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
March 21, 2012

Members participating in person: Gary Cupo; Darrel Farkus (Oxford); Patrick Gillespie (CIGNA); Joyce Gralha (Horizon); Margaret Koller *(arrived at 10:30)*; Thomas Pownall (Aetna Health Inc., *arrived at 10:30*); James Stenger; Neil Sullivan (DOBI); Tony Taliaferro (AmeriHealth); Dutch Vanderhoof.

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

I. Call to Order

E. DeRosa called the meeting to order at 10:15 A.M. 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. A quorum was present..

II. Public Comments

There were no public comments.

III. Minutes – *January 18, 2012*

P. Gillespie made a motion, seconded by D. Vanderhoof, to approve the minutes of the January 18, 2012 meeting, without change. The motion carried.

IV. Staff Report

Expense Report and Transfer of Funds

R. Lenox presented the March expense report, with expenses totaling $867, primarily for legal services from the Division of Law.

P. Gillespie made a motion, seconded by D. Vanderhoof, to approve the March expense report. The motion carried.

R. Lenox asked the Board to approve the transfer of $900 from the Board's Wells Fargo Money Market Fund to the Board's checking account in order to pay the operating expenses approved in the March expense report.

P. Gillespie made a motion, seconded by D. Vanderhoof, to approve the transfer of $900

from the Board's Wells Fargo Money Market account to the Board's Wells Fargo checking account. The motion carried.

SEH 2010 Loss Ratio and Refunds Report
Avnee Parekh (DOBI actuary) briefly discussed the final SEH Loss Ratio and Refund Report for 2010, which will be posted on the DOBI website. She noted that total premium declined by about .2% in 2010, which followed a decline in 2009, and that enrollment continued to decline from 820,000 lives at the close of 2009 to 769,000 at the close of 2010, and had fallen again in 2011, which ended with 702,000 lives. She stated that the average loss ratio was also down from 87.8% in 2009 to 83.4%, before refunds, for the standard market, and noted that the average loss ratio was also down in the non-standard market, but that, at 85.6% (before refunds), the loss ratio for the nonstandard market remained above that of the standard market. She stated that refunds had been owed for both standard market business (totaling $20.2 million), as well as the non-standard market business (totaling about $288,000). A. Parekh indicated that relative marketshares of the carriers (on a combined ownership basis) remains substantially unchanged. She stated that the average premium per covered person had increased between 2010 and 2009, but that the increase is lower than the rate increases on a same benefit basis, suggesting that employers are trying to control coverage costs by changing benefits, whether increasing cost-sharing, limiting some benefits or shifting more employees to closed panel HMO products. She noted that premium increases ranged between 20% to 30% for 2009, but were lower (around 15%) for early 2012.

Board members noted that enrollment is down substantially, and asked if it was clear why this was so. A. Parekh stated it was probably multiple factors, including the expense of the coverage and the impact of the recession on the economy, but that she thought enrollment would stabilize or possibly increase, since rates appear to be stabilizing.

V. Report of the Finance and Audit Committee (FAC)

Financial Statements
R. Lenox noted that the FAC had reviewed the Board's financial statements for the first six months of fiscal year 2012. She discussed the Statement of Net Assets, the Statement of Changes in Net Assets, the Statement of Cash Flows, and the Comparison of Budget to Actual Expenditures. She noted that operating expenses are running under budget by about $7500, and that the Board has about $137,514 remaining.

Fiscal 2013 Budget and Assessment
R. Lenox reported that the FAC had discussed the budget for fiscal year 2013, which the FAC recommended total $261,550.00. She explained that the recommended budget was substantially based on the budget and expenses incurred for fiscal year 2012, noting that the increase related to fringe, which is the same rate budgeted by the State and has increased for FY2013.

P. Gillespie made a motion, seconded by J. Gralha, to approve the budget as recommended. The motion carried.

R. Lenox told the Board that it will need to assess carriers now to assure funds for the FY2013 budget, which starts July 1, particularly since the FY2012 expenses have been running close to budget. She presented the spreadsheet showing the assessment for SEH Program members, which is based on the 2011 Exhibit CC data.

P. Gillespie made a motion, seconded by D. Farkus, to approve assessment of SEH Program members to fund the FY2013 budget at $261,550. The motion carried.

VI. Report of the Ad Hoc Committee (Retroactive Termination; Gender Affirmation)

E. DeRosa explained that the Board's Ad Hoc Committee had met multiple times. She noted that the Committee asked staff to circulate draft language based on the understanding reached at the January 31 Committee meeting. She explained that the Committee recognized that the issue is not specific to the SEH market, and was somewhat skeptical about recommending a change without further input from others (and she noted that not all Committee members had been able to attend all of the meetings). The Committee recommended changing the termination provisions as follows:

- permit only prospective terminations, with the effective date of termination being the date of notice to the carrier;
- allow carriers to hold premium for up to 90 days pending receipt of claims;
- if claims are incurred and reported during the 90-day period, allow the carrier to keep the premium between the date of notice and the following business day (under the assumption that the carrier can and should report the change to Navinet within one business day following receipt of a termination notice); and
- require carriers to return premium to the date of notice if no claims are incurred and reported.

