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 11, 2010

Directors present: Sandi Kelly (Horizon); Christine Stearns (*arrived at 10:15 A.M.)*; Neil Sullivan (DOBI); Tony Taliaferro (AmeriHealth); Mary Taylor (Aetna Health Inc).

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

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. Ethics Rules and Financial Disclosure Statement

Greg Pulliti, DOBI's Ethics Officer who also provides advice on ethics to the IHC Board, handed out the ethics rules for the IHC Board (the common rules plus those adopted specifically for the IHC Board) and requested that each director sign and return a statement acknowledging receipt of the rules to E. DeRosa by the Board's next scheduled meeting.

G. Pulliti also reminded the Board that the financial disclosure statements are now due by August 24, 2010, based on Executive Order 24 (Christie), but noted that no one is prejudiced by filing by the May 15 deadline.

III. Minutes – *March 9, 2010 Open Session*

S. Kelly made a motion to approve the Open Session minutes of the March 9, 2010 meeting, with amendments. T. Taliaferro seconded the motion. The motion carried by a unanimous vote.

IV. Staff Report

Expense Report

R. Lenox presented the May Expense Report, with expenses totaling $63,833.11. She noted that the expenses being paid included salaries and benefits for staff, a bill for the professional services of Withum, Smith+Brown (WSB) related to audits of carriers seeking reimbursements for losses for the two year calculation periods 01/02 through

05/06, and the program audits for FY09, a bill from the Division of Law, and a bill for Great Plains for software support.

T. Taliaferro made a motion to approve payment of the expenses for May 2010, which was seconded by M. Taylor. The motion carried by a unanimous vote.

Good Faith Marketing Reports for 2009

S. Kelly recused herself from any action taken with respect to the Horizon Good Faith Marketing Reports because of the interest of her employer in the outcome.

T. Taliaferro recused himself from any action taken with respect to the AmeriHealth Good Faith marketing Reports because of the interest of his employer in the outcome.

M. Taylor recused herself from any action taken with respect to the Aetna Life Good Faith Marketing Reports because of the interest of her employer in the outcome.

N. Sullivan recused himself from any action taken with respect to the Horizon Good Faith Marketing Reports because of the interest of his former employer in the outcome.

B&E Plans
E. DeRosa explained that this is the first year that carriers have been required to file a marketing report for both their standard plan and B&E plan business. She reported that all of the carriers had filed their Good Faith Marketing Reports for their B&E plans timely, and all provided the information required by N.J.A.C. 11:20-2.6.

S. Kelly made a motion to find the marketing efforts of each carrier for B&E Plans in 2009 to be acceptable based upon each carrier's submitted Good Faith Marketing Reports. C. Stearns seconded the motion. The motion carried as to each carrier: Aetna Life Insurance Company, AmeriHealth HMO, Celtic Insurance Co., CIGNA, Health Net, Inc., Horizon Blue Cross Blue Shield of New Jersey, and Oxford.

Standard Plans
E. DeRosa noted that, with respect to the Good Faith Marketing Report for the standard plans, Aetna Life Insurance Company, AmeriHealth HMO, CIGNA, Horizon Blue Cross Blue Shield of New Jersey and Oxford Health Insurance Company had submitted reports as required by N.J.A.C. 11:20-24.6. She noted the following:

- CIGNA's report was late, but complete
- The reports for Aetna, Horizon and Oxford are also complete
- AmeriHealth's report had contained no rates or form information, but that she had requested it on May 5, 2010
- Celtic is not required to file a Good Faith Marketing Report for its standard plans because the carrier is not offering coverage in the small employer market.
- Health Net, Inc. probably should have filed a report, but did not, probably because it has already withdrawn from the IHC and SEH markets. She stated she had not followed up on the matter because the consequences of failing to prove

good faith marketing is forced withdrawal from the markets, which Health Net has done.

After discussion, E. DeRosa agreed to send a letter to Health Net confirming that the company had failed to file the report and was in the process of withdrawing. T. Taliaferro stated he would check on the missing AmeriHealth information.

