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
April 16, 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; Deputy Attorney General (DAG) Eleanor Heck.

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, and the Office of the Secretary of State in accordance with the Open Public Meetings Act. A quorum was present. Because there were several additional representatives from the Board members companies listening on the phone, she stated votes would be by roll call.

She noted that the primary purpose of the meeting was to continue discussion of what to use as a replacement for the Board's current requirement that carriers reimburse out-of-network services at the 80th percentile of PHCS.

II. Minutes – *March 13, 2012*

Minutes of the Open Session

The Board agreed to defer voting on the open session minutes of March 13, but noted the draft would provide background for the discussion to occur during this meeting.

III. Staff Report

Expense Report and Transfer of Funds

R. Lenox presented the Expense Report for April, with expenses totaling $21,764.10, which was composed of invoices for Microsoft Dynamics (for accounting software), for audit services from Withum Smith+Brown (WSB) for loss audits, and for staff salaries and fringe.

R. Lenox noted that, if the Board approved the expenses, it would also need to transfer funds from its Wells Fargo Money Market account to its checking account to pay the operating expenses.

S. Kelly made a motion, seconded by M. Taylor, to approve the April Expense Report, 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 presented. By roll call vote, the motion carried.

IV. TAC Report – Reimbursement Methodology

S. Kelly summarized TAC's general discussions regarding the replacement of PHCS, based on information presented by Navigant, noting that TAC started by suggesting payment should be a percentage of Medicare because it is the process most carriers use for large groups in New Jersey and nationally. She said TAC acknowledges that the range for the large group market tends to be between 150% to 180% of Medicare, so the Board might consider a reimbursement level within that range. She explained that TAC briefly discussed the possibility of varying reimbursement as a percentage of Medicare based on categories of providers, but members had concerns the process may be too complex to administer both at the Board level and the carrier level. She stated that TAC members eventually agreed there are several issues that need to be addressed to support whatever decisions the Board may make, and the two carrier representatives agreed to research the issues within their companies, including:

- How carriers determine allowed charges when there are gaps in the Medicare data, and how it is explained in the policy form
- What the difference is in premium for a PPO and HMO plan assuming reimbursement at 150% of Medicare versus the 80th percentile of PHCS for out-of-network allowed charges
- If there is quantifiable evidence that the use of PHCS has been harmful to the IHC market, and whether experience with PPO plans support a move away from the PHCS model
- How a tiered approach using a percentage of Medicare would be defined.

Board discussion ensued. S. Kelly clarified that, with respect to the Medicare data "gap" issue, the intent was to determine what data carriers use in the large group market with respect to services for which Medicare does not have adequate data to develop a fee for a procedure (because, for instance, it involves a service not typically provided to the primary population served by Medicare). She noted that AmeriHealth and Horizon follow the same process, so it would be helpful to obtain information from the other carriers to determine what other options may exist.

Board members raised the question of whether carriers should have the flexibility to deviate from a specified reimbursement level. E. DeRosa said that TAC did not discuss that matter in great detail, but thought the Board's rules could be revised to specify a floor for reimbursement from which it can be inferred higher levels of reimbursement were permissible. After some discussion, Board members agreed that such language is unlikely to result in much variability if the only option is to reimburse at a higher level.

Board members discussed the genesis of the standardization of the methodology for out-of-network reimbursement. It was noted that, when the Board first implemented the rule, few carriers offered PPO plans in New Jersey, and PPO plans were slow to gain momentum for most

carriers. M. Taylor said she believed a seminal question is whether Board members agree it is still necessary or appropriate to specify standards for determining allowed charges, and thus, whether it is necessary to specify a replacement for PHCS. Some Board members indicated that, while companies may prefer more flexibility to choose a reimbursement methodology (as is the case in the large group market), the differences between the large and small group and individual markets may warrant some controls in this regard, noting, for example, that small groups and individuals do not have benefits managers available to evaluate and negotiate reimbursement levels. Board members also expressed concern that the "apples-to-apples" comparison afforded by the standard plans would be significantly diminished if reimbursement for out-of-network services was largely unregulated.

It was noted that Navigant's data suggests setting allowed charges somewhere between 200% and 300% of Medicare RBRVS if the intent is to produce reimbursement levels that are roughly similar to current levels for many services. Some Board members expressed an unwillingness to reimburse at a level greater than what is typical in the large group market. When Navigant's alternative suggestion to use the Fair Health profiles subject to an upper cap based on a percentage of Medicare was raised, some Board members indicated they like the concept, but were concerned about the relative complexity of the system, and the need to hire a vendor to calculate the capped levels.

Board members agreed that having a better understanding of the impact on premium rates if reimbursement is set at varying levels of Medicare (no less than 150%), as well as the impact on rates if reimbursement is made using the Fair Health profiles at less than the 80th percentile would help the Board in making a decision. It was also agreed that there should be a study of the impact on certain CPT codes in an effort to better understand the potential for balance billing of consumers.

S. Kelly stated that the TAC focus had been primarily on premium rates rather than balance billing. She acknowledged that balance billing is a public policy issue for the Board to consider and evaluate. Board members requested that Navigant identify the most frequently-performed out of network procedures as well as the top procedures in terms of cost. Both Oxford and Aetna agreed to research the issues TAC is investigating to obtain a fuller set of responses.

VIII. Close of Meeting

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

[The meeting adjourned at 12:00 P.M.]