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
July 10, 2012

Directors present: Darrel Farkus (Oxford); Christine Stearns *(arrived at 10:10)*; Neil Sullivan (DOBI); Neil Vance (DOBI – *substituting for Neil Sullivan after 11:00)*

Directors participating by phone: Sandi Kelly (Horizon); Thomas Pownall (Aetna Health Inc.); Tony Taliaferro (AmeriHealth).

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 10:02 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. E. DeRosa noted that voting would be by roll call because half of the directors were participating by telephone.

II. Minutes – *Open Session of June 19, 2012*

T. Taliaferro made a motion, seconded by T. Pownall, to approve the minutes of the June 19, 2012 meeting, with amendments. By roll call vote, the motion carried.

III. Staff Report

Expense Report and Transfer of Funds – July

R. Lenox presented the Expense Report for July, with expenses totaling $18,963.52. She explained that the expenses were primarily for salaries and fringe to be paid to the SEH Board. She asked that the Board approve the transfer of $19,000 from the Wells Fargo money market account if the Board approved payment of the expenses.

S. Kelly made a motion, seconded by D. Farkus, to approve the July Expense Report and the transfer of $19,000 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. By roll call vote, the motion carried.

E. DeRosa requested that the Board approve the transfer of $128,000 from funds held in Treasury to the Board's money market account, explaining that the funds are for the purpose of paying Navigant. She further explained that Navigant had advised her that it would submit an

invoice in early July. She noted it takes awhile to transfer money from Treasury, and suggested that if the request to transfer funds is made now, the money would be available by the time of the Board's next meeting in August, so the invoice can be paid immediately following the Board's vote to approve payment. E. DeRosa stated that the funds would continue to earn interest regardless of whether held by Treasury or Wells Fargo.

D. Farkus made a motion, seconded by S. Kelly, to transfer funds totaling $128,000 from Treasury to the Board's Wells Fargo Money Market account in anticipation of payment of an invoice from Navigant for services rendered pursuant to contract. By roll call vote, the motion carried.

Public comment period during Board meetings
E. DeRosa stated the question arose as to whether the Board typically takes public comment at meetings (which the Board does), and that she was bringing the matter to the Board to determine whether this was something the Board wanted to be built into its working agenda. She explained that the IHC Board has routinely permitted the public to speak at meetings upon request, without any formal agenda notation, while the SEH Board allocates specific periods on the working agenda for accepting public comment, and pointedly asks twice (at the beginning and end of each meeting) if there are comments. It was noted that both Boards typically permit individuals to speak upon request without prior approval of the subject matter, or going through a formal process, although occasionally, speakers who want to provide a more lengthy presentation have asked to have the presentation added as a specific agenda item, which the Boards usually agree to do. After some discussion, the Board determined that its current, informal process of entertaining comments during its meetings upon request was adequate, and that there was no need to add one or more comment periods to the agenda.

IV. Operations and Audit Committee (OAC) report

E. DeRosa noted that the OAC did not actually meet, but that R. Lenox had sent out the financial statements and asked for comments or concerns, and received none. R. Lenox then presented the following financial statements for the period ending March 31, 2012: Statement of Net Assets, Statement of Changes in Net Assets, Statement of Changes in Assets & Liabilities – Loss Assessment Fund, Statement of Cash Flows, and Comparison of Budget and Actual Expenditures. Among other things, R. Lenox noted that the restricted cash account has funds being held with respect to the Time Insurance Company litigation, and that the unbilled accounts receivable is for Celtic Life Insurance, the audit of which revealed its incurred losses exceeded its reported losses by $25,000.

Board members inquired as to which loss assessment calculation periods remained open, and R. Lenox reminded them that it is the 1997/1998, 1999/2000 and 2001/2002 calculation periods that have not yet been closed.

V. Technical Advisory Committee (TAC) report

S. Kelly reported that TAC reviewed the quarterly Basic & Essential reports, and agreed to continue monitoring the information.

S. Kelly reported that, after some discussion, TAC made a recommendation to propose an out-of-network reimbursement standard of 150% of Medicare RBRVS, with DOBI's representative abstaining. She explained that N. Vance abstained from the recommendation because he was not persuaded that one reimbursement methodology is any more justifiable than another based on the information available thus far. S. Kelly noted that TAC also discussed the question of whether and how to reimburse those codes for which Medicare lacks pricing data (the "gap fill" issue), and several suggestions arose, including the possibility of using a percentile of the 2010 PHCS data adjusted by the Consumer Price Index. She noted, however, the carrier representatives wanted to talk more with their companies both in terms of how significant a problem the gaps may be, and the options used in other markets before making any recommendations.

E. DeRosa stated that TAC recommended seeking responses to several more questions: (1) what percentage of claims is processed using a gap filler because there is no Medicare data? and, (2) what types of claims most frequently require this treatment? She explained that TAC also indicated that selection of a gap filler should be based at least in part on its ease of administration by all carriers in the market, and suggested that carriers also indicate the pros and cons of using the PHCS as a gap filler.

E. DeRosa then presented the data that had been received to date on the earlier questions posed to carriers, explaining that not all carriers had yet responded to all questions, that data provided was inconsistent at times, and that the information received indicates there are lots of differences among carriers. She focused on the large group questions about what is being purchased in that market and the Board discussed the reported information

N. Vance stated that DOBI data, based on annual financial submissions, suggest that about 2/3 of large groups are enrolled in plans with out-of-network benefits, which was consistent with at least some of the data reported to TAC thus far.

E. DeRosa also noted that the information submitted by one carrier indicates there is evidence of higher trending unit costs for out-of-network claims versus in-network claims, and that she hoped to gather more information on this from other carriers. Board members discussed whether this is the result of some price manipulation or based on other causes, and asked whether carriers are able to distinguish between voluntary and involuntary out-of-network usage. There was some agreement that carriers probably could make the distinction based on coding, even if it is not information they currently capture for their own use.

E. DeRosa raised the point that she had begun drafting the summary document for the rule proposal amending the required reimbursement methodology. She explained that the summary document will need to set forth the Board's reasons for whatever change it decides to make. It

was noted that there may be no single reason and that various points may need to be discussed because they combine to support the Board's action (the more data available to support the multiple points, the stronger the support for the Board's action). It was suggested that the Board needs to focus on the message it is trying to tell, including, why out-of-network utilization tends to occur, whether it is primarily voluntary or involuntary, the primary types of claims incurred and the impact these costs have on premiums.

VI. Close of Meeting

The Board confirmed that its next meeting is on August 21, 2012 at 10 A.M., that being the final of the three additional meetings the Board scheduled.

T. Taliaferro made a motion, seconded by C. Stearns, to close the meeting of the Board. By a roll call vote, the motion carried.

[The meeting adjourned at 11:20 A.M.]