FINAL
MINUTES OF THE MEETING OF THE
NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM BOARD
AT THE OFFICES OF THE
NEW JERSEY DEPARTMENT OF BANKING AND INSURANCE
TRENTON, NEW JERSEY
May 16, 2012

Members participating in person: Gary Cupo; Darrel Farkus (Oxford); Patrick Gillespie (CIGNA); Joyce Gralha (Horizon); Margaret Koller; Thomas Pownall (Aetna Health Inc.); James Stenger; Christine Stearns; Neil Sullivan (DOBI); Dutch Vanderhoof.

Others participating: Ellen DeRosa, Executive Director; Chanell McDevitt, Deputy Executive Director; DAG William Puskus (DLPS).

I. Call to Order

E. DeRosa called the meeting to order at 10:10 A.M. E. DeRosa announced that notice of the meeting had been published in two newspapers 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. Public Comments

There were no public comments.

III. Election

E. DeRosa reminded the Board that the terms of three directors had expired, that the nominations had occurred and that absentee ballots had been due the day before the meeting. She noted that not all eligible SEH Program members had voted absentee, and upon determining there were representatives present at the meeting who intended to vote, she handed out ballots. When the votes were tallied with the absentee votes, it was determined that:

- AmeriHealth would continue another term as the representative of carriers primarily in the small employer market
- United would continue another term as the representative of carriers primarily in the large employer market
- there was a tie between Thomas Collins, Jr. and John Harmon, Sr. for the seat representing minority small businesses.

E. DeRosa noted that John Harmon, Sr. (a write-in candidate) is the President and Chief Executive Officer of the African-American Chamber of Commerce of New Jersey.

After acknowledging that the Board had never encountered a tie vote before, the Board agreed it would send out nomination solicitations again for this seat, and follow with an election. E. DeRosa stated she believed the process could be accomplished prior to the Board's next regularly-scheduled meeting in July.

IV. Minutes – *March 21, 2012*

T. Pownall made a motion, seconded by D. Vanderhoof, to approve the minutes of the March 21, 2012 meeting, without change. The motion carried.

V. Staff Report

Expense Report and Transfer of Funds
E. DeRosa presented the May expense report, with expenses totaling $1801 for legal services from the Division of Law.

P. Gillespie made a motion, seconded by C. Stearns, to approve the May expense report. The motion carried.

E. DeRosa asked the Board to approve the transfer of $1800 from the Board's Wells Fargo Money Market Fund to the Board's checking account in order to pay the operating expenses approved in the May expense report.

P. Gillespie made a motion, seconded by C. Stearns, to approve the transfer of $1800 from the Board's Wells Fargo Money Market account to the Board's Wells Fargo checking account. The motion carried.

Optional Benefit Riders

E. DeRosa reported that AmeriHealth submitted multiple riders to amend its HMO and HMO POS products as follows:

- One rider (Guest Advantage) amends the HMO and HMO POS product to give members access to network benefits when they are temporarily outside of New Jersey.
- Two separate riders, one to amend the HMO plan and the second to amend the HMO POS plan to add vision benefits for eye exams, eyeglasses, lenses and contact lenses.

She stated she sought clarification regarding the Guest Advantage rider, and received it, and thus, recommended that the Board find all of the AmeriHealth riders complete.

D. Farkus recused himself from discussion and any action that might be taken by the Board with respect to the rider submitted by Oxford because of the interest his employer has in the outcome of such action.

E. DeRosa reported that Oxford submitted a rider to amend its PPO plans to increase the therapy services from a limit of 30 visits to a limit of 90 visits per calendar year. She recommended finding the rider complete.

G. Cupo made a motion, seconded by P. Gillespie, to find the optional benefit riders submitted by AmeriHealth and Oxford complete. The motion carried.

