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
June 12, 2007

Directors participating: Darrel Farkus (Oxford); Sandi Kelly (Horizon BCBSNJ); Ulysses Lee (Guardian); Gale Simon (DOBI); Christine Stearns (*arrived at 9:40*); Mary Taylor (Aetna Health Inc.)

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.

II. Minutes

May 8, 2007

D. Farkus made a motion to accept the Open Session minutes of May 8, 2007, with amendments. G. Simon seconded the motion, and the motion was approved by a unanimous vote of the Board.

III. Report of Staff

Expense Report

R. Lenox provided a summary of the June 2007 Expense report, which included expenses totaling $11,880.90.

M. Taylor offered a motion to approve the payment of the expenses on the June 2007 expense report, and S. Kelly seconded the motion. The Board voted unanimously in favor of the motion.

Annual B&E Marketing Reports
E. DeRosa reported that all carriers required to submit a report for 2006 had done so, but that some of the submissions were missing required information, or the information submitted raised some questions for which she was seeking clarification. She noted that Aetna's B&E submission included an Aetna Health application rather than an Aetna Life

Insurance Company (ALIC) standard plan application form, but the B&E plan is written by ALIC; the Aetna Health application does not include reference to the B&E plans, as required by regulation, so Aetna will have to submit the correct ALIC application. She pointed out that CIGNA's report was substantially complete, but CIGNA failed to provide the required certification. She also noted that UnitedHealthCare submitted a report that indicated the company did not actively market because it was withdrawing from the individual market in 2006; however, the company was not in the withdrawal process for the entire 2006 calendar year, and should have submitted a certification regarding its B&E marketing activities. It was determined that no Board action regarding the reports is necessary at this time.

Medicare Resource-Based Relative Value Scale (RBRVS) and Prevailing Healthcare Charges System (PHCS)

E. DeRosa reminded the Board that there was still some issue regarding whether the IHC and SEH Programs should continue to require carriers to reimburse nonparticipating health care providers (non-facility) using the PHCS schedules, or move to another reimbursement mechanism, possibly Medicare's RBRVS. She reported that Horizon had hired a consultant to provide them with more information on the development of the RBRVS, and the relative impact of using the RBRVS to pay claims as compared to the PHCS. The consultant (Doug Anderson) had completed his report, and upon suggestion of Horizon, had presented the information to the Department of Banking and Insurance (DOBI) and the Board's staff. E. DeRosa reported that she found Mr. Anderson's presentation very helpful, and thought it might be helpful for the IHC and SEH Boards to hear the presentation as well, possibly at a joint board meeting in August or September. She also suggested that the Boards might also be interested in hearing a presentation from Concentra regarding their hospital payment mechanisms.

Board members discussed the question. M. Taylor expressed surprise that the issue was still open, given the abundance of comments received by DOBI in response to the proposal to require carriers in the large group market to pay at least 150% of Medicare RBRVS, and the discussions at the prior SEH meeting which noted the heightened sensitivity of the medical societies to any potential invocation of the Medicare RBRVS. G. Simon noted that while RBRVS might be off-the-table at least for purposes of DOBI action at this time, moving away from the billed charges requirement for hospital payments might still be an option for consideration. C. Stearns and several other board members expressed concern that the meeting might be very difficult to manage if there were a large turn-out of health care providers, lobbyists and/or legislators, but it was noted that the Boards have the right to establish the ground rules for the meeting. There was debate whether, if such a meeting occurred, the public should be permitted to present comments and/or ask questions of the consultant or the Board. It was noted that the primary purpose of the meeting with the consultant would be to educate Board members about how fees are derived using the Medicare RBRVS, and that if the Board were to seek or allow public input as to the desirability of moving to reimbursement using the Medicare RBRVS, it may be more appropriate to do so at a subsequent meeting.

