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
August 19, 2009

Members present: Gary Cupo; Joyce Gralha (Horizon); Sandy Herman (Health Net); Alan Maesaka (Aetna); Margaret Koller (*arrived at 10:08*); Niranjan Rao (*arrived 10:17*); Gale Simon (DOBI); Tony Taliaferro (AmeriHealth); Dutch Vanderhoof.

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

I. Pre-Meeting Discussion – Lack of Quorum

T. Taliaferro noted it was 10:05 A.M., but that a quorum was not present. He suggested that Board members currently in attendance proceed to consider agenda items requiring no action until such time as a quorum of Board members was present. 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.

II. Presentation of the 2009 Premium Comparison Survey and 2007 Loss Ratio and Refund Report

2009 Premium Comparison Survey
N. Vance provided an overview of the 2009 Small Employer Premium Comparison Survey, noting that the primary function of the survey and report now is as a tool for comparing how rates in the market have changed over the years, rather than as a shopping tool for employers. He stated that rate increases from 2008 to 2009 were less than 20% for all popular products, and that the rate increases varied more by territory and product this year than in the past. He said he had added a table showing the rates for a single person and family for an HMO Plan with a $20 copayment requirement and a Plan C POS with $20 copayment requirement, to show the variation in rates among the rating tiers not evident from the group rates shown in the premium comparison survey. N. Vance asked that any errors in the report be brought to his attention as soon as possible, because he intended to have the information added to the website in approximately a week.

2007 Loss Ratio and Refund Report
N. Vance reported that average premiums had increased in 2007, but total premium was essentially flat, which suggests that, in addition to enrollment declines, employers were buying plans with reduced benefits, greater cost-sharing requirements and/or increasingly purchased traditional HMO products during the period. He stated the medical loss ratio had jumped after being relatively stable for five prior years, but that the increase was primarily attributable to an

increase in Horizon's loss ratio and Horizon's dominance in the market. He said refunds were paid by HealthNet and Nippon Life in the standard market and by Oxford in the nonstandard market, but that in all instances, the refunds were small. N. Vance stated that, based on preliminary information, he expected substantially similar results for calendar year 2008, with it appearing that total premiums were about $3.5 billion, and the loss ratio will be about 86.1%.

III. Presence of Quorum and Introduction of New Board Members

At 10:25 A.M., E. DeRosa noted that a quorum was present. T. Taliaferro called the meeting to order. E. DeRosa stated that the Board now required nine members of the Board to be at the meeting in order to have a quorum because two additional seats had recently been filled. She introduced Dr. Niranjan Rao, a vascular surgeon and active with the Medical Society of New Jersey, who was appointed to fill the physician seat on the Board, and noted that Joann Petrizzo, who was unable to attend today's meeting, had been appointed to fill the second consumer representative seat on the Board. E. DeRosa reminded Board members that one seat – that of the labor representative – remained unfilled. She also stated that James Sweeney had resigned as the representative for CIGNA, and that CIGNA had not replaced him as yet.

IV. Public Comments

There was a request for greater understanding of the term "medical loss ratio." Board members explained essentially that the term refers to the percentage of premium that is paid out for health care claims. Further explanation was provided that the SEH law originally required carriers to meet a 75% loss ratio (or pay refunds on premiums to achieve it), but that in January of 2009, the law began requiring an 80% loss ratio.

V. Minutes – *June 17, 2009*

D. Vanderhoof made a motion, seconded by S. Herman, to approve the open session minutes of the June 17, 2009 meeting, as amended. The motion carried, with N. Rao abstaining.

VI. Staff Report

Expense Report – August
R. Lenox presented the expenses payable, totaling $5,240.37, which included the final bill from Withum, Smith + Brown for the fiscal year 2006 through 2008 administrative audits ($1173.43) and legal expenses at $3,873.

D. Vanderhoof made a motion, seconded by A. Maesaka, to approve payment of the expenses. The motion carried by a unanimous vote of the Board.

