September 9 October 8 October 14 November 12 December 4
December 11

**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
September 9, 1997**

Directors Participating: J. Beck (Aetna USHealthCare) *(arrived at 10:20 a.m.);* S. Kelly (Blue Cross and Blue Shield of New Jersey); J. Majcher (Department of Banking and Insurance); R. Rondum; E. Shrem; R. Smart (Mutual of Omaha); L. Specht (Prudential); L. Yourman

Others Participating: E. DeRosa, IHC Program Assistant Director; DAG E. Heck (DOL); W. Sanders, Interim Executive Director

I. Call to Order

J. Majcher called the Board meeting to order at 9:35 a.m. W. Sanders announced that notice of the meeting had been published in three New Jersey newspapers and posted at the Department of Banking and Insurance and the Office of the Secretary of State in accordance with the Open Public Meetings Act. A quorum was present.

II. Public Hearing

W. Sanders announced that the public hearing regarding the proposed changes to the policy forms text which creates an optional high deductible plan which could be used in conjunction with a medical savings account was scheduled to be held at the beginning of the Board meeting. He asked if any persons who wished to offer oral comments were present. No persons indicated an interest in offering oral comments. W. Sanders said the Board could proceed with other business and that the opportunity to offer oral comments would remain available for approximately the next hour, to accommodate any persons who may arrive after the scheduled opening of the hearing.

III. October Board Meeting

W. Sanders noted that the Board packets contained a copy of the Public Notice concerning the rescheduling of the October Board meeting. The meeting will be held on Tuesday, October 14, 1997. The previously scheduled October 7, 1997 meeting has been canceled.

IV. Minutes

S. Kelly offered a motion to approve the minutes of the Open Session of the August 12, 1997 Board meeting, as amended. L. Specht seconded the motion and the Board voted unanimously in favor of approving the minutes.

V. Report of the Interim Executive Director

Expense Report
S. Kelly offer a motion to approve the payment of the expenses shown on the September 9, 1997 expense report. L. Specht seconded the motion and the Board voted unanimously in favor of approving the payment of the expenses shown on the expense report.

Rulemaking
W. Sanders reported that the comment period for the proposal to amend the text of the optional text of the standard plans to allow high deductible option plans which could be used in conjunction with a medical savings account would expire at 5:00 on September 9, 1997. He advised the Board that no substantive written comments had been received. S. Kelly indicated that BCBSNJ had some minor comments and would discuss them with E. DeRosa after the Board meeting.

S. Kelly offered a motion to adopt the high deductible plan proposal, provided no substantive comments were received. E. Shrem seconded the motion and the Board voted unanimously in favor of the motion.

W. Sanders reported that the proposal to allow the optional well child coverage had not yet been drafted.

W. Sanders reported that the Board received comments to the proposed modifications to Exhibit K, the Carrier Market Share and Net Paid Loss Report and Exhibit Q, the Certification of Compliance. Staff developed draft responses and circulated the comments and draft responses to the Technical Advisory Committee and the Policy Forms Committee.

W. Sanders reminded the Board that Governor's Counsel requires that all significant rules go through the office of the Governor's Counsel. Thus, while the Board had voted to adopt the Withdrawal Regulation during the August Board meeting, the filing of the adoption with the Office of Administrative Law was delayed, as requested by Governor's Counsel. He reported that the vacation schedule of some persons in the Office of Governor's Counsel had delayed the required review of the text to be adopted. He indicated he did not expect there would be a problem with filing the adoption once these persons returned from vacation. He said the text was ready to be filed as soon as the approval is given.

S. Kelly suggested that the Withdrawal Regulation should be revised before it is adopted to include a requirement that carriers notify consumers of the special open enrollment period which will exist when a plan is non-renewed as a result of the action of the Board to eliminate a plan or a plan option. The Board did not agree to make this change to the regulation.

