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
January 8, 2013

Directors present: Darrel Farkus (Oxford); Sandi Kelly (Horizon); Christine Stearns *(left at 11:40)*; Neil Sullivan (DOBI); Tony Taliaferro (AmeriHealth – *arrived at 10:30*); Mary Taylor (Aetna)

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 10:05 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 November 13, 2012*

D. Farkus made a motion, seconded by M. Taylor, to approve the minutes of the November 13, 2012 meeting, with amendments. The motion carried.

III. Staff Report

Expense Report and Transfer of Funds – January

R. Lenox presented the Expense Report for January, with expenses totaling $42,265.25. 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 a payment to the Division of Law for legal services.

R. Lenox asked the Board to approve transfer of $42,300 from the Board's money market account with Wells Fargo, to the Board's Wells Fargo checking account to pay the expenses presented.

S. Kelly made a motion, seconded by D. Farkus, to approve the January Expense Report and the transfer of $42,300 from 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. The motion carried.

Update on the Amended Final Reconciliation for the 2005/2006 Loss Calculation Period
E. DeRosa reported that most of the funds due to the IHC Program had been collected for the reconciliation of the 2005/2006 calculation period loss audit, and staff believes the remaining amounts will be received shortly based on correspondence with the carriers. She requested that, in order to expedite the refund process, the Board authorize staff to issue payment of the refund when the total amount is received, rather than waiting for the Board's next meeting. She clarified that the amount to be paid to AmeriHealth is $13,322.60.

C. Stearns made a motion, seconded by M. Taylor, authorizing prompt payment of the amount owed by the IHC Program to AmeriHealth in accordance with the amended final reconciliation for the 2005/2006 loss calculation period following receipt of all amounts due from other carriers to the IHC Program. The motion carried.

IV. Operations and Audit Committee (OAC) Report

Final Administrative Assessment for Fiscal Years 2010 and 2011
R. Lenox reported that with the completion of the contract work by Navigant, the Board is in a position to make the final administrative assessment for fiscal years 2010 and 2011, ended June 30th respectively. She reminded Board members there had been a second assessment to fund the contract awarded to Navigant, and together the two administrative assessments had totaled $1,061,000. She reported that expenses had come in under budget by about $20,000 (based on over-accrual for both the Navigant contract and the WithumSmith+Brown contract for administrative audits), and in addition, the Board had earned interest of nearly $9,700. She explained that, with changes in assessment allocation based on members' relative net earned premium reported for the 2009/2010 calculation period as compared to the original assessment based on the 2007/2008 calculation period, actual expenditures versus the budget and interest earned, the IHC Program will issue refunds to carriers totaling $159,302, and will seek payments from carriers totaling $414.50. R. Lenox reminded the Board it has a policy of waiving payment of refunds that are less than $2.00, and noted that the total waived amount for this period is $2.32.

R. Lenox reported that the OAC as well as TAC reviewed the final administrative assessment and recommended the Board approve it. She explained that, if the Board approves the action, the Board also needs to authorize the transfer of $160,000 of its funds held in Treasury to the Board's Wells Fargo Checking Account to fund the refunds.

M. Taylor made a motion, seconded by S. Kelly, to approve the final administrative assessment for fiscal years 2010 and 2011 and to authorize the transfer of funds totaling $160,000 from Treasury to the IHC Board's checking account at Wells Fargo Bank for the purpose of issuing refunds owed to carriers, totaling $159,302, in accordance with the final administrative assessment report for fiscal years 2010 and 2011.

Financial Statements for FY13Q1

R. Lenox presented the financial statements for the program for the first quarter of fiscal year 2013, ended September 30, 2012, including: Statement of Net Assets, the Statement of Changes in Net Assets, the Statement of Changes in Assets and Liabilities – Loss Assessment Fund, the Statement of Cash Flows, and the Comparison of Budget and Actual Expenditures. R. Lenox noted that expenditures are currently running under budget.

V. Technical Advisory Committee (TAC) report

S. Kelly reported that TAC reviewed the final administrative assessment for the fiscal years ended June 2010 and 2011, and like the OAC, recommended the Board approve the assessment.

S. Kelly reported that TAC reviewed the third quarter (CY2012) Basic and Essential (B&E) reports from AmeriHealth, Oxford and Horizon, and suggested TAC continue to monitor the activity.

VI. Other Business – Staff Report

Draft White-Paper regarding Change in the Reimbursement Methodology for Out-of-Network Claims

E. DeRosa briefly explained the intent behind the draft, and asked for any comments from the Board. Board members suggested: more detail and data clarifying the changes that have occurred in the IHC market over time; the relative enrollment in plans with and without an out-of-network option across the IHC market (including B&E plans); an acknowledgment that B&E plans will no longer be an option in 2014; and, more discussion of the pros and cons of using a charge-based method as well as the RBRVS. It was suggested that the white-paper include a few examples of items of expense and the probable outcomes of reimbursement under PHCS, Fair Health and Medicare RBRVS to help illustrate the matter, and bring it more closely to laymen's terms. Board members agreed to provide information for the revised white paper.

