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 16, 2011

Members present: Thomas Collins; Gary Cupo; Darrel Farkus (United/Oxford); Joyce Gralha (Horizon); Margaret Koller; Thomas Pownall (Aetna); James Stenger; Neil Sullivan (DOBI); Tony Taliaferro (AmeriHealth); Dutch Vanderhoof *(arrived at 10:20 A.M.)*.

Others participating: Ellen DeRosa, Executive Director; Rosaria Lenox, Accountant; Chanell McDevitt, Deputy Executive Director; DAG Eleanor Heck (DLPS); Avnee Parekh (DOBI); Neil Vance (DOBI).

I. Call to Order

E. DeRosa called the meeting to order at 10:10 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. She determined a quorum was present.

II. Public Comments

There were no public comments.

III. Minutes – *January 19, 2011*

T. Taliaferro made a motion, seconded by J. Gralha, to approve the open session minutes for January 19, 2011, as amended. The motion carried.

IV. DOBI Report

Actuarial Presentation

A. Parekh presented the SEH Loss Ratio and Refund Report for 2009 to the Board. She noted a continuing decline in SEH enrollment, an increase in the average loss ratio for the standard plans to 87.8%, a slight decrease in the average loss ratio for non-standard plans to 87.3%, and that the purchasing alliances had received a small refund from Oxford. She also noted the inclusion of a new report about the two small employer MEWAs, which cover approximately 20,000 lives.

When asked if the decline in SEH standard plan enrollment was attributable to the MEWAs, A. Parekh stated she thought it unlikely, because the MEWAs had been around for several years, and their population had not grown proportionate to the market decline. When asked how Aetna could have been required to issue a dividend for some of its business when it posted over a 90% loss ratio, N. Vance responded that the dividend applied to Aetna's nonstandard business (3 small blocks of business), which is calculated separately from the SEH standard plan business and is written by Aetna Life Insurance Company, not Aetna Health Inc.

Rate Changes

N. Vance gave an overview of the rate changes that had been filed to date for 2011, and noted that they tend to range between 10-20%, which is lower than in 2010, when they ranged from 20-30%. He stated that for the first quarter of 2011, the range is mostly 10 to 15%, and that filings indicate a slight decline in the increases anticipated for the second quarter of the calendar year, so the increases are slowing. He stated that the data suggests carriers are pricing closer to trend than they were when the loss ratio requirement first rose to 80%.

N. Vance stated that the 2011 Premium Comparison Survey is in progress but not yet ready for release. He noted that, because several carriers had withdrawn some of their plan offerings for 2011, and thus, are using different plan offerings for 2011 premium survey illustrations, the comparison of rates from 2010 to 2011 will be less meaningful than in the past.

Rate Review Process

N. Vance discussed the current rate review process and the DOBI activity regarding a grant from the U.S. Department of Health and Human Services to review and possibly revise how rate review is handled. He stated that DOBI has had the responsibility to review rates for the SEH Program since the program's inception, and that, while the rates are essentially "file and use," the DOBI always reviews the filings against regulatory standards, and can disapprove the rate filings in the event they do not comply with the standards. He noted that the filings must be complete and be set to meet the statutorily-required minimum loss ratio, comply with the regulatory requirements for modified community rating, and the actuarial assumptions must be reasonable. He said that rate filings can be disapproved if the filing is incomplete, or not in compliance with the required elements (which include more than meeting the loss ratio requirement), and like other rate filings, can be disapproved if the rates are inadequate, or produce rates that are unfairly discriminatory. He provided as an example of unfairly discriminatory rates, the following: if two similarly situated individuals are covered under two plans that are the same except for the deductible, yet the person who purchases the plan with the $1000 deductible pays more in premium than the person who purchases the plan with the $500 deductible, that would be considered unfairly discriminatory based on the rating requirements of the SEH market. N. Vance also suggested that, although females would be expected to be rated higher than males at younger ages (when gender is permitted to be considered), it would generally be unreasonable to expect females to have a rate that is 2x the male rate at ages 50 and over. N. Vance clarified that "unfairly discriminatory" does not refer to the usual classes of discrimination in the legal sense, but rather, to actuarial discrimination in determining whether the rates reflect the expected costs for the class or a person within a class.

