive Session

M. Taylor made a motion, seconded by D. Farkus, to approve the executive session minutes of January 10, 2012, with an amendment. The motion carried.

III. Staff Report

Expense Report and Transfer of Funds

R. Lenox presented the Expense Report for March, with expenses totaling about $154,525, which primarily was composed of invoices for consulting services from Navigant, for audit services from Withum Smith+Brown (WSB) for loss audits of Celtic (for calculation period 2007/08), and for staff salaries and fringe.

When asked, E. DeRosa noted that the costs for Navigant thus far have been under budget. In addition, E. DeRosa told the Board that WSB indicated it received the management representation letter from Celtic, which essentially means the loss audit is complete, and the Board should be in a position soon to close the 2007/2008 loss calculation period.

M. Taylor made a motion, seconded by S. Kelly, to approve the March Expense Report. The motion carried.

R. Lenox stated that the IHC Board would need to transfer funds from its account with the New Jersey Department of Treasury (Treasury) to the Board's Wells Fargo accounts. She suggested the Board authorize transfer of $200,000 to its Money Market account to earn interest, but also approve a transfer of funds of up to $155,500 from the Board's Money Market account to its checking account to pay for operating expenses as they come due.

T. Taliaferro made a motion, seconded by C. Stearns, to authorize the transfer of $200,000 from Treasury to the Board's Money Market account and approve the transfer of $155,500 from the Money Market account to the Board's checking account for the purpose of paying the expenses presented in the March expense report. The motion carried.

EPO Standard Plan Design and Preventive Care

E. DeRosa reminded the Board members that she received a request to create a standard plan design to allow an exclusive provider organization (EPO) offering. She explained that the carrier, AmeriHealth, provided specific plan designs, and the draft language accommodating the designs. She urged the other carriers on the Board to look at the form and consider what, if any, changes their companies may be interested in for purposes of an EPO product, and discuss it with her. She noted that carriers are permitted to add increasing value riders to the standard IHC plans, so additional variable features within the base plan design may be helpful for some carriers.

E. DeRosa explained that she also included draft amendments to the standard plan design to address the federal Patient Protection and Affordable Care Act's (ACA) preventive care benefit requirements. She stated that federal regulations defined preventive care more broadly and complexly than the IHC standard plans do. She said that the preventive care change is effective for all newly issued and renewed plans on and after August 1, 2012 and will apply to both the standard plans and the Basic & Essential (B&E) plan, albeit the B&E plan's preventive benefit cap remains in place because of the waiver the IHC Board received from the federal government for the B&E plan. E. DeRosa noted that similar language will be proposed for the SEH standard plans as well.

She asked that carriers provide feedback on the proposed EPO design and the preventive care language within 3 weeks, so that another version of plan amendments can be distributed with the intent that the Board take action on the proposal at the May meeting. She indicated she expected to follow the Board's expedited rulemaking authority because: 1) the federal law will apply with respect to the preventive care benefits on August 1, and the Board cannot alter that; and, 2) the EPO plan design is optional, and carriers may choose not to offer it, so the changes are not particularly controversial. Upon discussion, it was clarified that the EPO plan design would count towards satisfying the three-plan offer requirement of carriers operating in the IHC market.

Nominations

E. DeRosa told the Board that notices for nominations for the seat of "an insurer authorized to write health insurance in New Jersey pursuant to Subtitle 3 of Title 17B of the New Jersey Statutes" had been sent to IHC Progrm member companies on or about March 5, 2012. She

noted that the pending vacancy is currently held by AmeriHealth. She also noted that the notices had been sent to the attention of the individuals who had most recently submitted a company's Exhibit K form. She reminded Board members that the elections will be held at the May IHC Board meeting. There was brief discussion about other vacancies on the Board, and pending term expirations, but it was noted that all of these are appointments.

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

Financial Statements
R. Lenox presented the financial statements for the quarter ended December 31, 2011 (FY12Q2), including the Statement of Net Assets, the Accounts Payable to Member Companies detail; Statement of Changes in Net Assets, the Statement of Changes in Assets & Liabilities (Loss Assessment Fund); the Statement of Cash Flows, and Comparison of Budget to Actual. She noted that IHC Program operations continue to run under budget.