E. DeRosa further explained that the Committee agreed that a significant education campaign would be necessary to explain the changes, particularly because there is a common belief among employers that they have 30 days to give notice to the carrier about a termination, and many employers and employees believe that health coverage runs to the end of the month in which the employee is terminated in any case. She further explained that coverage can run to the end of the month (the standard contracts have variable language that permits it), but only if the effective date was the first of the month. She noted that the end-of-month termination of coverage scenario still assumes the employer provides immediate notice to the carrier/broker of the employee's termination, not 30 days after the termination.

There was general discussion among the Board members, who noted that: the recommendation represents a significant institutional change that may not be easily implemented by all carriers or all brokers; while the recommended change may allocate risks among the interested parties more equitably, it may not be practicable for some subsets of health care providers to submit claims routinely within 90-days from the date of service, and legally, they have a longer period of time for claims submission; there does not appear to be any quantitative data indicating how large a problem retroactive terminations are for health care provider reimbursement, or whether the impact varies between types of health care providers; it was unclear how such data could be

derived; and, education of all interested parties is essential prior to making this change. The carrier members agreed they wanted to take the matter back to their respective companies to consider the issue further. Additionally, neither the physician representative nor all employer representatives were present and the Board hoped to receive their comments.

D. Vanderhoof made a motion, seconded by P. Gillespie, to table the issue until the next meeting of the Board. The motion carried.

IHC Navigant Project; Ad Hoc Committee formed

E. DeRosa reminded the Board that the IHC Board's consultant on out-of-network reimbursement methodologies, Navigant, had made a presentation to the IHC Board at its recent meeting (on March 13th). She explained that Navigant's power point presentation, included in the SEH Board's packet, is public information, but that the draft Navigant report is not. She gave a brief overview of the presentation, with input from SEH Board members who also sit on the IHC Board, noting that Navigant specifically compared and contrasted the PHCS profiles with the Fair Health profiles and Medicare's Resource-Based Relative Value Scale (RBRVS). She explained that, in general, Navigant found that the Fair Health profiles yield substantially similar results to the PHCS profiles, which is not surprising because the profiles are derived from the same charge-based data (although the Fair Health profiles average about 3% higher than the PHCS profiles). She further explained Navigant found that, on average, reimbursement at the 80th percentile of Fair Health (and PHCS) tends to result in reimbursements above 400% of RBRVS for hospital expenses and above 250% of RBRVS for professional fees, and is above the national trends for usual commercial payment levels.

The SEH Board discussed the Navigant power point presentation, noting the following: Navigant's project was to provide factual data, not necessarily to recommend one reimbursement methodology over another; there is some concern that carriers have been paying significantly above RBRVS and the national averages, but there is also concern that changes in the reimbursement requirements will result in significant increases in noncovered charges for consumers; the two boards do not have to come to the same conclusions on out-of-network reimbursement requirements, but it would be simpler for carriers (and other interested parties) if they chose the same standards and parameters; because there will be a need to have some discussions with stakeholders, there is some imperative to move along the discussion and decision-making process.

N. Vance and E. DeRosa explained that the IHC Board has asked its Technical Advisory Committee (TAC) to look at the Navigant report more closely, and develop some recommendations, noting a particular interest in the idea of using a percentile of the Fair Health profiles up to a maximum percentage of RBRVS as a cap. E. DeRosa noted that the IHC Board had agreed to schedule three additional Board meetings (for April, June and August). The SEH Board, which does not have a committee similar to TAC, agreed to form an ad hoc committee to discuss the matter, including jointly with TAC, if possible. The following members agreed to participate on the ad hoc committee:

- CIGNA
- Horizon
- Aetna
- G. Cupo
- Oxford
- DOBI
- M. Koller

The SEH Board decided against adding a meeting in April, but agreed that it would add meetings as necessary after a report of the new ad hoc committee at the Board's May meeting.

Nominations
E. DeRosa noted that nominations had been sent out for three positions on the Board: a small employer representing minority interests, a carrier in the small employer market and a carrier in the large employer market. She noted that the nomination forms had not specified that the small employer needed to represent the interests of minority small employers, and that a new form would be issued, but she also raised the question of how to determine that a nominee factually represents the interests of minority small employers. After some discussion, it was agreed that the criteria should be liberally construed to include someone who is both an employer and a minority, as well as someone who can show they represent minority business interests through other association.

V. Public Comments

There were no public comments.

VI. Close of Meeting

D. Vanderhoof made a motion, seconded by M. Koller, to adjourn the meeting. The motion carried.

[The meeting adjourned at 11:55 A.M.]