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 8, 2012

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

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

I. Call to Order

E. DeRosa called the meeting to order at 10:00 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.

II. Minutes – *March 13, 2012 and April 16, 2012*

Minutes of the Open Session of March 13, 2012
C. Stearns made a motion, seconded by D. Farkus, to approve the minutes of the March 13, 2012 meeting, with amendments. The motion carried.

Minutes of the Open Session of April 16, 2012
S. Kelly made a motion, seconded by C. Stearns, to approve the minutes of the April 16, 2012 meeting. The motion carried.

III. Election

E. DeRosa reminded Board members that the term of AmeriHealth Insurance Company of New Jersey, filling 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 expired. She further reminded them that solicitations for nominations had been sent out to the IHC membership in March, and ballots with the nominee (plus the opportunity to vote for a write-in candidate) had been sent in April. She explained that absentee ballots were due to the Board prior to the May meeting date, all Board members had voted, and there were no additional members of the IHC Program present at the meeting, so there were no additional ballots to be cast. She stated that AmeriHealth Insurance Company had been elected to continue serving in its recently expired seat.

IV. Staff Report

Expense Report and Transfer of Funds – April
R. Lenox stated that she was re-presenting the Expense Report for April, because the previous presentation showing expenses totaling $21,764.10, was erroneous. She explained that all of the

expenses were presented in the original April spreadsheet, but one of the expenses was not included in the calculation of the total. R. Lenox stated the correct total was $22,667.94, but that the original transfer request for $21,800 in April had been sufficient for purposes of paying the operating expenses for that time period.

E. DeRosa advised that the April 16th meeting had not been properly noticed in two newspapers as required by the Open Public Meetings Act. She explained that the Star Ledger and Trenton Times are under common ownership and share at least some common operations, and apparently, this resulted in the Star Ledger inadvertently failing to advertise the April meeting, while the Trenton Times printed it twice. She stated that the Star Ledger has agreed to run the notices for the remaining Board meetings at no charge. E. DeRosa also stated that the only action taken by the Board at the April meeting was approval of the expense report and transfer of funds. She requested that the Board approve the revised expense report, and ratify the transfer of $21,800 between the Board's Wells Fargo accounts.

S. Kelly made a motion, seconded by D. Farkus, to approve the April Expense Report as revised, and the transfer of $21,800 from the Board's Wells Fargo money market account to the Board's Wells Fargo checking account for the purpose of paying the expenses incurred. The motion carried.

Expense Report and Transfer of Funds – May
R. Lenox presented the expense report for May, totaling $12,286.92, primarily for salaries and fringe, but also WithumSmith+Brown (WSB), and the Trenton Times. She requested that the Board approve the transfer of $12,300 from its Wells Fargo Money Market account to its Wells Fargo checking account, in order to pay operating expenses for May.

M. Taylor made a motion, seconded by T. Taliaferro, to approve the May Expense Report, and approve the transfer of $12,300 from the Board's Money Market account to its checking account, both at Wells Fargo, for the purpose of paying the May operating expenses. The motion carried.

Policy Form Amendments: Exclusive Provider Organization (EPO); Oral Cancer Drugs; Preventive Services
E. DeRosa reminded the Board that a carrier had requested the development of language for an EPO policy form, which she drafted based on the carrier's intended use, and suggestions that she had invited other carriers to provide. She noted that she also had included language to bring the policy forms into compliance with the federal preventive services requirements, plus a catch-all phrase to address possible revisions in the future by federal authorities with respect to preventive services.

E. DeRosa said she drafted amendments to address the recently enacted oral cancer mandate and shared the draft with the New Jersey Association of Health Plans to determine whether carriers could administer the provisions as drafted.

After further discussion, Board members agreed to review the EPO and preventive services language distributed at the meeting, and requested that the draft oral cancer drug benefit language be shared with the Board.

Good Faith Marketing
E. DeRosa explained that the good-faith marketing reports are due May 1 annually, and reminded the Board that there are two reports: Report to Demonstrate Good Faith Effort to Market Individual Benefits Plans (which must be filed by all carriers offering health benefits plans to small employers), and the Report to Demonstrate Good Faith Effort to market the Basic and Essential Health Care Services Plan (which must be filed by all carriers offering health benefits plans in the individual market). She stated that the requirements for demonstrating a good faith effort are substantially similar.