Recommendation of Auditing Services for NJ Protect
E. DeRosa reminded the Board that at its January meeting, it had approved issuance of a new Scope of Work (SOW) for auditing services for NJ Protect to be sent to the most recent list of auditing firms under contract with the New Jersey Department of Treasury (Treasury). She explained that the SOW had been issued, and four firms responded with quotes. She stated that the Evaluation Committee, which is separate from the OAC, had determined the quote from one firm was non-responsive because the documents submitted did not include a plan for completion of the project (the firm also had not followed instructions on how to submit the quote), and chose not to score the quote. E. DeRosa explained that the Evaluation Committee thought the remaining three quotes all had potential, but considered WSB's to be the strongest of the three, both in understanding of the project and in setting forth a detailed plan for completing the audit, and recommended awarding the engagement to WSB. She stated that the member of the OAC who is not part of the Evaluation Committee had subsequently concurred with the recommendation based on her own review of the quotes.

The Board discussed the recommendation, confirming that: (1) the hourly prices quoted by WSB are higher than under previous engagements, because WSB had been under contract with Treasury for two years beyond the old contract's original term, and had been unable to increase pricing while under the old contract, but had done so when bidding on Treasury's new cooperative agreement for auditing services; (2) the pricing is greater for 2011 and onward compared to 2010 because NJ Protect is being audited for full calendar years of operation starting in 2011, there are two carriers to audit starting in 2011 instead of one, and additional non-financial data are being audited; and, (3) the costs for the audits will be paid from the administrative funds for NJ Protect, not by the IHC Board, so the Board does not have to make any assessments to pay for the audits.

When asked, E. DeRosa stated that the most recent weekly enrollment figures show that NJ Protect has just over 900 active enrollees, but she noted that the weekly enrollment data and monthly enrollment data often have variances because of activity that occurs during the course of

the month (i.e., disenrollment activity). There was discussion that enrollment numbers had not been as large as originally anticipated.

M. Taylor made a motion, seconded by C. Stearns, to award the engagement for auditing services for NJ Protect to Withum Smith + Brown. The motion carried.

E. Heck stated she would draft the engagement letter.

V. Report of the Technical Advisory Committee (TAC)

S. Kelly reported that TAC reviewed quarterly B&E plan reports from AmeriHealth, Oxford and Horizon (the carriers offering riders to their B&E plans) to monitor for any adverse impact on the market. She stated TAC recommended continued monitoring. She noted that TAC had also reviewed the presentation that Navigant will present to the Board today. She also noted that TAC had reviewed a brief rate action summary for CY2011, prepared by the DOBI.

N. Vance presented the rate action summary, noting that it is partly an update of the summary he had provided to the Board in the Fall, and a written version of that oral presentation. He stated that the main points are: (1) enrollment is growing, and approaching 140,000 lives; (2) about half of the enrollment is in Horizon's B&E plans; (3) Horizon and one other carrier have had loss ratios in the low 80s two years in a row, meeting statutory requirements and suggesting some level of stability in pricing; (4) two carriers have very high loss ratios during the same period, but because these carriers have a very small share of the IHC market, and because the IHC market represents a relatively small share of each carrier's business, there is not reason for much concern; and (4) annual rate increases have been between 5% to 15%, with the rate increases for the product with the largest enrollment being 5% on average, down from the rate increases in recent years.

VI. Update on Health Insurance Exchange (HIX) Planning

The Board requested an update on HIX planning activities. N. Sullivan stated that KPMG is continuing to work on IT and operational gap analyses, but is winding down its activities in this regard and finalizing its reports. He stated that the DOBI had applied for a Level 1 implementation grant in December 2011 and received the notice of award in late February. He explained that the money requested was primarily meant to keep certain research and analysis moving forward (for example, with respect to determining essential health benefits), so that New Jersey can keep its options open, but was not intended for nor sufficient to build much infrastructure, noting that Governor Christie has not yet committed the state to the building of a HIX.

When asked about the relaxation of the June 29, 2012 Level 2 implementation grant application deadline, N. Sullivan explained that the primary impact of the change in the Level 2 grant application requirements is that it appears States no longer must show they have clear governance authority for a HIX by that date or in order to apply for a Level 2 grant; instead, states may now apply for Level 2 funding as late as the end of December 2013. He further explained, however, that the January 1, 2014 start date for the HIX, and the requirement that the

HIX be financially self-sufficient by 2015 had not changed, which means that States must continue to be proactive if they intend to establish a HIX within the deadlines.

When asked whether the DOBI obtained information on the most popular small employer health benefits plans, E. DeRosa explained that it probably was a moot point. She explained that the federal government clarified that the determination of a plan did not include riders, and that being the case, it was not necessary for the DOBI to reach out for more information from carriers on their SEH plans, because the SEH Board has data on enrollment and the plan design for the base standard plans. She stated that it is clear already that the plan with the largest enrollment in the SEH market is the HMO plan. N. Sullivan said that the Level 1 grant is intended to fund consulting services to further evaluate the features and utilization of the features of this plan as well as other benchmark options that can be considered for purposes of establishing an essential health benefits package.