L. Yourman asked that a press release be prepared to notify the public of the special open enrollment opportunity. She suggested that while the elimination of Plan A and some plan options may be perceived as bad news, the report would be balanced with the good news of the open enrollment opportunities. The suggestions would be considered by the Marketing Committee.

W. Sanders noted that the rule-making process requires that interested parties and carriers receive either a notice or a copy of all proposals and adoptions. The forms proposal to be considered later during the meeting would necessitate a mailing to approximately 1000 persons/firms. He reminded the Board that all mailings are done by staff.

WEB Site
W. Sanders directed the Board to the memorandum included in Board packets which discusses the WEB page. He said the information located on the WEB is information previously published by the Board. He noted that the IHC Board is not charged for placing the information on the Department's WEB site. He commented that staff has received compliments from consumers concerning this information. W. Sanders said the L. Yourman had contacted him to advise him of some minor errors. He noted that the premium data had been input by other persons, but that staff was investigating ways to release the premium data to the person who places the data on the site to eliminate the necessity to re-input. He asked that any Board member who has suggestions concerning the information available on the site to provide the comments to him. He would relay them to E. Shrem for consideration by the Marketing Committee.

Legislative Activity
W. Sanders said that he had reported during the August Board meeting that the Health Care Quality Act, P.L. 1997, c. 192 would require carriers offering managed care plans to offer point of service plans. Upon further review of an awkwardly constructed section of the law, it appears that the requirement applies only to group plans and would not require managed care carriers to offer point of service plans in the IHC market.

He reported that he was working on a Bulletin to summarize the changes of P.L. 1997, c. 146 as well as the Health Care Quality Act, and that the draft would be circulated to the Legal Committee for comments.

Activity in Other States
W. Sanders said that he has provided factual information concerning the New Jersey IHC Act to persons in Kentucky and Massachusetts. Both states have been working on individual health reform. He emphasized that staff has been careful to not provide

recommendations. The Board had some discussion concerning the perceptions of various entities concerning the New Jersey individual reform.

Rate Increases
W. Sanders said that a recent rate increase implemented by Trustmark generated a very high volume of calls to staff as well as written inquiries. The Department of Banking and Insurance has been assisting with the handling of the calls and letters.

Outreach
W. Sanders said he would speak to the South Jersey Underwriters on September 23, 1997. He reported that E. DeRosa would speak to the Central Jersey Life Underwriters Association on September 10, 1997.

Interest Calculation and Assessment
W. Sanders reported that P. Lechner has been working on the calculation of interest due to BCBSNJ, National Casualty and Time.

W. Sanders said that work on the IHC Program assessment for 1996 would begin soon.

2nd Quarter 1997 Enrollment Data
Enrollment reports from each carrier have been received and forwarded to A. Reese. W. Sanders said he hoped to have the 2nd quarter data for the October Board meeting.

VI. Report of the Assistant Director

Advisory Bulletin 97-IHC-05
E. DeRosa said that she had included a copy of this draft bulletin in the Board packets. She said she incorporated comments offered by Board members. She noted that the Bulletin would be released coincident with the filing of the Withdrawal Regulation adoption.

S. Kelly asked if the type of special enrollment period being extended to persons whose coverage is non-renewed due to the Board's action to eliminate Plan A and the low deductible options should be extended to persons whose coverage is non-renewed due to a carrier acting to withdraw a plan option. W. Sanders suggested that if the Board wished to take such action it should be put in a regulation and that the draft bulletin was intended to only address the enrollment period to be made available due to the Board's elimination of a plan or plan option.

[J. Beck arrived at 10:20 a.m.]

R. Rondum agreed that customers should have the opportunity to purchase richer coverage when a plan they have is non-renewed. W. Sanders suggested that such opportunity should be included in a regulation.

S. Kelly asked that the enrollment period be expressed as 2 months rather than 60 days. E. DeRosa suggested that the use of days would be more equitable since months have different durations and the month prior and following the date of non-renewal would not necessarily coincide with a calendar month. The Board agreed that 60 days was appropriate.

