FINAL
MINUTES OF THE ANNUAL 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
November 13, 2012

Directors present: Darrel Farkus (Oxford); Sandi Kelly (Horizon); Christine Stearns *(arrived at 10:25 A.M.)*; Neil Sullivan (DOBI); Tony Taliaferro (AmeriHealth); Mary Taylor (Aetna)

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

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.

II. Minutes – *Open Session of September 11, 2012*

S. Kelly made a motion, seconded by D. Farkus, to approve the minutes of the September 11, 2012 meeting, with amendments. The motion carried.

III. Staff Report

Expense Report and Transfer of Funds – September

R. Lenox presented the Expense Report for November, with expenses totaling $26,690.93. She explained the expenses were primarily for WithumSmith+Brown (WSB) with respect to the FY12 administrative audit, and salaries and fringe to be paid to the SEH Board, but also included printed checks and public notices for the Board's 2013 meeting schedule.

R. Lenox asked the Board to approve transfer of $26,700 from the Board's money market account with Wells Fargo, to the Board's Wells Fargo checking account to pay the expenses presented.

D. Farkus made a motion, seconded by T. Taliaferro, to approve the November Expense Report and the transfer of $26,700 the IHC Board's Wells Fargo Money Market account to the IHC Board's Wells Fargo checking account for the purpose of paying the expenses incurred. The motion carried.

IV. Operations and Audit Committee (OAC) Report

Administrative Audit for Fiscal Year 2012
E. DeRosa reported that WSB presented its audit report to the OAC, finding that the financial statements fairly present the financial position of the Program in all material respects for FY12. E. DeRosa noted the opinion is an "unqualified opinion," or, as the partner for WSB described it, "clean and green." E. DeRosa commended R. Lenox for her outstanding accounting practices.

Amended loss audit for 2005/2006
E. DeRosa explained that, during the course of the audit, WSB looked at the exemption-request files, and found documentation indicating that AmeriHealth was not given proper credit for the non-group lives covered during the 2005/2006 period, and consequently was invoiced and paid $13,000 more than it should have for the 2005/2006 loss assessment. She stated that staff confirmed the exemption percentage, and that, it will be necessary to issue an *amended* final reconciliation for that loss calculation period. She noted that both the OAC and the Technical Advisory Committee reviewed the amended reconciliation and recommended the Board authorize it.

M. Taylor made a motion, seconded by S. Kelly, authorizing the issuance of invoices for the amended final reconciliation for the loss assessment for the 2005/2006 calculation period, with a refund to be paid to AmeriHealth when amounts due are collected. The motion carried.

Update on Open Loss Audits
E. DeRosa provided an update on the status of the audits of Time Insurance Company for the 1997/1998 and 1999/2000 loss calculation periods. E. DeRosa stated that the 2001/2002 loss calculation period audit also remains open because WSB needs the D&T final report for the 1999/2000 loss calculation period to verify certain starting numbers for the 2001/2002 loss calculation period.

V. Technical Advisory Committee (TAC) report

S. Kelly reported that TAC discussed the question of how to address carrier reimbursement of out-of-network items of expense for which no fees can be derived from the Medicare Resource-based Relative Value Scale (RBRVS), for one or more reasons (hereafter, the reimbursement for missing fees is referred to as "gapfill"). She explained that, after reviewing the data from the IHC carriers over the past several months (including data from the SEH market), and taking into consideration the Navigant report, TAC recommended: (1) requiring carriers to use the Medicare RBRVS in general; (2) requiring carriers to reimburse at 150% of the RBRVS, except when not possible; and, (3) when it is not possible to use the RBRVS, permitting carriers to use whatever methodology each carrier currently employs for gapfill in the New Jersey large group market.

Discussion ensued regarding the reasons why TAC made the recommendations it did. There was general agreement among the carrier members of the Board that 150% of the RBRVS is consistent with what is typically reimbursed in the large group market.

A question arose as to whether permitting the gapfill to be based on individual carrier practices will result in inconsistent application and encourage carriers to compete on price by ratcheting-down on the gapfill. It was acknowledged that the possibility of competition on the gapfill exists, but is considered unlikely because the gapfill constitutes a small percentage of overall charges. It was also acknowledged that inconsistent application may occur (meaning, carriers might change methodologies periodically without notice), but could be controlled somewhat by requiring carriers to provide a description of the methodology to the IHC Board prior to use, with the IHC Board posting the descriptions on the IHC Program web pages (similar to the process used with respect to the underwriting guidelines for the SEH Program).