IHC Board members discussed whether to collaborate with the Small Employer Health Benefits Program (SEH) Board in holding a stakeholder meeting. Those IHC Board members who also sit on the SEH Board explained the SEH Board's intent in pursuing a stakeholder meeting is to foster respect for the decision-making process even if everyone is not satisfied with the ultimate decision of the Board. While some IHC Board members expressed an interest in gathering stakeholder input, there was concern about timeliness of the process, and it was suggested that the IHC Board proceed with its own stakeholder meeting if it appears the SEH Board's stakeholder meeting will not be held soon.

Some IHC Board members raised concern that 150% of RBRVS will be opposed by the medical community and consumer groups and may generate strong reactions. The Board agreed it will be critical to present well-reasoned explanations and credible information as the basis for any proposal the Board will develop. Board members suggested that E. DeRosa and N. Sullivan speak with Governor's Counsel regarding the Board's intentions as soon as possible following the February Board meeting.

Amendments to IHC Health Benefits Plans to Comply with the New Jersey Benchmark Plan selected in accordance with the federal Affordable Care Act (ACA)
E. DeRosa discussed the draft amendments to the Plan A/50 through D form required to bring the standard plans into compliance with New Jersey's benchmark plan selected in accordance with the federal ACA. She stated that the draft does not address cost-sharing, and suggested that TAC be assigned the task of discussing the actuarial value and relative metal values of the plans in order to determine what ranges on cost-sharing would be considered acceptable. She said she would like comments back from Board members by January 25th, so that she can make revisions and the Board can take action on the proposal in February. She indicated an intention to employ the expedited rulemaking process, so that the Board might adopt the amendments in March, after which carriers may start applying for certification of plans as "qualified health plans" using the revised standard plan forms.

She noted the following changes to the plans (changes to the HMO plan will be similar):

- Cost-sharing for the prescription benefit will have to be applied toward satisfaction of the maximum out-of-pocket (MOOP) limit.
- There can be no dollar limits on essential health benefits; thus, the dollar limit on hearing aids (for children) and applied behavioral analysis or related structural behavior programs must be removed.
- The limit for coverage (120 days) in an extended care or rehabilitation facility must be removed because the benchmark does not have that limit
- The federal Mental Health Parity and Addictions Equity Act (MHPAEA) applies, which means all visit limits and day limits on treatment of mental illness as well as treatment of substance abuse no longer must be removed.
- A limited fertility benefit is added (limited to artificial insemination and prescriptions to enhance fertility) because of the benchmark plan.
- Dental benefits for children (18 years old and younger), substantially similar to that included in New Jersey's Children's Health Insurance Program (NJFamilyCare) are added to comply with the ACA's essential health benefits requirement.
- Vision benefits for children (18 years old and younger), substantially similar to that included in the Federal Health Benefits Plan vision insurance program (FedVIP) are added to comply with the ACA's essential health benefits requirement.
- Preexisting condition limitation periods (and associated continuity of coverage provisions) are eliminated to comply with the ACA.
- Language regarding the grace period is revised to take into consideration the timetable (and process) specified by the federal government for individuals enrolled in commercial coverage through a health insurance exchange and receiving premium tax credits pursuant to the ACA (i.e., establishing a 90-day grace period). She noted that even for individuals not receiving premium tax credits the ACA specifies coverage

terminates at the end of the grace period rather than any earlier date, but otherwise permits the grace period to be 31-days.

E. DeRosa noted she had considered removal of the conversion privilege for divorced spouses, but she thought it might be more prudent to leave the language until there is a statutory amendment instead (the provision being based on N.J.S.A. 17B:26-2i), since the language is no longer warranted in a guaranteed issue individual market.

The Board discussed whether there could be different individual plans inside and outside the health insurance exchange. The general conclusion was that the plans should be the same given existing statutes, which specify the only individual plans that may be offered in New Jersey are those developed pursuant to the IHC law, and the law requires all individual plans to be available to every eligible person. In addition, Board members noted that the ACA's essential health benefits requirements apply to policies both inside and outside the health insurance exchange. The question also arose as to whether carriers can satisfy their 3-plan minimum IHC requirement by offering less than the full complement inside or outside the health insurance exchange, given that doing so results in offering to only a subset of individuals (those eligible for premium tax credits, or those who are not). No conclusion was drawn.

E. DeRosa noted that there are other things the Board needs to discuss, including whether and how the Board and/or carriers will withdraw certain products and address migration of enrollment, the process of getting consistent information to all interested parties, actuarial values and metal level determinations, loss ratios, and many other issues. It was suggested that carriers (and others) send her queries and to-do suggestions, so that a more comprehensive list can be put together along with an eventual frequently-asked questions document with answers when answers become available.

N. Sullivan noted carriers will have some flexibility with respect to cost-sharing, which the DOBI will review, but the Board will set some standards. In response to specific questions from Board members, N. Sullivan: acknowledged DOBI is aware of issues regarding the medical loss ratio and stated DOBI intends to vet some questions and provide guidance where possible, but the format hasn't yet been determined.

VII. Public Comment

A question was presented by a member of the public regarding employer plans and increased deductibles using flexible spending accounts and/or health savings accounts, but it was determined the comment was more appropriate for the SEH Board to address.

VIII. Close of Meeting

T. Taliaferro made a motion, seconded by S. Kelly, to adjourn. The motion carried.

[The meeting adjourned at 12:25 P.M.]