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
August 12, 2014

Directors participating: Sandi Kelly (Horizon); Lisa Levine (United); Thomas Pownall (Aetna); Gale Simon (DOBI); Ryan Petrizzi (AmeriHealth).

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

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, the Office of the Secretary of State and submitted to the State House Press Corps, in accordance with the Open Public Meetings Act. A quorum was present. She stated that voting would be by roll call because many of the directors were participating by phone.

E. DeRosa introduced Celeste Hill, the program's new administrative assistant.

II. Minutes – *June 10, 2014*

T. Pownall made a motion, seconded by G. Simon, to approve the minutes of June 10, 2014. In voting by roll call, the motion carried.

III. Staff Report

Expense Report and Transfer of Funds

E. DeRosa stated that the Board has expenses totaling $96,617.46 on the August 2014 expense report, primarily for the IHC Board's portion of salaries and fringe (a portion of which was related to FY2014, and the remainder related to FY2015), as well as expenses billed by the Division of Law. She stated that the Board would need to approve a transfer of $96,000 from its Wells Fargo Money Market account to its Wells Fargo Checking account, if the Board approved payment of its operating expenses on the August expense report.

S. Kelly made a motion, seconded by L. Levine, to approve payment of the expenses, and to approve the transfer of $96,000 from the Board's Wells Fargo Money Market account to its Wells Fargo Checking account in order to pay August operating expenses. In voting by roll call, the motion carried.

Audit Update
E. DeRosa reported that Deloitte & Touche (D&T) had completed draft reports and management representation letters for both the 1997/1998 and 1999/2000 audits of Time Insurance Company (Time), and submitted them to her on July 22, 2014, and that she had forwarded these on to Time.

IV. Report of the Technical Advisory Committee (TAC)

S. Kelly reported that TAC met to review an analysis of the aggregated out-of-network claims of 3 carriers. TAC made recommendations on how to consolidate and categorize some of the claims. She noted that the analysis is trying to identify claims by both frequency and dollar amounts, the result thus far being more than 10 categories. She stated that TAC's expectation is that it will be able to identify which categories of providers would have a positive or negative impact as compared to use of a percentage of Medicare RBRVS.

E. DeRosa stated that it is clear at this point that hospital costs are not the real drivers of the out-of-network services, but rather, professional services, predominantly specialties, and a surprisingly large amount of physical therapy and occupational therapy. She stated she expects the report will be very robust, after which she anticipates being able to update the White Paper.

V. Consumer Complaints regarding COBRA and Individual Coverage

E. DeRosa reported that the Department has received a number of complaints regarding gaps in coverage resulting from exhaustion of continuation coverage (whether due to COBRA or NJ small group continuation), as well as nonrenewal of some pre-2014 plans on dates other than the 1st or 15th of a month. She noted that there has also been some expressed distress from the inability of people to terminate COBRA coverage voluntarily and establish a triggering event that would allow them to purchase an individual policy. It was agreed that there were too many people with these issues not to try to find a solution for at least some of the problems.

Two possible solutions were identified with respect to the potential gaps in coverage: (a) off-Marketplace, allow for policies to be effective on dates other than the 1st and 15th of a month, with prorata rates for the initial bill; or, (b) off-Marketplace, allow for early termination or a brief period of double coverage, so that the new policy can be effective on the 1st or 15th of the month. It was agreed that, for Option (b), some standards regarding proof of the impending triggering event as well as proof that the event actually occurred (i.e., that the person factually terminated the other coverage) would be necessary. Following further discussion of systems issues, the carrier board members agreed each needed to see what processes would work best for them operationally. There was general agreement that it would be preferable for everyone to be able to address the situation the same, but that that might not be the result. The Board agreed to discuss the issue again at its next Board meeting, but also agreed that it is acceptable for carriers to work with people to avoid gaps in coverage for those people who intend to avoid such gaps.

With respect to voluntary termination of COBRA due to cost, it was acknowledged that federal law does not recognize this as a triggering event.

VI. Re-enrollment

E. DeRosa reminded Board members that all policies (non-grandfathered and non-transition policies) are meant to renew on January 1 annually. She noted that CCIIO is issuing materials for use with Marketplace plans advising current insureds of the need to re-enroll, and the steps to take. She said that, although plans sold off-Marketplace also renew on January 1, she believed it was acceptable for carriers to use the current process for renewal, requiring no re-application process or issuing of new policies or ID cards.

S. Kelly pointed out that, even for plans sold off-Marketplace, carriers are supposed to send rate renewal notices with information about the Marketplace, and subsidy possibilities, so that individuals can better understand the range of options available to them. In addition, she stated that the information was supposed to be sent and received by currently covered individuals prior to the start of the open enrollment period.

It was also noted that individuals who received an exemption for one year, and purchased a catastrophic plan will need to pursue the exemption process again in order to remain eligible for catastrophic coverage. E. DeRosa indicated that she was not certain whether CCIIO is being proactive with respect to this segment of people, and said she would ask the State Officer whether guidance will be forthcoming.

VII. Close of Meeting

G. Simon made a motion, seconded by T. Pownall, to adjourn the meeting. In voting by roll call, the motion carried.

[The meeting adjourned at 11:15 A.M.]