C. Stearns and other Board members also expressed concern that a consultant, paid by Horizon, could create a perception of bias. S. Kelly explained the purpose of the project had been to obtain a better understanding of how the Medicare RBRVS functions, and the degree to which the Medicare RBRVS may be adaptable in order to address divergence in fees derived by the Medicare RBRVS and PHCS. She stated that, although the consultant's report isolated the categories of health care services and/or health care providers for which there is a divergence in fees paid by the Medicare RBRVS and PHCS, the consultant's report did not specifically address the magnitude or frequency of the divergence, nor make any specific recommendations as to the adjustments that could be made to remedy the issue. S. Kelly noted that this would provide a basis for further study and not immediate action by the Board. Some Board members indicated that, regardless of the report's intent, the public might perceive the report as biased specifically because it was commissioned and paid for by a carrier, and suggested that the bias hurdle might be overcome if the Board were to hire its own consultant to study the issue. Other Board members suggested that the perception of bias was unlikely to be overcome regardless of who paid for the consultant, but disagreed whether such a perception should halt the project.

E. DeRosa reminded the Board that staff had contacted employees at the Centers for Medicare and Medicaid (CMS) in an effort to have someone from the agency provide the Boards with more detailed information about the Medicare RBRVS, but was unable to get a commitment from CMS. Thus, if the Board wants more information, a consultant is the only apparent option. There was a suggestion that the Boards seek input from the Rutgers Center for State Health Policy, an employee of which sits on the SEH Board (Margaret Koller).

The Board finally agreed there should be a presentation on how the Medicare RBRVS operates, but did not agree on the specifics of how to proceed. The Board requested that staff inform the SEH Board that the IHC Board would like to jointly hire a consultant for purposes of studying the Medicare RBRVS, perhaps obtaining some recommendations from Joel Cantor (Rutgers Center for State Health Policy). In addition, the Board requested that G. Simon obtain a perspective from the DOBI Commissioner on how to proceed in terms of consultant presentations and public meetings, and requested that G. Simon provide the Board with a summary of the comments to the controversial 150% Medicare RBRVS rule proposal (amendments to 11:22-5) so that the Board could get a better sense of the concerns raised by health care providers and other interested parties. G. Simon noted that, because of the volume of the comments received, she did not expect a summary to be available for quite some time.

IV. Report of the Technical Advisory Committee (TAC)

S. Kelly recused herself from any Board action regarding the Horizon rate filing reviewed by the TAC.

E. DeRosa reported that the TAC met on June 7, 2007, and reviewed Horizon's request to extend its existing rates for its B&E Plan, and stated that TAC had recommended finding the filing complete.

M. Taylor made a motion to accept the recommendations of the TAC and find the Horizon rate filing (extending the existing rate) for the B&E plan to be complete. D. Farkus seconded the motion, and the Board voted unanimously to find it complete.

D. Farkus recused himself from any Board action regarding the Oxford rate filings reviewed by the TAC.

S. Kelly reported that TAC had reviewed two filings from Oxford, one for its HMO Plan and one for its SCA plans, and had recommended finding both filings complete.

M. Taylor made a motion to accept the recommendations of the TAC and find the Oxford rate filings for both its HMO and SCA plans to be complete. U. Lee seconded the motion, and the Board voted unanimously to find it complete.

S. Kelly reported that TAC had reviewed the quarterly enrollment reports for the ridered B&E plans required to be submitted by AmeriHealth, Horizon and Oxford. TAC will continue to monitor the filings to evaluate whether adverse selection is being avoided to the extent possible.

V. Report of the Legal Committee

E. DeRosa noted that a portion of the Legal Committee discussion would take place in executive session.

Amendments to rules and policy forms to implement the intent of the Civil Union Act (P.L. 2006, c. 103)
E. DeRosa reminded the Board that it had requested revisions to the draft amendments to the rules and policy forms presented to the Board at the May 8, 2007 meeting, so revisions had been made and presented to the Legal Committee for review. The Legal Committee had recommended approval of the revised draft, with the knowledge that the Attorney General's office was still reviewing it.

The Board discussed the revised draft proposal. C. Stearns suggested that the treatment of children of civil union partners be on par with children of domestic partners was inappropriate, and that they should be treated akin to a stepchild. S. Kelly suggested that children of civil union partners and domestic partners be separated, with a clarification added that the child of a domestic partner must rely upon the contractholder for support or maintenance in order to be considered a dependent under the policy.

C. Stearns also recommended revisions to the definition of "family unit" to better clarify the similarity in treatment of civil union partners and spouses and the distinction in treatment of domestic partners and civil union partners.