When questioned about driving forces behind the decrease in enrollment in the SEH Program, N. Vance stated he believed that program design features, rather than rating requirements, per se, are the primary drivers. He said he would defer to N. Sullivan on the issue, noting that some design changes had already occurred, and that he believes these design changes will prove successful in time.

N. Sullivan stated that part of the drop in enrollment is attributable to the change in the economy since 2008. He said, however, that he believed that allowing employers to "slice and dice" their

groups among plans had not been helpful, nor had the proliferation of plan variations in the market. He said that, while the correction of both of these situations had been painful, and may have resulted in some loss of enrollment initially, he thought the regulatory and market corrections to plan portfolios and selection options would result in decreased costs and would eventually result in improved enrollment. He noted that it is problematic that certain health care providers are encouraging out-of-network utilization of services, and that work is ongoing to try to stem that tide.

N. Vance observed that, in the last two years, the changes in the rating standards for the Individual Health Coverage (IHC) market has resulted in IHC products being more competitively priced for participants in younger-aged groups relative to plans in the SEH market. He suggested that the SEH market likely lost some good risks to the IHC, but that he believed any trend in this direction would already be slowing. When asked whether the individual Basic & Essential (B&E) plans compete with the SEH standard plans, he said the difference in the rate compression (B&E plans being rated in 3:1 rate bands, and SEH standard plans being rated within 2:1 rate bands) could be having a deleterious effect on the SEH Program, but he noted that the standard IHC Plans permit a 3.5:1 rate band now, albeit, not all carriers have chosen to move their community rating practice to the new standards. N. Vance stated he believes that the gender rating permitted in the B&E market is the primary factor competing with SEH (and IHC) standard plans rates, rather than the rating compression, per se.

V. Staff Report

Expense Report
R. Lenox reported that the March expenses totaled $1340.22, primarily for legal expenses from the Division of Law, Withum, Smith + Brown's (WSB) expenses associated with the FY10 audit, which is now complete, and her CPA license, the cost of which is shared with the IHC Board.

D. Vanderhoof made a motion, seconded by D. Farkus, to approve payment of the expenses on the expense report for March. The motion carried.

Transfer of Funds
R. Lenox requested that the SEH Board authorize the transfer of $1350 from the Board's administrative funds held in the Wells Fargo Money Market Account to the Board's checking account at Wells Fargo for the payment of the approved operating expenses.

D. Vanderhoof made a motion, seconded by D. Farkus, to approve transfer of $1350 from the SEH Board's Wells Fargo money market account to the Board's Wells Fargo checking account for the purpose of paying operating expenses. The motion carried.

Optional Benefits Riders

D. Farkus recused himself from discussion and any subsequent action that the Board might take with respect to optional benefit riders submitted by Oxford Health Plans or Oxford Health Insurance because of the interest of his employer in the outcome of Board action on the matter.

E. DeRosa explained that Oxford Health Plans submitted three optional riders addressing some cost-sharing features of the HMO-based plan. She explained that: 1) one rider would amend the HMO and HMO-POS products to remove cost-sharing for preventive services; 2) one rider would amend the HMO-POS plan to permit for a plan year accumulation of the deductible; and, 3) one rider would amend Oxford's HMO plans to permit a deductible as low as $200, and to exclude prescription drug charges from accumulating towards the maximum out-of-pocket for the plan. E. DeRosa explained Oxford Health Insurance was submitting a rider that would amend Oxford's PPO and POS Plans B, C, D and E in the same manner as the third rider submitted to amend the Oxford HMO Plans. She stated that staff recommended finding the rider filings complete.

