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
May 8, 2007

Directors participating: Darrel Farkus (Oxford); Sandi Kelly (Horizon BCBSNJ); Ulysses Lee (Guardian – *by phone*); Steve Lenox; Gale Simon (DOBI); Christine Stearns; Mary Taylor (Aetna Health Inc.); Lisa Yourman (*by phone*)

Others present: Ellen DeRosa, Executive Director; DAG Vicki Mangiaracina (DLPS); Rosaria Lenox, Program Accountant; Chanell McDevitt, Deputy Executive Director.

I. Call to Order

E. DeRosa called the meeting to order at 9:30 A.M. She 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 by roll call.

II. Minutes

April 17, 2007

G. Simon made a motion to accept the Open Session minutes of April 17, 2007, with amendments. S. Kelly seconded the motion, and the motion was approved by a roll call of the Board, with L. Yourman abstaining.

III. Report of Staff

Expense Report

R. Lenox provided a summary of the May 2007 Expense report. There was brief discussion about the expenditure for Microsoft Dynamics (a technical support package). R. Lenox explained that the full cost is billed to the IHC Program because the contract for the services is between the IHC Program and the vendor; however, the actual cost will be split 50% with the SEH Program.

M. Taylor offered a motion to approve the payment of the expenses on the May 2007 expense report, and L. Yourman seconded the motion. The Board voted unanimously by roll call in favor of the motion.

Collections of late fees accumulated for the 1997/1998 and 1999/2000 interim reconciliations and 2001/2002 assessment

E. DeRosa reported that bills had been sent out on April 27, 2007 requesting carriers that paid their assessments late submit interest payments. E. DeRosa reported that a number of carriers have called for further explanation or to dispute the bill, but no payments have been received. Staff has agreed to look again at the interest penalty for at least one carrier that submitted payment late but sought advice in a timely manner on the question of offsets.

Disbursements of funds
R. Lenox reported that letters had been sent to 114 carriers regarding pending disbursements. These letters generally request verifications of addresses, account numbers for wire transfers, and similar information that will help staff assure that payments are sent appropriately. Approximately 50% of the carriers that received letters have now responded. Staff intends to disburse funds once a majority of carriers have responded. R. Lenox explained that staff did not provide carriers the option of a wire transfer when the distribution would be less than $100,000 because of the associated costs. R. Lenox also explained that when a carrier is owed money for multiple periods, staff intends to distribute the money in one check or wire transaction with notations designating the periods.

Annual Marketing Reports
E. DeRosa reminded Board members that marketing reports for the B&E plans were due on March 1, but that only one carrier had submitted anything thus far (UnitedHealthCare).

Annual Financial Disclosure Statements
E. DeRosa reminded Board members that their financial disclosure statements are due by May 17.

IV. Report of the Technical Advisory Committee (TAC)

S. Kelly reported that the TAC met on May 3, 2007, and reviewed the B&E quarterly and annual reports, and a rate filing by Aetna Health Inc. The TAC noted no specific issues with the B&E reports, and will continue to monitor the filings to evaluate whether adverse selection is avoided to the extent possible.

M. Taylor recused herself from any action regarding the Aetna Health Inc rate filing reviewed by the TAC.

S. Kelly reported that the TAC reviewed the Aetna HMO rate filing for its deductible and coinsurance HMO product. TAC recommended finding the rate filing to be complete.

G. Simon made a motion to accept the recommendations of the TAC and find the Aetna Health Inc rate filing for the HMO deductible/coinsurance plan to be complete. L. Yourman seconded the motion, and the Board voted unanimously by roll call in favor of the motion.

V. General Discussion

L. Yourman asked whether the IHC Board would be discussing pending legislation. She noted that of some interest is "Grace's Law" (A-289) and the mental health parity bill (S-807). L. Yourman asked whether the IHC Board could do an analysis of the cost that A-289 would represent for the IHC Program. S. Kelly noted that the Mandated Health Benefits Advisory Commission (MHBAC) had already done a broad cost analysis, and the MHBAC's report is available on the Department of Banking and Insurance's website. There was also discussion about S-807 (mental health parity), which was scheduled to be heard on May 10 before the Senate Appropriations Committee.

