**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**
**September 13, 2016**

**Directors participating:** Sandi Kelly (Horizon); Lisa Levine (United/Oxford); Tom Pownall (Aetna); Brendan Peppard (DOBI); Tony Taliaferro (AmeriHealth)

**Others participating:** Ellen DeRosa, Executive Director; Chanell McDevitt, Deputy Executive Director; Rosaria Lenox, Managing Financial Officer; Eleanor Heck, Deputy Attorney General; Ryan Schaffer, Deputy Attorney General

## I. Call to Order

E. DeRosa called the meeting of the IHC Board to order at 10:00 A.M. E. DeRosa announced that notice of the meeting had been published in three newspapers of general circulation and posted at the Department of Banking and Insurance ("DOBI"), on the DOBI website, at 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 some directors were participating by phone.

## II. Review of Minutes – *August 9, 2016*

**T. Taliaferro made a motion, seconded by B. Peppard, to approve the minutes of the open session of the meeting of August 9, 2016. By roll call vote, the motion carried.**

## III. Election of Officers and Organization of Committees

E. DeRosa noted that this meeting constituted the annual meeting for the Board, at which it typically re-elects its Chair and Vice Chair, and determines the composition of standing committees. She stated that the current Chair is S. Kelly, while the current Vice-chair is T. Pownall. She asked if there were nominations.

**B. Peppard nominated, and T. Pownall seconded, S. Kelly to serve another year as Chair, to which S. Kelly agreed. By roll call vote, the S. Kelly was elected.**

**S. Kelly nominated, and B. Peppard seconded, T. Pownall to serve another year as Vice Chair, to which T. Pownall agreed. By roll call vote, T. Pownall was elected.**

E. DeRosa reported the current composition of the standing committees, as follows:

Legal Committee: Aetna, DOBI, Horizon
Technical Advisory Committee: AmeriHealth, DOBI, Horizon
Marketing Committee: Horizon, United HealthCare
Operations and Audit Committee: Aetna, DOBI, United HealthCare

E. DeRosa noted that there is room for an additional member to serve on the Marketing Committee, and indicated an expectation that the Individual Buyer's Guide will need updating for 2017, which is within the purview of the Marketing Committee. T. Taliaferro said he would see if someone from AmeriHealth may be available to sit on that committee.

**S. Kelly made a motion, seconded by B. Peppard, to reconstitute the composition of the standing committees as they currently exist, with the addition of AmeriHealth to the Marketing Committee. By roll call vote, the motion carried.**

## IV. Report of Staff

*Expense Report*
R. Lenox presented the expense report for August, totaling $16,273.83, primarily for salaries and fringe. R. Lenox explained that a transfer of $16,000 from the Board's Money Market account to its checking account would be necessary to pay the expenses, if approved.

**T. Pownall made a motion, seconded by S. Kelly, to approve payment of the expenses reported, and the transfer of $16,000 from the Board's Wells Fargo Money Market account to its Wells Fargo checking account to pay the operating expenses. By roll call vote, the motion carries.**

## V. Report of the Operations and Audit Committee (OAC)

R. Lenox presented the financial statements for the fiscal year ended June 30, 2016, with the Management Discussion and Analysis. Among other things, she noted that the IHC Board issued the final administrative assessment for the fiscal years ended June 30, 2014 and 2015, and had assessed carriers based on the budgeted administrative expenses for those fiscal years. R. Lenox reported that IHC Program assets totaled $16,816,390, which represented a decrease from the prior year, primarily for payment of operating expenses. She reported that the Program continues to have restricted cash and restricted net assets related to cash advances and assessment credits made against reported net reimbursable losses for the 1997/1998 and 1999/2000 calculation periods. She reported that total expenditures decreased by nearly $8,700 compared to fiscal year 2015 primarily as a result in a decrease in the accrual for audit costs, salary expense, overhead and printing costs, offset by an increase in fringe benefit rates. R. Lenox also discussed the fiscal year end Statement of Net Assets, Statement of Changes in Net Assets, Loss Assessment Fund Statement of Changes in Assets and Liabilities, Statement of Cash Flows, and the Comparison of Budget and Actual Expenditures, which showed a favorable year-end balance. She stated that the audit for fiscal year 2016 should begin in October or November.

## VI. Adoption of Proposed Amendments

E. DeRosa discussed the draft notice of adoption of the proposed amendments, explaining that, as drafted, there are some changes between the adoption and the proposal that she believed are not substantive, and thus, do not require another notice of proposal. She explained that a hearing was held on August 18, 2016, but there were no attendees; however, she further explained that written comments were received, and went on to discuss them, as follows:

- One commenter had several comments expressing concern about the procedures the Board used for the proposal, but the Board surmised the comments were based on a

misunderstanding of the nature of the Board's proceedings and the Board's requirements for rulemaking, and responded accordingly, making no changes based on the comments.

- There were several comments opposing the proposed amendment to allowed charges. The comments argued: the Board failed to provide stakeholders with an opportunity for input; the Board must require carriers to reimburse covered out-of-network claims using FAIR Health data sets which the commenters considered to be the natural solution to the repeal of the requirement that carriers reimburse covered out-of-network services at the 80$^{th}$ percentile of PHCS; a requirement to use FAIR Health is the only transparent option; a requirement to use FAIR Health is the only option that would assure that a significant portion of the out-of-network charges are paid; and, the Board should require use of FAIR Health because other states and other state agencies are using it. E. DeRosa explained there were no changes to the proposed amendments based on the comments because: (1) stakeholders had opportunity for input in the process; (2) FAIR Health is not the legal successor to PHCS; (3) carriers may choose to use FAIR Health if they wish to do so; (4) whatever methodology the carrier chooses must provide consumers with the ability to find reimbursement information, and thus will be transparent as to the reimbursement; (5) the methodology chosen does not entirely determine the charges that a person will be responsible for with respect to covered out-of-network services, because out-of-network health care provider charges are not constrained by the reimbursement methodology; and, (6) the fact that a state or state agency is using a specific reimbursement methodology for one program, or one purpose does not necessitate that other states or agencies use the same methodology for different programs or purposes.
- There were comments opposing changes the Board was making to comply with other state laws, but the Board rejected making any changes based on these comments, believing it is within the Board's right and its obligation to make the changes to assure that the Board can operate effectively with respect to quorums, and submission of proprietary information.

E. DeRosa explained that one of the agency-initiated changes is being made to address discussions with the Employee Benefit Security Agency of the U.S. DOL with respect to the small employer plans that she believes should apply to the individual plans as well. She explained that the change clarifies in the policy language that the request for prompt notification of an emergency room visit is intended to assure the appropriate processing of claims, and failure of prompt notification is not an excuse for nonpayment of the claim. She explained that the second agency-initiated change is to make the language in the schedule page and the body of the policy forms regarding vision benefits consistent, in that the benefits are based on a 12 month period, rather than a calendar year.

**T. Taliaferro made a motion, seconded by T. Pownall, to approve the draft notice of adoption of the proposed amendments subject to clerical and technical corrections discussed in the meeting. By roll call vote, the motion carried.**

There was discussion as to whether the Board wanted to permit carriers to use a Compliance and Variability Rider to amend inforce policy forms, and it was agreed that carriers should have that option. Carrier Board members requested time to check with operational teams to determine whether and how long the rider might be necessary to include with newly issued policies. E.

DeRosa agreed to draft the rider, but final determination of its use was pended to the next meeting.

## VII. Close of meeting

**S. Kelly made a motion, seconded by B. Peppard, to adjourn the meeting. By roll call vote, the motion carried.**

*[The meeting ended at 11:07 A.M.]*