VI. Report of the Finance and Audit Committee (FAC)

E. DeRosa stated that R. Lenox had prepared, and the FAC had reviewed, the final reconciliation of administrative expenses and assessments for the fiscal year ended June 30, 2011, and noted that the FAC had recommended issuing invoices and refunds according to the reconciliation. She explained that the total expenses for FY2011 were about $27,000 less than budgeted, and that the audit for the fiscal year had been completed, so final assessments could be made. She noted that the original assessments were based on member carriers' net earned premium for calendar year 2009, but that the final assessment is calculated using the 2010 net earned premium, so it was possible that, notwithstanding expenses coming in under budget, some carriers actually owe the SEH Program money, although a total of $27,570.98 (including interest earned) was recommended to be refunded to carriers. She also noted that an amount of less than $1.00 owed to one carrier would not be refunded.

D. Farkus made a motion, seconded by J. Gralha, to approve the final assessment of the administrative expenses for the fiscal year ended June 30, 2011, and to authorize staff to issue invoices and refunds to carriers accordingly. The motion carried.

E. DeRosa asked the Board to approve the transfer of funds totaling $27,570.98 from the Money Market account to the Board's checking account to refund carriers for the FY2011 final administrative assessment. She also asked the Board to authorize the transfer of $50,000 from the funds in the Department of Banking and Insurance (DOBI) to the Board's Money Market account for the purpose of earning interest.

D. Farkus made a motion, seconded by D. Vanderhoof, to approve the transfer of $27,570.98 from the Board's Wells Fargo Money Market account to the Board's Wells Fargo checking account for the purpose of refunding carriers amounts due them as a result of the FY2011 final administrative assessment, and to authorize the transfer of $50,000 from the funds in the DOBI to the SEH Board's Wells Fargo Money Market account for the purpose of continuing to earn interest for the SEH Program. The motion carried.

VII. Report of the Ad Hoc Committee (Policy Issues)

E. DeRosa reported that the Ad Hoc Committee considering various policy issues had met again to discuss whether its previously recommended solution was reasonable, and whether there is data to support the contention that retroactive terminations are a problem. She noted that the Committee requested that Dr. Rao provide more information, and he faxed examples of situations he had encountered. E. DeRosa stated that the Committee agreed that it could not quantify the problem's frequency or intensity. She said the Committee, as a whole, continued to agree that the offered solution would help to reduce the problem. She distributed draft amendments to a standard HMO POS contract form that includes language consistent with the recommendations of the Committee.

Board discussion ensued. One Board member explained that carrier systems are not designed to accommodate a delay in providing a premium refund and would process a refund as a credit on the following bill. Some business/member maintenance tools used by brokers would also have

to be altered. Some Carrier members questioned the extent of the problem, noting they have not received complaints from providers. N. Sullivan stated that the DOBI receives a steady stream of complaints from providers who receive information from Navinet that a patient is eligible for services and then later find the patient's coverage was retroactively terminated and the carrier has taken action to recoup payments made on behalf of that patient.

D. Vanderhoof noted that the problem cannot be specific to the small employer market, and suggested a solution targeted to the small employer market will yield limited results. He suggested it may be more appropriate for the DOBI to address the situation.

It was acknowledged that currently the health care provider suffers the financial consequence of delayed reporting of coverage termination yet they are the party least able to control any piece of the process. The Board agreed that some change in the process may be appropriate such that the responsibility of employers, brokers and carriers is better aligned to the financial risk. Dan Kalosieh of Aetna volunteered to outline the issue based on the Board's discussion.

D. Vanderhoof made a motion, seconded by P. Gillespie, to table further discussion on the issue until the next Board meeting. The motion carried.

VIII. Additional Policy Amendments

Preventive Services; Oral Anti-Cancer Medications
E. DeRosa alerted Board members to other amendments in the draft contract forms she had distributed. She explained that the additional draft amendments:

- revise the policy forms to incorporate the federal language regarding preventive care services/benefits as required by the federal Affordable Care Act (ACA), plus she suggested adding a catch-all provision that would allow for automatic updating as the federal preventive care requirements evolve over time;
- address the oral anti-cancer medication coverage mandate enacted in New Jersey late in 2011 and effective beginning July 2012. She explained that the language is structured so that a person who gets the drugs from a pharmacy will receive a pharmacy benefit, but has the opportunity to resubmit the claim to the carrier, which must then determine whether the coverage under the medical benefits or pharmacy benefits is more favorable to the covered person and adjust benefits accordingly.