Adoption of the SEH Readoption with Amendments
E. DeRosa explained that the SEH Board's rules implementing the SEH Program had been approved for readoption by the Governor's Counsel, but that Governor's Counsel had not agreed to adoption of proposed amendment allowing carriers to reimburse hospitals at the 80th

percentile of the Ingenix Prevailing Healthcare Charges System (PHCS). She explained that, to avoid expiration of the rules generally, which Governor's Counsel had indicated was undesirable, she had submitted the adoption to the Office of Administrative Law without adoption of the proposed amendment, although all other proposed amendments were adopted. She noted that, because there was no action with respect to that provision of the proposal, the adoption document contained no discussion of comments or responses on that provision, but that if the SEH Board wanted to take action on the proposed amendment prior to the proposal's expiration date on January 5, 2010, the Board would have to address the comments specific to the proposal then.

A. Maesaka made a motion to move the meeting into Executive Session to further discuss the readoption and obtain legal advice. The motion was seconded by D. Vanderhoof, and the Board voted unanimously in favor of it.

[The Board was in executive session from 10:35 until 11:05 A.M.]

E. DeRosa reported that, although the readoption and adopted amendments will be published in the New Jersey Register on September 21, 2009, the effective date for both the readopted rules and the amendments is August 18, 2009 because of the Board's rulemaking process, which specifies that the Board's actions are effective upon submission to the Office of Administrative Law.[1] However, she reminded Board members they had agreed to a delayed operative date with respect to the implementation of changes to the standard plans. She said that she used April 1, 2010, so that carriers would have some time to make policy form changes and prepare to reissue policies. She stated she would issue a bulletin explaining: the delayed operative date; the requirement to reissue policies; the requirement for submission of riders that will need modification, particularly those that make changes in the standard plan schedule pages; and, the requirement for new Certification of Compliance forms to be filed.

Joint Evaluation Committee

E. DeRosa reminded the Board that it had issued an RFP for auditing services jointly with the Individual Health Coverage (IHC) Board, and that a single bid had been received. She noted that the joint evaluation committee currently included Neil Vance from the Department of Banking and Insurance (DOBI) and Kevin Ericson from Oxford/United, who participate in both the IHC Board's Operations and Audit Committee (OAC) and the SEH Board's Finance and Audit Committee (FAC). She further stated that the IHC Board had appointed one additional non-OAC member, and the SEH Board needed to appoint at least one more of its members to the joint evaluation committee, but that the member could not be a participant on the FAC based on Executive Order 122 (McGreevey), or have overlap with the IHC Board membership, otherwise the IHC Board would have a quorum issue. Following discussion, M. Koller agreed to participate on the joint evaluation committee. The SEH Board elected not to add any other members to the committee.

[1] N.J.S.A. 17B:27A-51e. The special statutory procedure provided to the SEH Board avoids the dichotomy that exists under the more general rulemaking procedures at N.J.A.C. 1:30-6.6, which specify that readopted rules are effective upon the date of filing the adoption with the Office of Administrative Law, while adoption of a newly proposed rule or proposed amendment typically is not effective until publication in the New Jersey Register.

Transfer of funds
R. Lenox stated that, because the SEH Board had previously approved preparation of refunds based on the audited fiscal year 2006 through 2008 administrative expenses, totaling nearly $79,000, it would be necessary to transfer funds from the DOBI account to the SEH Board's Wachovia account, and recommended a transfer of $100,000.

D. Vanderhoof made a motion to transfer $100,000 from DOBI's account to the SEH Board's checking account at Wachovia (Wells Fargo) for the purpose of paying SEH Board expenses, including refunds of $78,860.51. M. Koller seconded the motion, and the Board voted unanimously to approve it.

Autism mandate
E. DeRosa advised the Board that Governor Corzine had signed A-2238 (P.L. 2009, c. 115) on August 13th, and that the new law had an effective date of about February 9, 2010. She explained she would be drafting language to the policy forms to comply with the new law, and hoped to have the language adopted and incorporated into the policy forms prior to April 1, 2010, when reissues will be required to begin.

VII. Finance & Audit Committee (FAC)

R. Lenox explained the FAC had reviewed the FY2009 final reports, which she highlighted for the Board, and she highlighted some of the information contained in the Statement of Net Assets, the Statement of Changes in Net Assets, the Statement of Cash Flows and the Comparison of the Budget and Actual Expenditures. She noted that $27,782 remains unspent, but that she had also increased the accrual for the audit for FY2009 because of increased costs related to the FY2008 audit. She noted inclusion of the management discussion and analysis for fiscal year 2009.