E. DeRosa noted that AmeriHealth is required to submit both reports, and had submitted neither as yet, while all of the other carriers had submitted both reports, including Celtic, which is not offering coverage in the small employer market. She recommended that, for the demonstration of good faith marketing of Basic and Essential plans, the Board find the following carriers in compliance for 2011:

- Aetna Life Insurance Company
- Celtic
- CIGNA
- Horizon Blue Cross Blue Shield of New Jersey
- Oxford

She recommended that, for the demonstration of good faith marketing of individual standard health benefits plans, the Board find the following carriers in compliance for 2011:

- Aetna Life Insurance Company
- CIGNA
- Horizon Blue Cross Blue Shield of New Jersey
- Oxford

She noted again that Celtic was not included in this recommendation because it does not participate in the small employer program and so is not required to comply with the good faith marketing rules for sale of individual standard plans.

M. Taylor recused herself from further discussion or action that might be taken specifically with respect to Aetna because of the interests of her employer in the outcome of the action.

S. Kelly recused herself from further discussion or action that might be taken specifically with respect to Horizon because of the interests of her employer in the outcome of the action.

D. Farkus recused himself from further discussion or action that might be taken specifically with respect to Oxford because of the interests of his employer in the outcome of the action.

C. Stearns made a motion, seconded by T. Taliaferro, to find that Aetna, Celtic, CIGNA, Horizon and Oxford complied with good faith marketing requirements in marketing Basic and Essential Plans in 2011, and to find that Aetna, CIGNA, Horizon and Oxford complied with good faith marketing requirements in marketing individual standard health benefits plans in 2011. The motion carried.

V. Operations and Audit Committee (OAC) report

R. Lenox reported that the OAC had reviewed the final reconciliations of the loss assessments for the loss calculation period for 2007-2008, and the administrative assessments for FY2007 and FY 2008, and had recommended the Board take action to issue invoices.

Final Reconciliation of Loss Assessments for Calculation Period 2007-2008

R. Lenox reported that the audit of Celtic – the only carrier reporting a loss for the 2007-2008 calculation period – was complete, and that WithumSmith+Brown (WSB) had determined that Celtic's losses were actually $25,220 more than claimed by Celtic. She stated that, with the audit complete, the IHC Program was ready to issue the final reconciliation of assessments for the period. She noted that the assessment reconciliation process included consideration of 6 carrier exemptions, interest earned by the IHC Program totaling $4,539, late fees totaling $21.68 collected from one carrier, plus reallocation of *de minimus* assessment amounts. She said that a total of $20,659.33 will be billed among 25 IHC Program members.

Final Reconciliation of the Administrative Assessment for Fiscal Years Ended June 30, 2008 and June 30, 2009

R. Lenox reported that, with the 2007-2008 loss calculation period finalized, the administrative assessments for that period can also be finalized. She explained that the initial administrative assessment for FY2008 and FY2009 was based on the net earned premium reported on the Exhibits K for the 2005-2006 loss calculation period, but that the reconciliation is made using the net earned premium from the 2007-2008 Exhibit K. She noted that, although the actual expenses of the IHC Program for the period were less than budgeted and interest earned by the IHC Program had been applied, refunds to carriers and amounts due to the IHC Program also depends on whether a carrier's relative market share has increased between the two calculation periods. She stated that the IHC Program is issuing refunds totaling $289,373.47, but that some carriers owed the IHC Program relatively small sums, totaling about $2,529.

Board members asked for information about the remaining outstanding loss audits. E. DeRosa stated that there are three loss calculation periods outstanding:

- 1997-1998 (which includes the agreed upon procedures (AUPs) of AEGON/UICI and audit of Time Insurance Co.)
- 1999-2000 (which includes the AUPs of AEGON/UICI and audit of Time Insurance Co.)
- 2001-2002 (which includes the audit of Time Insurance Co.)

She stated that the Deloitte and Touche (D&T) AEGON/UICI AUPs are close to completion and she had expected the reports to be issued already. She said that D&T indicates the Time audit report is in partner review, but that there is still one issue to be resolved. She reminded Board members that the 2001-2002 Time report prepared by WSB cannot be finalized until D&T's Time audits are finalized.