D. Vanderhoof made a motion, seconded by T. Taliaferro, to find the Oxford Health Plan and Oxford Health Insurance rider filings complete. The motion carried.

Elections
E. DeRosa stated that staff had sent out nomination forms on or about March 11, 2011 for the SEH Board elections for this year, which is to be held during the scheduled May 18, 2011 meeting. She explained that the seats ultimately to be voted upon include the following:

- Two persons representing small businesses (positions currently held by Christine Stearns and James Stenger)
- A health, hospital or medical service corporation (a position currently held by Horizon Blue Cross and Blue Shield)
- Two health maintenance organizations (positions currently held by Aetna Health Inc. and CIGNA Healthcare)

E. DeRosa stated that it was acceptable for a company to nominate and later vote for itself, but she reminded Board members that only SEH member-carriers can nominate candidates and vote, so it is incumbent upon representatives like those representing small businesses, to seek from an SEH member-carrier both a nomination and votes. She stated she expected to send out the ballots in mid-April. Responding to questions, E. DeRosa explained that there are several Board seats that are appointed by the Governor with the consent of the Senate, and therefore, are beyond the Board's control. She noted that, despite term limits, appointees may continue to participate on the Board until a replacement is appointed or they resign, and that vacancies in appointed seats continue until a new appointment is made.

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

Financial Statements
R. Lenox reported that the FAC met to review and discuss the second quarter financial statements for FY 2011, which included a Statement of Net Assets, a Statement of Changes in Net Assets, a Statement of Cash Flows, and a Comparison of Budget and Actual Expenditures. She noted that program expenses are running under budget by about $6385.

Reconciliation of Assessments for Fiscal Year 2010 (FY10)

R. Lenox reported that the FAC again discussed the reconciliation of the administrative assessments following the close of the FY10 audits, and submission of WSB's final bill for the audit. She explained that the budgeted administrative assessment had been made based upon CY2008 premium, while the reconciliation is made based upon CY2009 premium and actual administrative expenses. She noted that, while the audit fee had been a little higher than budgeted, other expenses were slightly lower, and a small amount of interest needed to be distributed. She stated that, based upon the adjustments made, the Board would be collecting about $5900 from some carriers (primarily Horizon), and refunding approximately $16,000 to others, for a net refund of about $10,100. She stated that the FAC had recommended approval of the final reconciliation and issuance of invoices and refunds.

R. Lenox stated that, in order to send the refunds, she was asking the Board to approve the transfer of $16,010.24 from the Board's money market account to its checking account. She also requested that the Board authorize a transfer of $64,000 from the money market account to the DOBI for payment of staff salaries and fringe benefits.

T. Taliaferro made a motion, seconded by D. Vanderhoof, to transfer a total of $80,010.24 from the SEH Board's Wells Fargo Money Market Account to the Board's Wells Fargo checking account for the purpose of paying $16,010.24 in refunds to carriers in accordance with the assessment reconciliation spreadsheet as recommended by the FAC, and payment of $64,000 to DOBI for salaries and fringe benefits related to SEH Program staff. The motion carried.

Budget for FY2012

R. Lenox reported on the draft budget for the fiscal year ending June 30, 2012, which the FAC discussed and recommended approving. She noted that, although salary and fringe benefits were assumed to increase slightly, other expenses were expected to be slightly lower based on current expenditures, so the draft budget is only about $1200 higher for FY2012 than it is for FY2011. She noted that the FAC recommended approval of the proposed budget.

T. Taliaferro made a motion, seconded by J. Gralha, to approve the proposed budget of $259,400 for the fiscal year ending June 30, 2012 as recommended by the FAC. The motion carried.