When asked about the anticipated impact of the ACA upon insurance and uninsurance rates in New Jersey, N. Sullivan responded that the Rutgers Center for State Health Policy had done some preliminary research on the subject, which had been posted to their website.

[The IHC Board took a break from 10:55 A.M. until 11:05 A.M.]

VII. Navigant Presentation

Presentation by the Consultants – the draft presentation slides are attached
Michael Nugent and Donna Kinzer spoke on behalf of Navigant.

Questions and Comments from the Board
Board members asked for certain clarifications regarding methodology and presentation of the data. The consultants responded thus:

- Columns in tables labeled as "Carrier Charges" refers to the charges presented to carriers by providers; the consultants agreed to rename the columns as "Provider Charges."
- Data for participating and nonparticipating providers had been combined because there were relatively few claims from nonparticipating providers for certain procedure codes, so combining claims data made the data more robust for all claims categories. In addition, the consultants noted that certain claims data for non-participating providers is presented in tables separately from participating providers to illustrate differences.
- There was no module for ambulatory surgery centers; data shown is based on non-hospital claims.
- Navigant did not specifically make comparisons of demographically-similar markets to New Jersey data because the task had not been included as part of the scope of work, but the consultants noted that mark-ups on costs tend to be lower in urban areas than rural areas, perhaps because of competition in the urban markets and the higher rates paid by Medicare in urban markets. When asked whether the comparisons of the impact of differing methodologies was reasonable for New Jersey, the consultants stated they

believed the comparative data was not an unreasonable reflection of the impact to be expected for New Jersey.

- The reference to commercial claims includes claims from both insured and self-funded products, but does not include Medicare, Medicaid, TriCare or other federal government-sponsored programs.
- There are payers that currently reimburse claims based upon a percentile of a fee profile subject to a maximum percentage above Medicare. The consultants suggested that if the IHC Board were to pursue an option like this, the Board should seek a vendor to professionally produce the reimbursement methodology, to avoid unduly burdening carriers with loading multiple sets of data to get the needed results. The consultants further noted that the method would require some significant maintenance and modeling, for which the vendor should be responsible.
- Medicare does not publish a single number for a specific procedure, but rather, Medicare's payments are composite numbers developed from multiple factors. The consultants offered Medicare's Diagnosis Related Groups (DRGs) as an example, which includes factors for disproportionate share hospital (DSH) payments and for graduate medical education. The consultants explained that some payers use Medicare now, with some creating models in which some of the Medicare components, such as DSH are removed, but that there is inconsistency in how the modeling is being done. The consultants confirmed that Navigant had not removed any of the Medicare fee components for this project.
- There are options for addressing gaps that may exist for certain types of providers or codes in a payment method, including for example, using hospital combined outpatient benchmarks to reimburse ASCs, or asking Fair Health to produce benchmarks to fill specific gaps, if the Board elects to use Fair Health.
- Navigant weighted the results to reflect the frequency of codes billed, and show more clearly the distribution of claims for both participating and nonparticipating providers.
- Claims from calendar year 2010 for small employer business was included to assure that the data was robust, given the significant difference in size between the small group and individual markets; the consultants had been particularly concerned about assuring the robustness of the data for nonparticipating providers.
- Fair Health has a statistical modeling routine they use to address instances in which procedure codes are underrepresented in a profile.
- The term "adequate" can be defined within the report to better explain how it is that Fair Health profiles are an adequate replacement for PHCS, noting that "adequate" only means the reimbursement produced by the two profiles is about the same, and is not a determination whether the reimbursement levels are otherwise reasonable. E. DeRosa explained the scope of work had requested the consultant show the Board a payment method that produces similar results to the PHCS, while also showing other options that might be available, but the scope of work had not requested the consultant to give an opinion as to which profile the Board should select.

- Evaluation and management (E&M) codes are the most frequently billed codes, but do not represent the largest dollar values. The report does not specifically provide data on the 100 most frequently-utilized codes. The consultants indicated they were amenable to producing a comparison of the 100 most frequently billed codes by different reimbursement methodologies, but noted that they have to revisit the Fair Health disclosure limitations before doing so, because Fair Health may not be willing to have their data displayed in the report by specific codes (as opposed to code groups). The consultants noted that Fair Health's sale of their benchmark data is one of their revenue streams. It was noted that Fair Health has a process for looking up data for individual codes on their website, but there is a limit to the number of look-ups one can perform during a given period of time, and Fair Health does not display the data otherwise at this time.
- There is no single way to gauge what is "fair and reasonable," but rather, there is a range of methods, and it is not clear that there is any way to determine which method is more reasonable or appropriate. The consultants stated that some carriers pay exactly the same amount to participating and nonparticipating providers, while Medicare actually pays a little less to nonparticipating providers, and then sets a limit on how much the nonparticipating provider may balance bill the patient. The consultants explained that they included some charge to cost and reimbursement to cost data to provide the IHC Board with some additional context.