M. Taylor made a motion to find the marketing efforts of each carrier that submitted a Good Faith Marketing Report for Standard IHC Plans in 2009 to be acceptable based upon each carrier's submitted reports, except that a finding that AmeriHealth's marketing effort is acceptable is contingent upon AmeriHealth submitting the information required to complete its Good Faith Marketing Report for 2009. C. Stearns seconded the motion. The motion carried as to each carrier: Aetna Life Insurance Company, AmeriHealth HMO, CIGNA, Horizon Blue Cross Blue Shield of New Jersey, and Oxford.

V. Report of the Technical Advisory Committee (TAC)

E. DeRosa reported that TAC had met twice since the last Board meeting. She stated TAC met once to consider the B&E quarterly and annual reports from AmeriHealth and Horizon (Oxford's having been considered earlier), loss assessment reconciliations and an administrative assessment to fund the consulting contract for reimbursement methodologies. She noted that, with respect to the B&E reports, TAC recommended continued monitoring.

S. Kelly reported that, with respect to the loss assessment reconciliations, TAC had found some changes were needed because the 35% cap had not been applied as it should. She noted the change in actual allocated dollars was minimal. She stated that TAC had agreed to review the revised reconciliation in June, before the Board's scheduled July meeting.

S. Kelly reported that the TAC had also met to consider the bids submitted in response to the Board's Request for Proposal (RFP) for actuarial and statistical services, which would give rise to the additional administrative assessment. S. Kelly noted that there had been two bidders, Navigant and Burgess, and that the TAC had recommended Navigant based on the quality of the proposal as well as the cost, which was nearly half the cost proposed by Burgess.

The Board had extensive discussion about the qualifications of the bidders, the Board's intentions when it issued the RFP, and the changes in the health insurance environment since the RFP had been issued. The Board decided to take the opportunity to review the bids and make a decision at a later meeting. The Board agreed there was no need to consider an additional administrative assessment unless and until a contract award was made.

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

R. Lenox reported on the financial statements for the IHC Program for the period ended March 31, 2010, including Statement of Net Assets, Statement of Changes in Net Assets, Statement of Cash Flows, and the Comparison of Budget to Actual Expenditures. It was noted that the IHC Program is likely to refund carriers approximately $44,000 for FY2010 administrative costs, because the Program is currently running under budget. R. Lenox also explained that the OAC had recommended splitting assessment amounts into four quarters on the financial statements, with amounts held as deferred income until the quarter occurs, and later recorded to revenue for the current quarter (under Administrative Funds). R. Lenox noted a new statement had been created: Statement of Changes in Assets and Liabilities – Loss Assessment Fund, which has a balance of $11,370,740 as of March 31, 2010, after approximately $2 million in deductions had been taken (primarily as payments for losses to Celtic, but also as a matter of accruals for loss audits), plus nearly $500,000 in additions had been received from Protective as a refund of loss reimbursements, assessment credits and audit costs.

R. Lenox stated that she and E. DeRosa had asked Wachovia about accounts with some investment components that would preserve principal. She explained that Wachovia offers a no risk "High Performance Money Market Account" along with a "Custom Business Checking" account, which would allow the Board to earn some interest and avoid monthly service fees if both accounts retained a balance of $5,000, while allowing for online banking transfers between accounts. R. Lenox noted that the OAC had some concerns whether the system would have an adverse impact on internal controls, and explained that transfers would be done only after approval by the Board and would be reflected in the minutes, as currently occurs. She also stated the intent is to maintain the balance for both accounts combined below the FDIC limit of $250,000. R. Lenox noted she is not a signatory for the Board's accounts (E. DeRosa, C. McDevitt and N. Sullivan are at this time), so both she and the OAC members believed the IHC Board's auditors would be satisfied with the arrangement.

S. Kelly made a motion to transfer $150,000 from the IHC Board's Treasury account to Wachovia for the purpose of opening a Custom Business Checking account as well as a High Performance Money Market account for the IHC Program at Wachovia. T. Taliaferro seconded the motion. The motion carried by unanimous vote.