R. Lenox stated that, in order to fund the FY2012 budget, the SEH Board would need to approve assessments soon, and thus, the FAC reviewed and recommended approval of administrative assessments for the fiscal year ending June 30, 2012. She explained that, if the Board approved the FY2012 assessment, the invoices for it would go out about the same time as the FY2010 reconciliations, but that carriers would not be permitted to net the transaction. R. Lenox reminded Board members that the FY2012 administrative assessment is based on CY2010 premium, and will be reconciled based on CY2011 premium.

D. Vanderhoof made a motion, seconded by T. Collins, to authorize the assessment of carriers for the total amount budgeted of $259,400 for the fiscal year ending June 30, 2012 in accordance with the recommendations of the FAC. The motion carried.

VII. The federal Patient Protection and Affordable Care Act/Health Care and Education Reconciliation Act (ACA) and Health Insurance Exchanges Activity

N. Sullivan explained that the DOBI has a contract with the Rutgers Center for State Health Policy (RCSHP) to conduct multiple forums with various stakeholders, as required by the ACA as part of the process for evaluating whether to establish one or more health insurance exchanges in New Jersey. He gave an update on RCSHP's progress, stating that RCSHP had completed the forums with health care providers and would complete the forums with consumers by tomorrow, but still had forums with carriers, brokers and employers to perform throughout March and part of April.

E. DeRosa introduced Larry Altman, Horizon's Vice President of Health Reform, who offered to provide an overview to the SEH Board of the requirements of the ACA generally as they related to health insurance, and specifically with respect to health insurance exchanges. Mr. Altman briefly described the law (a combination of the Patient Protection and Affordable Care Act, enacted March 23, 2010 and the Health Care and Education Reconciliation Act, enacted March 30, 2010, informally referred to collectively as the Affordable Care Act or ACA), and touched upon those areas of the law significant to health insurers that had already been, or likely soon would be effective, including:

- the Early Retiree Reinsurance Program.
- creation of the federal health insurance web portal.
- the requirement that dependents continue to be covered (at the option of the dependent and parent) through a parent's plan until age 26 without demonstration of dependency status.
- the ban on application of preexisting condition limitation periods to individuals up to age 19.
- Removal of annual limits and phase-out of lifetime limits (but subject to possible waivers).
- prescription of standards and definitions for calculating medical loss ratios, in which the federal threshold for "unreasonable" rate increases that result in some level of increased scrutiny includes those rate increases exceeding about 10% year over year. He noted he believes the federal government will rely substantially on existing state rate review systems, and pointed out that New Jersey's system has been and continues to be rather robust, so the effect on New Jersey may be relatively light.
- Preexisting Condition Insurance Programs (in New Jersey, it is referred to as NJProtect, in which both Horizon and AmeriHealth are participating carriers).

Mr. Altman spoke briefly about the individual mandate – the requirement that everyone have some form of comprehensive health insurance beginning in 2014 or be subject to financial penalty (in most instances) – which is currently being challenged on constitutional bases through the courts, and noted that there should be some discussion about how to address adverse selection issues in the event the individual mandate provision is stricken, but other ACA insurance reforms remained in place.

Mr. Altman went on to discuss the topic of health insurance exchanges (HIX), noting that the ACA requires access to an HIX be available in each state for small employers and individuals, whether the HIX is state-specific, regional or through an as yet nonexistent federal program, and that the law speaks about the HIX for small employers and individuals separately, but permits them to be combined in whole or in part. He stated that States have quite a bit of flexibility in designing an HIX with respect to many of its functions, its infrastructure, and its governance. He explained that consumers of certain income levels (from 133% to 400% of the federal poverty level) will be eligible for subsidies on a sliding scale to purchase coverage available through the HIX, that at least four levels of coverage (as yet, largely undefined) must be available: bronze, silver, gold and platinum; plus, a catastrophic plan must be available for the young invincibles.

