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
June 11, 2013

Directors present: Darrel Farkus (Oxford); Christine Stearns; Neil Sullivan (DOBI)

Directors participating by phone: Sandi Kelly (Horizon); Tony Taliaferro (AmeriHealth); 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 10:00 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, the Office of the Secretary of State and submitted to the State House Press Corp, in accordance with the Open Public Meetings Act. A quorum was present. She stated that votes would be by roll call because of participation of multiple Board members by telephone.

II. Minutes – *May 14, 2013*

D. Farkus made a motion, seconded by M. Taylor, to approve the minutes of May 14, 2013. By roll call vote, the motion carried, with S. Kelly abstaining.

III. Staff Report

Expense Report

R. Lenox presented the expense report for June, with expenses totaling $13,294.56. She explained that expenses are primarily for salaries and fringe, and also legal services. R. Lenox indicated that, in order to pay the expenses if approved, the Board would need to approve a transfer of funds from the Board's money market account to its checking account.

T. Taliaferro made a motion, seconded by D. Farkus, to approve the expenses on the June 2013 report, and the transfer of funds in the amount of $13,300 from the Board's Wells Fargo Money Market account to the Board's Wells Fargo checking account for the purpose of paying the expenses on the June 2013 report. By roll call vote, the motion carried.

III. Transition to 2014 standards – *Notice to Consumers*

E. DeRosa presented the draft letter she prepared for Basic & Essential (B&E) plan consumers pursuant to the request of the Board at its prior meeting. She noted that the letter was written with the intent that it would be on State letterhead and signed by her, but distributed by the

carriers to their policyholders in September, and with carrier-specific information sent contemporaneously or subsequently, depending upon the renewal dates of the policyholders. She welcomed suggestions.

It was suggested that the letter be shortened to fit on 2 pages. It was also suggested that carriers might send the letter out as part of a 90-day nonrenewal notice process, rather than in September, or that carriers be given the choice of when to use the letter. It was also suggested that the communication should be posted on the Board's website, along with additional information regarding the transition process and substantive differences between the market in 2013 and 2014 (to provide New Jersey-specific details). It was agreed that Board members will provide comments to E. DeRosa, and she will revise the letter and redistribute it to the Board for consideration.

IV. Good Faith Marketing

E. DeRosa reminded Board members that discussion had been postponed on this topic previously because information received had been incomplete. She stated that information (a certification of rate filings) for one carrier (CIGNA) is still missing, despite contacting the company. She explained that the Board has no separate enforcement authority in this matter, so if the Board finds the company has not met good faith marketing standards, it will be incumbent upon the Board to provide notice to the Department of Banking and Insurance (DOBI), which will take action in its discretion.

After further discussion, the Board agreed to have staff ask for the information from CIGNA again. It was also noted that Celtic is required to submit a report for its B&E plan offerings, but not for its standard plan offerings, given the differences in criteria for marketing of the two different categories of plans.

M. Taylor recused herself from discussion and any action taken specifically with respect to Aetna's B&E marketing filing, because of the interest of her employer in the outcome of the Board's action.

S. Kelly recused herself from discussion and any action taken specifically with respect to Horizon's B&E marketing filing, because of the interest of her employer in the outcome of the Board's action.

T. Taliaferro recused himself from discussion and any action taken specifically with respect to AmeriHealth's B&E marketing filing, because of the interest of his employer in the outcome of the Board's action.

D. Farkus made a motion, seconded by C. Stearns, to accept the good faith marketing reports of Aetna, AmeriHealth, Horizon, CIGNA and Celtic with respect to their separate B&E plans. By roll call vote, the motion carried.

D. Farkus recused himself from discussion and any action taken specifically with respect to Oxford's B&E filing, because of the interest of his employer in the outcome of the Board's action.

S. Kelly made a motion, seconded by M. Taylor, to accept the marketing report of Oxford with respect to its B&E plans. By roll call vote, the motion carried.

M. Taylor recused herself from discussion and any action taken specifically with respect to Aetna's standard plan good faith marketing filing, because of the interest of her employer in the outcome of the Board's action.

S. Kelly recused herself from discussion and any action taken specifically with respect to Horizon's standard plan good faith marketing filing, because of the interest of her employer in the outcome of the Board's action.

T. Taliaferro recused himself from discussion and any action taken specifically with respect to AmeriHealth's standard plan good faith marketing filing, because of the interest of his employer in the outcome of the Board's action.

D. Farkus recused himself from discussion and any action taken specifically with respect to Oxford's standard plan good faith marketing filing, because of the interest of his employer in the outcome of the Board's action.

C. Stearns made a motion, seconded by N. Sullivan, to accept the marketing reports of Aetna, AmeriHealth, Horizon, and Oxford with respect to their separate standard plan offerings. By roll call vote, the motion carried.