She requested that Board members review the draft and provide her with suggestions on the oral anti-cancer medication provisions prior to the next Board meeting. She recommended that the Board exercise its discretion to use expedited rulemaking since these amendments are required by law and should be promulgated as soon as possible.

Summary of Benefits and Coverage
There was brief discussion about the requirement pursuant to the ACA that, as of September 23, 2012, carriers begin issuing Summaries of Benefits and Coverage (SBC) to employers and employees. E. DeRosa stated some carriers have contacted her regarding what would be necessary for compliance.

IX. Report of the Ad Hoc Committee (Out-of-Network Reimbursement Methodology)

E. DeRosa reminded the Board that a second Ad Hoc Committee was formed to address the issue of what out-of-network reimbursement methodology should replace the PHCS for the small employer market. The Committee met and discussed certain issues, then assigned its carrier members the task of responding to the following questions:

- What evidence is there that use of a charge-based profile has been harmful to the SEH market?
- What percentage of Medicare is typically offered to large group employers?
  - Is the percentage the same for all categories of services?
  - What percentage is most often selected?
  - What is the difference in rates from one option to another?
- What are the pros and cons of establishing a standard but allowing carriers to use an optional benefit rider to amend the basis for the allowed charge?

E. DeRosa distributed the responses to the homework questions, and discussion ensued. There was general agreement that use of a charge-based profile as the basis for out-of-network reimbursement had led to higher trend increases in non-network charges compared to network charges. It was suggested that the fact that one carrier spends as much as 28% of claims dollars out-of-network indicates that reimbursement for out-of-network services is too high. It was noted that the use of Medicare RBRVS as a basis for out-of-network reimbursements is becoming increasingly common, and all carriers on the Committee use a percentage of the Medicare RBRVS for groups not covered by the SEH law. It was acknowledged that the percentages of Medicare RBRVS range widely, both in terms of what is offered to employers, and what is selected by employers.

There was discussion about the history of Fair Health, and reasons why some carriers are concerned about using it in addition to it being a charge-based system much like PHCS. Notably, there is question about Fair Health's ability to operate after the expiration of the funding required under the New York Consent Order under which it was formed. There is also some concern about Fair Health's transparency relative to Medicare's because of limitations on monthly access to data.

Board members discussed the pros and cons of setting a reimbursement standard, but allowing variation. Although there was general agreement that a standard should be set, there was also agreement that it was unlikely carriers would offer employers the option for a richer reimbursement through riders. There was concern that varying reimbursement levels by categories of services or health care providers may be too complicated for the carriers and the consumers.

It was noted that one difference between carrier use of the Medicare RBRVS and its use by the federal Medicare program is that the federal government not only sets what it will pay, but also limits what providers may collect from Medicare beneficiaries, while carriers do not have any control over out-of-network charges in the commercial market. It was urged that the Board be mindful that this piece is out of the Board's control, and consumers are the vulnerable parties.

X. Public Comments

There was no public comment.

XI. Special Announcement

J. Stenger announced that today's meeting would be his last as a Board member. He gave E. DeRosa a letter stating he was resigning from the Board. J. Stenger explained that his contract with Benefit Mall had expired and he decided it would be a good opportunity to retire from 40 years in the insurance business and relocate at least half-time to a sunnier place of residence. The Board wished him well, and thanked him for his 10 years of service.

E. DeRosa noted that because J. Stenger is resigning from an elected position an election would be necessary to fill it. Tthe new nominations to be sent out to address the minority business representative seat would also solicit nominations for another representative of small business.

XII. Close of Meeting

D. Vanderhoof made a motion, seconded by P. Gillespie, to adjourn the meeting. The motion carried.

[The meeting adjourned at 11:55 A.M.]