Further Board and Public Discussion
The Board members further discussed how to determine the best reimbursement methodology, and permitted input from the public, as well as Navigant, although Navigant's presentation had ended. The following issues were highlighted:

- The Board must balance the need to keep premiums down with the out-of-pocket costs borne by covered persons.
- In 1993, the Board viewed the requirement that all insurance companies use a common reimbursement methodology for out-of-network claims as an additional means of standardizing the coverage and ensuring that out-of-network benefits did not become illusory; however, the statute does not specifically state that the Board must establish a reimbursement methodology that produces uniform results. At the time the standard plans came into existence, there was no standard reimbursement method, several carriers had proprietary schedules, and the Medicare RBRVS was in its infancy. The HIAA PHCS was considered an equitable solution.
- Tools for controlling out-of-network reimbursement may have no direct impact upon situations in which use of out-of-network providers occurs involuntarily (e.g., instances in which in-network hospital admissions involve one or more out-of-network providers rendering services), because the law requires that covered persons receive coverage as if all of the services were rendered on an in-network basis; however, the ability to control costs in elective out-of-network situations is valuable.
- Because rules regarding "qualified health plans" have not been released, and it is unknown whether they will address reimbursement, the impact of the federal ACA

implementation is unclear. The consultants suggested that this lack of certainty may be a reason to phase in changes in how out-of-network reimbursement is regulated, noting that, as more people become covered, and both demand and delivery of health care services change, costs-to-charge and reimbursement ratios may also change.

- When the DOBI proposed its rule that out-of-network reimbursement be no less than 150% of Medicare, it did so in response to numerous large group form filings indicating that reimbursements were less than that and moving downward at the same time that DOBI was receiving complaints from providers about compensation. There were more than 4000 comments on the rule. Most of the commenters misunderstood the purpose, which was to set a floor for reimbursements, not a ceiling as commenters believed. In addition, there were health care providers who argued that Medicare does not reimburse adequately at virtually any level, and while this was actually a national debate, it was also heard at the State level. DOBI allowed its proposal to expire, which means that carriers continue to be unfettered in their reimbursement methodology in the large group market. The DOBI remains sensitive to the issue, and everyone agrees that many providers are as well.
- Fair Health was charged with producing a benchmark for reimbursements that used billed charges and was designed in a manner similar to PHCS. The overriding difference is that the Fair Health benchmark is produced by a non-profit, independent entity that avoids any real or perceived conflicts of interest, while the producer of the PHCS (Ingenix) was perceived otherwise, particularly given its relationship to the UnitedHealthGroup. Having completed its assignment, Fair Health is talking about developing additional benchmarks based on criteria other than billed charges.

Next Steps
The Board discussed what its next steps should be. The Board suggested that Navigant finalize the report based on recommendations discussed in the meeting. The Board also requested that the TAC further analyze the report, and make some recommendations to the Board. There was agreement that the issues facing the Board are ultimately ones of policy, not only of what reimbursement methodology to specify, but whether to specify one, and how to implement it if one is specified. The Board determined that it would schedule additional Board meetings in April, June and August, and suggested that carriers bring technical people to these meetings to help discuss the issues.

The question was then raised as to what the interest is of the Small Employer Health Benefits (SEH) Program's Board of Directors in this matter, and at what point information should be shared with the SEH Board. It was acknowledged that rulemaking would occur separately, although the rulemaking might be closely timed, but that there would need to be some dialogue between the boards prior to the rulemaking process.

M. Taylor made a motion, seconded by N. Vance, to move the IHC Board's meeting into Executive Session for the purpose of receiving advice from counsel. The motion carried.

[The Board was in executive session from 1:00 P.M. until 1:30 P.M.]

The Board reiterated its intent to have additional meetings, and clarified that it would discuss further procedures, including whether to hold stakeholder meetings, at a later date. The Board clarified that it was asking the TAC to make a recommendation for a substitute for PHCS. The Board acknowledged that the question of whether to change the approach to defining standardization is a policy issue for the Board to decide, and indicated that the Board might appoint an ad hoc committee to explore the issue further.

It was noted that, regardless of whether it holds one or more stakeholder meetings, the Board may have to hold a public hearing when it engages in rulemaking, in order to comply with the requirements of New Jersey's Administrative Procedure Act (APA), which requires agencies hold a public hearing when there is "sufficient public interest" in a proposal.

VIII. Close of Meeting

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

[The meeting adjourned at 1:40 P.M.]