VIII. Report of the Ad Hoc Committee

E. DeRosa reported that the ad hoc committee met in July to discuss how to address mental health parity as required by the federal Mental Health Parity and Addiction Equity Act (MHPAEA), and the difference in how small employers are defined in federal and state law. She noted that, although the federal law expressly exempts small employers, because of the differences in counting, not all employers considered small employers under New Jersey law would be exempt small employers under federal law. She explained that the ad hoc committee agreed that, short of a statutory amendment to New Jersey's definition of small employer, the Board could add language to the policy forms similar to that used for COBRA indicating that some small employers may be subject to MHPAEA while others may not be, and requiring the carriers to administer the benefit appropriately, based on variable language within the policy forms, asking that E. DeRosa check with the Centers for Medicare and Medicaid (CMS) to assure that the approach would be acceptable. The ad hoc committee believed carriers collect adequate information currently to be able to distinguish which small employers would be subject to MHPAEA. E. DeRosa reported that her contact at CMS indicated the approach would be acceptable if there were assurances the carriers could appropriately administer the benefits.

E. DeRosa expressed doubts, however, that the current forms collecting census data from employers would allow carriers to clearly determine which employers are subject to MHPAEA, and whether the carriers could readily administer the benefit even if the small employers were easily identified. Board members discussed the fact that a rate differential was likely, which would result in doubling of the existing quote options that all carriers maintained, and might result in off-anniversary rate increases based on the belief that eligibility for MHPAEA is immediate upon loss of the small employer exemption status, regardless of coverage anniversary dates. It was noted that the rating change would be problematic given the 60-day notice of rate change requirement, and further, the new requirement might necessitate an annual census review at the beginning of each calendar year. It was noted by audience participants that this issue is similar to the one that exists for Medicare Secondary Payer requirements.

Board members debated the value of including the benefit in all of the small employer plans, in which event anti-selection would be minimized, and requested that carriers consider whether, if all small employers were subject to the benefit, the increase in costs would be as significant as originally predicted. The Board members noted that including the provisions for all small employers would eliminate certain problems, and make administration easier.

Board members agreed the Board should meet in September to discuss the matter further. The Board requested that staff develop a mock form for capturing the census data necessary to allow the carrier to distinguish the "federally-defined" small employers from New Jersey small employers, and also asked carriers sitting on the Board to re-evaluate the cost implications of compliance with MHPAEA for all SEH plans.

E. DeRosa stated she would send out notice of the September meeting when the dates were finalized. It was agreed that the meeting could be by teleconference.

IX. Public Comments

There was a question whether the continued consideration of the proposed amendment to N.J.A.C. 11:21-7.13 for use of the PHCS was going to be limited to non-network hospitals or would the Board further consider the reimbursement requirements for other non-network providers. Board members responded that the only issue was whether to apply the PHCS to out-of-network hospital charges, noting that carriers already may use the 80th percentile for PHCS when paying out-of-network claims submitted by other health care providers, except in the limited instances in which the Medicare schedule is required to be used for orthotics and prosthetics.

There was a question whether there would be any additional opportunity to comment on the SEH proposal regarding application of the PHCS to non-network hospitals. E. DeRosa responded that the opportunity to comment on the proposal – both the proposed readoption and the proposed amendments – had already closed, and that if and when the Board takes action on the part of the proposal not yet adopted, the Board would respond to the comments already received regarding the specific provisions in question.

There was a question whether anyone was still offering SEH standard plans without riders. Board members responded that all carriers must still offer the standard plans without any riders. E. DeRosa explained that there are two kinds of riders, those generated by the Board, and those generated by carriers. She noted that carriers can offer riders that enhance (increase) the benefits of the standard plans, and may also offer riders that decrease the benefits of the standard plans, but that the decreasing riders are filed with DOBI, not the SEH Board.

IX. Close of Meeting

D. Vanderhoof offered a motion to adjourn the Board meeting, which was seconded by A. Maesaka. The Board voted unanimously in favor of the motion.

[The meeting adjourned at 12:00 noon.]