M. Taylor made a motion, seconded by T. Taliaferro, to issue invoices and pay amounts due to carriers as set forth in the final reconciliation of the loss assessments for calculation period 2007-2008, and the final reconciliation of the administrative assessments for FY2008 and FY2009. The motion carried.

R. Lenox asked the Board needs to approve a transfer of funds from its Treasury account to the Wells Fargo checking account in order to issue the administrative assessment refunds.

C. Stearns made a motion, seconded by D. Farkus, to transfer $289,373.47 from the IHC Board's funds held in Treasury to the Board's checking account in Wells Fargo for the purpose of issuing refunds of administrative assessments to carriers. The motion carried.

VI. Technical Advisory Committee (TAC) Report – Reimbursement Methodology

E. DeRosa reported that TAC decided to defer discussion of the Basic & Essential Annual Reports. She stated that TAC had reviewed the final reconciliations of the loss assessments for the 2007-2008 calculation period and the administrative assessment for FYs 2008 and 2009, and had recommended the Board release the assessments.

E. DeRosa stated that the focus of the TAC meeting was on the out-of-network allowances "homework" assignment, which required it to consider the responses from multiple IHC carriers to several questions, as follows:

1. How do carriers determine allowed charges for out-of-network services when Medicare has no allowed charge available, how transparent is the process, and how is the process described in the policy/contract?
2. What would be the relative premium of a closed panel HMO and/or PPO product at 150% of Medicare for allowed charges versus the same products using the 80th percentile of PHCS?
3. How would a tiered approach using a percentage of Medicare be defined?
4. Is there quantifiable evidence of whether the use of the PHCS profile has been harmful to the IHC market?
5. How would the experience of PPO plans support a move away from the PHCS?

E. DeRosa reported there is no single method carriers use to fill gaps in the Medicare allowances. She stated it seemed carriers had different interpretations of the second question, and noted the information suggested only slight pricing differences if 150% of Medicare or the PHCS profile at the 80th percentile is used. The Board discussed reasons for the small difference in pricing.

E. DeRosa reported that all carriers considered tiering (i.e., varying reimbursement percentages by service or provider) to be administratively difficult, but thought setting tiers by CPT ranges

might be most do-able. M. Taylor stated Aetna's system is currently able to tier by broad provider categories. It was noted that arguments for tiering have less merit if the reimbursement rate is set high enough as a percentage of Medicare, and that reimbursements between 300% and 350% of Medicare approximate the 80th percentile of PHCS in most instances.

There was discussion regarding the future of Fair Health (the PHCS replacement), and the approaching date after which carriers subject to the New York settlement establishing Fair Health would no longer be required to support Fair Health. It was noted that carriers were already moving to use of the Medicare RBRVS in the New Jersey large group market and in all markets in other states even before the New York settlement occurred.

There was discussion as to how to explain the Board's desire not to use a charge-based system, and choice of *any* specific reimbursement level. It was suggested the discussion of non-network reimbursement methodologies for the IHC Program is becoming academic because so few plans with significant non-network benefits are being purchased in the individual market, and even today, the Board discussed proposal of an EPO plan option. It was noted that in the SEH market, 65% of the plans purchased now are closed panel products. N. Vance said this data is evidence the IHC and SEH Boards must approach non-network reimbursement standards differently if the goal is to preserve a meaningful non-network plan option for the IHC and SEH markets.

E. DeRosa reported that the SEH Board has formed an ad hoc committee to look at the out-of-network reimbursement issue, but noted it is at a disadvantage because it only has access to the brief presentation materials prepared by Navigant and not the final Navigant report. The IHC Board members agreed to release the Navigant report to the SEH Board, recognizing that the release makes the document subject to public disclosure upon request.

S. Kelly stated that TAC has more work to do. She explained that E. DeRosa had reached out to Navigant to obtain the top 10 CPT codes in terms of utilization and the top 10 CPT codes as cost drivers, and that TAC still wanted to look at Oxford's responses to the questions, which had not been available at TAC's last meeting. She indicated that there will be a revised homework assignment based on the discussions at this Board meeting.

VI. Other Business

E. DeRosa stated that UNUM had asked to make a presentation to the Board today regarding the sale of certain types of individual policies, but that UNUM subsequently asked to defer the presentation until a later date, as yet undetermined.

VII. Close of Meeting

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

[The meeting adjourned at 12:05 P.M.]