VII. Report on the Federal Patient Protection and Affordable Care Act (PPACA)

N. Sullivan provided an overview of the PPACA (Public Law 111-148), enacted March 23, 2010. He noted that there is another regulator to pay attention to now: HHS' Office of Consumer Information and Insurance Oversight, which is being headed by Jay Angoff, former Missouri Insurance Commissioner, a former Deputy Commissioner of Insurance in New Jersey, and a health policy analyst for former Governor Florio. He said that the National Association of Insurance Commissioners (NAIC) also has significant input in the process, and that there are weekly teleconferences on multiple subjects between HHS, the NAIC, various state regulators, and certain other organizations. He explained that

there is a New Jersey workgroup composed of Governor Christie's health policy advisors, and employees of the Departments of Human Services, Health and Senior Services and the DOBI.

Temporary High Risk Pool

N. Sullivan explained that, presently, the DOBI is primarily focused on the temporary high risk pool (HRP) required by the federal legislation. He said it appeared New Jersey would be allotted approximately $141 million in total for the HRP, and that the money would pay for claims that are in excess of premiums. He explained that the HRP is only available for people who have been uninsured for at least 6 months who have a preexisting condition, and can not be used to subsidize the entire market. He explained that states were to indicate by April 30th if they intended to pursue their own HRP mechanism, or wanted the federal government to do it, noting that New Jersey filed an intention to set up its own program. He noted that the official HHS solicitation had been received on May 10, 2010, so work on the proposal in response to the solicitation had just begun, but that New Jersey is trying to meet the preferred June 1, 2010 deadline, with the expectation HHS will approve or disapprove the proposal by July.

N. Sullivan explained that N. Vance believed the HRP could be run through the IHC Program with some tweaking of certain existing standard plans. He noted the HRP coverage must provide an actuarial benefit of 65%, caps on the out-of-pocket cost-sharing, and no lifetime maximums. He stated the belief that the standard premium can be varied in order to maximize use of the federal funding, and that no carrier should be at a financial risk. He stated the goal is to have HHS agree to a narrow definition of creditable coverage and a broad definition of preexisting condition, to reach as many people as possible.

In response to questions about use of NJ FamilyCare, N. Sullivan explained everyone believes legislation would be necessary to modify that program. He also stated that, contrary to the belief that using NJFamilyCare would maximize the FMAP (federal medical assistance percentage) for New Jersey, the FMAP is only available for state dollars, which the PPACA funding is not.

N. Sullivan stated that he expected some IHC regulatory changes will be required for purposes of implementing the HRP, but not legislation. He noted the alternative is to let the federal government set up the program, but it is not clear how they would operate in a guaranteed issue state.

Additional possible IHC Program Impacts

N. Sullivan explained that there are also other changes that will become operative in September, some of which *may* result in changes for the IHC Program, including:

1. extension of dependent coverage to age 26. The interim federal rules do not permit actual dependency to be a factor. A notice requirement will apply in the first plan year after the September operative date.
2. elimination of cost-sharing for preventive services and screens

3. elimination of lifetime limits for essential benefits (essential benefits being as yet undefined)
4. with respect to medical loss ratios, a definition or establishment of parameters around the concept of quality of care initiatives
5. parameters around the concept of "excessive" rate increases

Web Portal
N. Sullivan also noted that HHS is working on establishing a federal web portal through which consumers can get basic information about health insurance available in their respective states. He said HHS is required to have the portal up and running by July 1, but plans several generations of it, with a significant update expected in October of 2010.

Insurance Exchanges
N. Sullivan stated that significant guidance is still required from HHS on how the exchanges are to be developed. He said we know the exchange must be operated by a government or nonprofit entity, and must be able to provide information about both commercial insurance options, Medicaid and State Children's Health Insurance Programs, and be able to advise and enroll applicants, monitor carriers' required disclosures, determine whether rates are excessive, and "rank" plans. He said the exchanges must be operational by January 2014, and the federal government has funds available to help build the infrastructure. N. Sullivan stated that the law suggests there will be exchanges for individuals to use and for employers to use, but that these can be combined. He noted that States can make the exchange the sum total of the market for individual and small group coverage – with small group being defined by 2016 as employers with up to 100 employees. N. Sullivan indicated he expected the exchange to be an interagency design, possibly with a new office of some sort, but that the IHC Program/Board will have many action items to address both with respect to the temporary high risk pool and the exchange in the near future.

VIII. Close of Meeting

S. Kelly made a motion to adjourn the meeting. M. Taylor seconded the motion, which carried by a unanimous vote.

[The meeting adjourned at 12:30 A.M.]