In response to questions from SEH Directors, Mr. Altman stated the following:

- Some of the differences between the existing SEH market and the HIX is that the HIX would have a purchase web portal with calculators, and information about (and backroom access to) the Medicaid program and probably other public assistance programs, a call center, and navigators, among other things.
- Whether there is room for brokers is an open question, and brokers will have to find their niche in light of the undefined role of "navigators" which a broker and carrier cannot be, at least not acting in the traditional broker and carrier function. N. Sullivan pointed out that brokers will have an opportunity to help define the business model.
- Legislation will be necessary to institute an HIX in New Jersey.
- Construction of an HIX is likely to be quite complicated – requiring significant IT infrastructure modifications both on the part of the State and carriers.
- Two potential live HIX models are the exchanges created in Massachusetts and Utah. California recently passed legislation authorizing establishment of an HIX. Utah's existing exchange is a passive information distribution channel that allows for interested parties to research and shop for small group options. California's HIX is supposed to be an active market regulator and will determine via bid which carriers and products will be offered through the HIX, and it is assumed this will be a successful model for California simply because of the number of potential enrollees the HIX will be able to deliver. Massachusett's existing exchange has established standards for participation, but doesn't really negotiate pricing as a function of carrier participation.
- Massachusetts always had a low uninsured rate, and brought it down to 3% with its existing exchange. However, the exchange's budget was much higher than expected as were the costs for coverage. Some changes were implemented, and carriers were permitted to exclude some major health care delivery systems in order to keep costs down, and further tweaking may be necessary.
- There may be some ways to drive costs down: product design, and whether products are the same or similar inside and outside the HIX; plenty of product choice blended with significant transparency; carrier ability to develop different types of networks; changes in compensation methodologies. Use of Accountable Care Organizations (ACOs) and medical homes may help to contain some costs, but the HIX is unlikely to solve most of the delivery system cost problems.
- ACOs have the potential to provide better care coordination, and help stabilize or even possibly reduce costs, particularly if risks can be shared with and among the health care

providers. However, if an ACO fails to have adequate competition with other ACOs or non-ACO health care providers, there is a strong potential for an ACO to drive up costs because of its enhanced negotiating position.

- Some ACOs, like Kaiser and Geisinger, have been able to keep costs down while also providing good quality of care.

Board members discussed additional issues, including whether it made sense for an HIX to be engaged in the billing and collection of premiums process, which is something carriers do well. It was noted that the State has flexibility on how the HIX is designed in this regard, but that there may be scenarios in which having at least some billing and collections through the HIX may be preferable when dealing with subsidies, and from an employer's standpoint if the employer decides to offer a defined contribution plan and allows employees significant choice of plan options in the HIX. There was also discussion about whether there would continue to be a market for individual and small group outside of the HIX, and agreement that some market may need to continue, because there are some people who will not be allowed to purchase through the HIX (such as undocumented residents), and to provide additional plan choices. There was discussion about adverse selection issues, mandates to purchase insurance, subsidy eligibility, penalties that apply to individuals who fail to purchase coverage, and penalties that apply to employers who offer "unaffordable" coverage that pushes some employees into the subsidized HIX market.

VIII. Self-funded schemes

D. Vanderhoof noted that CIGNA, Trustmark and Assurance have been meeting with brokers to discuss their "level-funded" products that they are offering in the small employer market. He noted the companies say they will "loan" small employers the money necessary for the small employer to pay obligations under the small employer's "self-funded" attachment points. He said the plans are not guaranteed issue or guaranteed renewable, and that the companies had openly stated they intend to compete with the four biggest carriers in New Jersey through these plan offers. D. Vanderhoof also stated there was an admission that the companies are acting like banks. He suggested that New Jersey should consider regulating the companies as banks if they are going to issue loan products. N. Sullivan stated that the suggestion was duly noted.

IX. Public Comments

There were no public comments.

X. Close of Meeting

T. Taliaferro made a motion, seconded by M. Koller, to adjourn the meeting. The motion carried.

[The meeting adjourned at 12:05 P.M.]