S. Kelly made a motion to approve proposal of the amendments with the suggested revisions. C. Stearns seconded the motion, and the Board voted unanimously to approve it.

VI. Report of the Operations & Audit Committee (OAC)

E. DeRosa explained that the OAC had reviewed the target enrollment numbers prepared by staff based on carrier information. The information had been revised based on the prior recommendation to read the Board's rules strictly to include all Medicare lives in the count (whether enrolled on a group or individual basis). Then, the numbers had been revised again because of an acknowledgment that one carrier had included NJKidCare B,C and D lives with its Medicaid enrollment, notwithstanding the regulations exempting such lives from the count. The OAC considered it appropriate for staff to send out the target enrollment reports for both the 2003/2004 and 2005/2006 periods, with separate explanations.

E. DeRosa reminded Board members that the target enrollment numbers for the 2003/2004 calculation period indicate that they are revised because the Board had sent out target enrollment numbers at an earlier time (consistent with the regulations), prior to the challenges to the loss calculations. Because the time periods for reporting of lives for both the 2003/2004 and 2005/2006 periods were now past, staff recommended having carriers submit their exemption requests and certifications of enrollment in one step rather than two, as is traditional.

M. Taylor recommended some further clarification in the bulletins accompanying the target enrollment numbers advising carriers that if they wish to request exemptions for both period, they must submit two separate requests. V. Mangiaracina also suggested revising the bulletins to permit carriers an additional 30 days (for a total of 60 days from receipt of the bulletin) to provide certification of enrollment, just in case they should have any difficulty putting together the data. Thus, carriers would have 30 days from receipt of the bulletin to make the exemption request and 60 days from receipt of the bulletin to provide certification of enrollment, although carriers could still provide both the exemption request and the certification simultaneously (within 30 days) if they wanted to do so.

G. Simon made a motion to approve distribution of the two bulletins regarding filing of exemption requests and certification of enrollment for the 2003/2004 and 2005/2006 calculation periods, as revised. C. Stearns seconded the motion, and the Board voted to approve it, with U. Lee abstaining.

E. DeRosa reminded the Board that it had requested she draft a memorandum to Donald Bryan explaining the problems with the existing statutory target enrollment formula. She noted that she had indicated in the memorandum that the Board is recommending removing Medicare and Medicaid lives from the denominator, and instead suggesting that a growth goal of some percentage greater than 1.00 (perhaps 110% or 120%) be

substituted. V. Mangiaracina suggested revisions to make it clear that the Boards are asking DOBI whether it would support changes to the statute. The Board requested specimen target enrollment data illustrating targets using 110% and 120%.

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.

U. Lee made a motion to move the meeting into Executive Session. C. Stearns seconded the motion, and the Board voted unanimously to approve it.

[Executive Session: 11:25 A.M. to 11:30 A.M.]

VII. Report of the OAC continued

Financials, distribution of funds and budget
R. Lenox discussed the Q32007 financials, and noted that the OAC had no concerns regarding it. She stated that the Board owes carriers approximately $15,000,000 at this time due to the various reconciliations, and is in the process of sending out the payments. She is still verifying some of the carrier information.

R. Lenox noted that the OAC had requested that staff put together a straw budget for FY2008 based on current expenses, so that the FY2008 budget will avoid substantial over-assessing for administrative functions.

Late Fee Penalty
E. DeRosa reported that she had presented to the OAC for consideration United States Life Insurance Company of the City of New York's request for a waiver of the late fee issued against it for late payment of the December 18, 2006 assessments. The company made the request because they had sought advice from staff about netting the payments prior to the due date, but nevertheless their payment ended up being one day late. (The late payment totaled $766.88.) E. DeRosa reported that the OAC had recommended waiving the late payment in this instance.

M. Taylor made a motion to grant United States Life's request for a waiver of payment of the late fee penalty. S. Kelly seconded the motion, and the Board voted unanimously to approve it.

VII. Final Business and Close of Meeting

D. Farkus offered a motion to close the meeting. U. Lee seconded the motion. The Board voted unanimously in favor of the motion.

The meeting adjourned at 11:40 A.M.