It was noted that there are several reasons for allowing carriers to use their existing methodologies: (1) there is no consistent gapfill method among the carriers in the IHC market; (2) one gapfill method is not inherently more reasonable than all others presented; and (3) it is administratively simpler to permit each carrier to expand their use of their existing gapfill method (for the large group market) into the IHC market. One Board member suggested that, to assure gaming of the gapfill by carriers did not occur, the IHC Board could periodically review data to monitor activity, similar to the way in which the IHC Board monitors the impact of the Basic & Essential plans upon the standard plan market.

It was agreed that transparency suffers when there is no consistent gapfill method, but argued that consumers can obtain a general cost for gapfill procedures by contacting the carrier, whether using an online tool or calling customer service. It was acknowledged that in all cases – whether using RBRVS or a gapfill method – the consumer will only know what the carrier is paying, and not what the health care provider charges will be (i.e., not what the consumer will owe).

The IHC Board acknowledged that the primary issue is whether to use the RBRVS at 150%, not the gapfill. The Board also acknowledged that it still needs to state the case for moving to the RBRVS as opposed to any other reimbursement method. E. DeRosa suggested the IHC Board develop a white paper, similar to what is being drafted for the SEH Board, explaining the issues relevant for the individual market. It was agreed that an economic discussion is necessary, explaining that a move to the RBRVS is a way to maintain the products with out-of-network benefits.

In summary, the IHC Board agreed to the following concepts:

- carriers should pay at 150% of RBRVS generally
- for purposes of gapfill, carriers may use the methodology they use for large groups
- carriers must submit the methodology (or a description of it) to the IHC Board prior to use
- the IHC Board will post the methodology or description thereof on the Board's web page, along with a general discussion about the RBRVS, and links to carriers' online tools, as available

- a white paper with a goal of providing a consumer-friendly explanation of why the IHC Board is doing what it is should be drafted (the white paper would also provide a foundation for the summary and impact statements required in the rulemaking process)

E. DeRosa told the Board that the SEH Ad Hoc Committee that had been assigned the task of addressing the out-of-network reimbursement issue had suggested that the SEH Board hold one or more stakeholder sessions in an effort to educate and obtain feedback from interested parties on the issues. The IHC Board discussed whether to co-host or otherwise participate in the stakeholder meeting(s). It was noted that a different outreach effort may be necessary to obtain individual consumer input, but E. DeRosa stated that M. Koller from the Rutgers Center for State Health Policy (RCSHP), and a director on the SEH Board, is providing help with the stakeholder meeting(s), and she and RCSHP have a proven record in obtaining consumer input at all levels. The IHC Board agreed to seek approval from the SEH Board to co-host the stakeholder meeting(s).

The IHC Board also agreed to hold another meeting by conference call on December 7, 2012 at 9:00 A.M. to receive a report on the SEH Board meeting, and make further plans based on that.

VI. Public Comment

Diane Autin, representing the Statewide Parent Advocacy Network (SPAN) asked to speak. She stated she was surprised that the content of the meeting was without any reference to the changing dynamic which will occur in 2013/2014 when a health insurance exchange will be established through some means in New Jersey. She noted that the decisions the IHC Board is trying to make may be of a very short-term nature.

In addition, she stated her belief that it is important for the Board to take a position on how the health insurance exchange is created in New Jersey. She indicated that it is SPAN's position that it is very important for the health insurance exchange to be developed and run by the State, and questioned why New Jersey would move to the middle when it is already a leader in the health reform arena. She advocated that partisan politics be set aside and that the Governor commit to doing what is best for the citizenry. She noted she and Renee Steinhagen (of New Jersey Appleseed) and Jeff Brown (of NJ Citizen Action) are at the meeting specifically because of the federal deadline on November 16th for filing of a letter of intent by Governor Christie as to whether the State will create and run the health insurance exchange in New Jersey. Ms. Steinhagen and Mr. Brown concurred with Ms. Autin's sentiments.

VI. Close of Meeting

S. Kelly made a motion, seconded by D. Farkus, to adjourn. The motion carried.

[The meeting adjourned at 11:45 A.M.]