VI. Report of the Legal Committee

Does "nongroup persons" include people covered under a group Medicare policy?

E. DeRosa reminded the Board that it had requested she draft a memo to the Department of Banking and Insurance highlighting the problems presented by the current process for determining target enrollment numbers, which in turn, raised the issue as to how group-enrolled Medicare lives are to be counted. The Legal Committee had previously considered the question, but could not come to a consensus, and sought input on whether Medicaid considers contracts for Medicaid managed care products to be group or nongroup. Medicaid indicated it considers its contracts to be group contracts. The Legal Committee debated whether to treat Medicaid and Medicare analogously, but it was also noted that N.J.A.C. 11:20-8.4(b)3 – which explains how to complete Part D of Exhibit K – specifies that all Medicare lives are to be included for reporting purposes. Thus, the Legal Committee recommended that carriers should include all Medicare lives on the Exhibit K regardless of how enrolled unless and until the rules are amended to exclude group-enrolled Medicare lives. (The question remains whether the Board should revise the rules to make exceptions for group-enrolled Medicare lives based on the existing statutory language for nongroup persons.) The Legal Committee's recommendation to include *all* Medicare lives would require Horizon to revise its Exhibit Ks for two reporting periods.

The Board discussed the existing standards for calculating target enrollment numbers, and the changes in the meaning of both Medicaid and Medicare since 1992, when the target enrollment provisions were enacted. It was noted that in 1993, approximately 24,000 Medicaid and Medicare lives were included in the target enrollment count, and now there are about 2,000,000, making it impossible for any carrier to reach the target enrollment. Board members acknowledged that it would be most desirable to obtain a legislative change. E. DeRosa agreed to update the memo regarding the target enrollment problem for the Board to review.

Amendments to rules and policy forms to implement the intent of the Civil Union Act (P.L. 2006, c. 103)

E. DeRosa reported the Legal Committee had reviewed the draft amendments to the IHC rules and policy forms to implement the intent of the Civil Union Act, and recommended the draft for proposal.

The Board discussed the draft proposal. S. Kelly noted that upon further consideration, Horizon recommended revising the language regarding children to treat the child of a civil union partner like a stepchild, rather than similar to the child of a domestic partner. In addition, she recommended changing the definition of "Family unit" at N.J.A.C. 11:20-1.2 to allow civil union partners to be added. It was noted that the family unit terminology arises primarily in the context of high deductible plans, and acknowledged that civil union partners may not be eligible for the tax advantage under federal law (for the savings mechanism), but that adding a civil union partner to health benefits plans with which there may be a medical/health savings account should still be an option under state law. V. Mangiaracina stated that she would look more closely at the issue.

C. Stearns noted that the definitions at N.J.A.C. 11:20-1.2 should also be revised to treat a child of a civil union partner as a stepchild, not the same as a child of a domestic partner. It was also noted that the relevant definition in the rules had never included stepchildren (although the policy forms always have), so the rules need to be amended to correct that oversight.

The Board asked that the draft be revised and brought back to the Board for further review.

VII. Executive Session

E. DeRosa said the Board would need to go into Executive Session to consider draft Executive Session minutes, and discuss current or pending litigation. She said the Board may conduct additional business following Executive Session.

C. Stearns offered a motion to begin Executive Session for the stated reasons. D. Farkus seconded the motion. The Board voted unanimously by roll call in favor of the motion.

[Executive Session: 10:30 A.M. to 11:10 A.M.]

VII. Final Business and Close of Meeting

E. DeRosa reported that two carriers have claimed losses for the 2005/2006 reporting period. Guardian is claiming reimbursable losses of $452,685 and Celtic is claiming reimbursable losses of $608,596 (totaling $1,061,281).

L. Yourman offered a motion to close the meeting. S. Kelly seconded the motion. The Board voted unanimously by roll call in favor of the motion.

The meeting adjourned at 11:15 A.M.