V. Report of the Operations and Audit Committee

Financial Statements for 3Q13

R. Lenox presented the Board's financial statements for the 3rd quarter of fiscal year 2013. She discussed the Statement of Net Assets, the Statement of Changes in Net Assets, the Statement of Changes in Assets and Liabilities, the Statement of Cash Flows, and the Comparison of Budget to Actual Expenditures. She noted that the Board has nearly $130,000 remaining for the 4th quarter of the fiscal year, and is expected to come in under budget on about the same basis as it did for FY2012.

Loss Audits

E. DeRosa reported that the OAC will be speaking with Deloitte & Touche (D&T) regarding progress on the Time Insurance Company audit (for calculation periods 1997/1998 and 1999/2000) and the next steps.

VI. Report of the Legal Committee

E. DeRosa reported that the Legal Committee met to discuss changes to the Board's definitions per the Board's request. She noted that, while the Committee has begun work on the revisions, it also recognized that some of what it is assigned to do may depend on other changes to the rules, and thus, its product may not be finalized until other rule changes are more concrete.

VII. Report of the Marketing Committee

E. DeRosa reported that the Marketing Committee met to discuss the enrollment reports currently required and suggested changes to them for the Board to consider without yet taking action.

D. Farkus explained that the Committee thought it would be appropriate to maintain the existing report for the duration of the expected transition period in order to track enrollment migration out of the existing plans, and to add two separate reports to separately track enrollment inside and outside of the federally-facilitated marketplace. He stated the Committee expected the current reporting form would be dispensed after reporting for calendar year 2014 is completed. C. Stearns added that, while the reporting seems like a lot, the goal of the Committee was to try to capture as much of the information deemed useful early on, rather than possibly adding reporting elements bit-by-bit over time.

M. Taylor stated that there are states that have or are in the process of establishing an All Payers Claims Database which will capture enrollment data separately for plans sold on and off the Marketplaces, so she does not see expansion of the reporting requirement for both sides of the IHC market as unreasonable, but stated that it would certainly be beneficial for carriers operating in multiple states if the data requests could be as consistent as possible.

There was discussion about whether carriers should be expected to report data by cost-sharing levels (in ranges) or simply by metal levels. It was suggested that it may be possible to only ask for information by metal level eventually, but that such a decision really depends on how many plans within each metal level carriers decide to offer. However, it also was suggested that, even if carriers are offering only a single plan per tier, the metal level is a relatively poor proxy for cost-sharing expectations given the ranges that can exist for each metal level. It was also noted that employers as well as policymakers like to see trends over time and make comparisons among similar types of businesses as well as between individual and group markets, which cost-share ranges would more readily reveal than would metal levels.

Carrier members were asked to take the draft report back to staff who completes the reports to determine if the elements requested can be captured for the report. It was agreed that the rules would have to explain how to complete the report (at least in its current draft) to reduce the possibility of double-counting.

VIII. Miscellaneous: Grandfathered Plans, Medicare, Application, IHC three-plan requirement

Grandfathered plans
There was brief discussion about grandfathered plans and whether any carriers will continue to have them. It was acknowledged that some still exist, albeit a very small number; however, it was suggested that most carriers would consider it appropriate for both the consumer and the carrier to terminate grandfathered plans and offer replacement policies. There was a question whether carriers should go through the withdrawal process for grandfathered plans. N. Sullivan suggested that carriers see what their business looks like and report back, so that the DOBI can address the matter.

Medicare eligible with IHC plan
E. DeRosa noted that there are a few people who kept their IHC plans after becoming Medicare eligible who may need to be dealt with separately from other enrollees, since they will not be eligible to purchase a standard individual policy in 2014 to replace what they now have. She suggested that the Board should consider whether these people should have options.

Application/Conversions
The question arose whether carriers will use an application for conversions from an old to a new plan, and agreed that the HINT form needs to be reviewed for use.

IHC requirement to offer at least three plans
The question arose whether the IHC three-plan requirement can be satisfied if one (or two) of the plans is offered only through the Marketplace. N. Sullivan stated that it was his understanding that the federal government's position is that what is offered through the Marketplace must also be offered outside of the Marketplace in order to satisfy the federal guaranteed issue requirements, because not everyone is eligible to purchase coverage through the Marketplace.

IX. Out-of-Network Reimbursement

The Board discussed again whether to work with the SEH Board regarding stakeholder sessions with respect to the out-of-network reimbursement issue given that the SEH Board decided to move ahead with stakeholder engagement, with the intent to hold stakeholder sessions in late July or August. While the Board continued to have concerns about using the increasingly outdated fee schedules, it was also acknowledged that the timing for such discussions is extremely poor because of all of the other issues involved with implementation of the health care reforms scheduled to begin in 2014. Several Board members viewed the move to a percentage of the Medicare schedule to be a significant policy decision that they were not entirely certain they were prepared to address, and it was suggested that carriers and others assess the priorities of their organizations and discuss the matter again in July.

X. Close of Meeting

D. Farkus made a motion, seconded by C. Stearns, to adjourn the meeting. By roll call vote, the motion carried. *[The meeting adjourned at 12:00 noon.]*