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
June 19, 2012

Directors present: Darrel Farkus (Oxford); Sandi Kelly (Horizon); Christine Stearns *(arrived at 10:20)*; Tony Taliaferro (AmeriHealth – *arrived at 10:15*); Mary Taylor (Aetna Health Inc.); Neil Vance (DOBI)

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

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 – *May 8, 2012*

Minutes of the Open Session of May 8, 2012

D. Farkus made a motion, seconded by M. Taylor, to approve the minutes of the May 8, 2012 meeting, with amendments. The motion carried, with N. Vance abstaining.

III. Staff Report

Expense Report and Transfer of Funds – June

R. Lenox presented the Expense Report for June, with expenses totaling $14,191.64. She explained that the expenses were primarily for salaries and fringe, but also included charges from the Office of the Attorney General, and for required continuing education for herself. She asked that the Board approve the transfer from the Wells Fargo money market account of $14,200 if the Board approved payment of the expenses.

M. Taylor made a motion, seconded by D. Farkus, to approve the June Expense Report and the transfer of $14,200 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.

Policy Form Amendments: Exclusive Provider Organization (EPO); Oral Cancer Drugs; Preventive Care Services

E. DeRosa explained that she had amended the definition of wellness benefits in the Basic & Essential (B&E) Plan specimen form to include oral contraceptives as required by the preventive care mandate under the federal Affordable Care Act. Although the B&E Plan does not feature a prescription drug benefit the preventive care requirements which include coverage for oral contraceptives make no distinction between plans that cover prescription drugs and plans that do not. She noted that the coverage for oral contraceptives would be subject to the $600 limited benefit. She explained she also amended the specimen form to make the provisions describing the internal appeal process consistent with federal requirements (striking the Stage 2 internal appeal level, which can no longer be required for nongroup policies). It was acknowledged that carriers not using the specimen form would need to file appropriate changes to their own B&E policy forms.

E. DeRosa reminded the Board that following a carrier request she developed language for an EPO option for Standard Plans A/50 through D. She explained that she had received suggestions from additional carriers as to the variables they might be interested in for an EPO plan and that the current draft reflected the additional requests as well as the EPO language presented previously to the Board.

With the EPO schedule pages showing some new cost sharing options for prescription drug coverage C. Stearns asked whether the standard plans could include a mail order option for prescription drugs. It was noted that no carriers have ever expressed an interest in including mail order provisions in the standard individual plans. The Board agreed to consider the issue further during upcoming Board meetings. A carrier interested in offering a mail order benefit could develop and file an increasing rider to provide a mail order prescription drug benefit.

E. DeRosa noted that previously-drafted language to bring the policy forms into compliance with the federal preventive services requirements was still included, and that she had made a few revisions to the forms for clean-up. She stated that the same amendments to the utilization management appeals description as were made to the B&E plans were included for the standard plans.

E. DeRosa brought the Board's attention to text to address the anti-cancer oral drug benefits. The Board agreed that the draft contract language should be proposed as presented, but as a variable provision, with instructions permitting carriers to substitute language specifying a process that results in the consumer receiving benefits as medical or prescription drug, whichever is the most favorable, for prescribed oral anti-cancer drugs.

E. DeRosa suggested that the Board use expedited rulemaking for these policy form amendments because the time for compliance with the preventive care and anti-cancer requirements is very short.

M. Taylor made a motion, seconded by T. Taliaferro, to propose using the Board's expedited rulemaking authority the draft amendments, with revisions as discussed, for the

B&E Plan and the standard plan, including the new EPO language. The motion carried, with C. Stearns opposing.

Good Faith Marketing
E. DeRosa reminded the Board that it had previously taken action with respect to the good faith marketing reports filed by carriers for the standard IHC plans and the B&E plan, with the exception of AmeriHealth HMO, which had not submitted its reports prior to the Board's May meeting, but had done so since then.

T. Taliaferro recused himself from the discussion and any action that may be taken with respect to the good faith marketing reports of AmeriHealth HMO, because of the interest of his employer in the outcome of the action.

She noted that AmeriHealth HMO is required to submit both reports, because it offered plans in both the IHC and SEH markets. The Board reviewed the summary of the reports, and E. DeRosa recommended the Board find AmeriHealth in compliance for 2011 with respect to marketing for both the IHC standard plans and the B&E plan.

C. Stearns made a motion, seconded by S. Kelly, to find that AmeriHealth HMO met the good faith marketing requirements in marketing Basic and Essential Plans in 2011, and complied with good faith marketing requirements in marketing individual standard health benefits plans in 2011. The motion carried.

V. Technical Advisory Committee (TAC) report

S. Kelly reported that TAC reviewed some additional information that E. DeRosa requested from Navigant showing the top 10 CPT codes in terms of out-of-network utilization and the top 10 CPT codes as cost drivers (not including emergency room services), noting the breakdown tended to be by category, not specific procedures because Navigant generally did not have access to the data in that fashion.

S. Kelly stated TAC continued to discuss using 150% of Medicare RBRVS, noting that this would be similar to what is sold and bought in the large group market. To provide evidence of the options available in the large group market she said carriers on the Board have been asked to provide information regarding what large employers are actually buying in terms of the reimbursement level.

The Board agreed that the objective was not to identify a methodology that is comparable to the 80th percentile of PHCS, but rather, to identify an appropriate methodology. Some Board members speculated that a proposal to use a methodology that produces very different results from 80th percentile PHCS which has been used since 1993 would be met with resistance. D. Farkus reminded the Board that a prime reason the Board decided to use the PHCS in 1993 was because it was what most carriers were familiar with and used. In 2012, Medicare RBRVS is the tool predominantly used by carriers in New Jersey and nationally. Several Board members agreed that selection of a percentage of Medicare's RBRVS would, like the selection of the

PHCS in 1993, be based on current trends and ease of administration for carriers, provider familiarity, and relative transparency for consumers.

The Board discussed possibly selecting a percentage of Medicare greater than 150%. Regarding the "gaps" in Medicare, some Board members suggested continuing to use the most recent PHCS data.

The Board asked E. DeRosa to compile a list of the information TAC has identified as being helpful to identify a replacement for PHCS. Recognizing an interest in using Medicare as is used in the large group market, the Board also asked TAC to identify what could be used to address the "gaps" in Medicare data.

VI. 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 12:15 P.M.]