S. Kelly expressed concern that the Bulletin indicated that the effective date of coverage applied for within the 30 days following non-renewal would be effective on the date of application. She said she thought it should take effect as of the date of non-renewal. E. DeRosa said she consciously specified the date of application in order to avoid adverse selection, and she did not think it was appropriate to require carriers to backdate coverage. S. Kelly said BCBSNJ believed the risk of adverse selection was slight and that using a date of application would mean the person would have a lapse in coverage. After some discussion, the Board decided the Bulletin could permit carriers to elect to make coverage earlier than the date of application.

Policy Forms Proposal
E. DeRosa explained the process by which the policy form proposal text was prepared. She said she had drafted changes to Plans D, HMO and the application and circulated the drafts to the Policy Forms Committee. As result of vacations and other deterrents to scheduling a meeting, the Committee was unable to meet to discuss the drafts. E. DeRosa received written comments from Committee members and incorporated all comments she believed appropriate. She summarized all comments she did not incorporate and explained her basis for not incorporating them in a memo to the Policy Forms Committee. She said that some of the comments made by Committee members seemed to warrant discussion by the Board.

<u>Residency</u>: E. DeRosa explained that the draft forms contained a definition of Resident, based on the definition set forth in P.L. 1997, c. 146. The eligibility text of the forms bases eligibility on this residency definition. However, she said the drafts applied the residency requirement only to the primary covered person. That is, the spouse and child dependent need not be a resident. She said this was consistent with a prior Board decision as was reflected in the existing non-HMO policy forms. One member suggested that the HMO form should continue to require that the spouse be a resident, consistent with the current HMO form. S. Kelly said the Board, in an 11/6/95 rule proposal had indicated that spouses to be covered under an HMO plan must be residents because HMO carriers are not able to issue coverage to persons outside their approved service area. The Board was not in favor of requiring that spouses be residents. The Board directed the Staff to check with the Department concerning the requirement S. Kelly mentioned. If required, the HMO form should state that a spouse must be a resident. *[Note: Following the meeting, staff discussed the issue with the Department. The Department advised that spouses need not be residents to be eligible for coverage as a dependent under the IHC HMO plan.]*

<u>Notice of Termination Upon Relocation Outside NJ</u>: E. DeRosa said she has received a number of calls concerning the date coverage ends if a person moves outside NJ. The

current forms indicated that coverage would end subject to 30 days notice from the carrier. However, the forms did not indicate the timing for the carrier learning of the relocation. In many instances, it appeared a covered person relocated and failed to advise the carrier for some time. Once the carrier learned of the relocation, the required 30 days notice had been given. Since this seemed to be a problem area for agents and carriers, she said she drafted the forms to state that coverage would end 30 days after the person moved from NJ. One Committee member suggested that coverage should end immediately. The Board did not agree with the immediate termination and was likewise reluctant to terminate coverage 30 days after relocation. The Board asked that the current approach be reintroduced into the draft forms. Thus, coverage will end subject to 30 days notice from the carrier. That notice will be given whenever the carrier learns of the relocation outside NJ.

PPO/POS: E. DeRosa said that while the Policy Forms Committee had not had the opportunity to present the Board with an analysis of PPO and POS issues, she recommended that the Board respond to very specific plan design requests from three carriers. Three carriers that participate in the SEH market had asked to be able to write PPO and POS plans in the IHC market that are consistent with the options available in the SEH market. E. DeRosa said that the proposal text includes alternate insert pages for PPO and POS plans, patterned after the SEH plan design for PPO and POS plans. R. Rondum said that since the population between IHC and SEH is transient, it made sense to her to allow a consistent plan design. S. Kelly suggested that the plan design should be more flexible and asked that the Board remain open to other designs if carriers request other plan designs. The Board agreed to remain open to considering other designs, while agreeing to propose a design based on the SEH plan design at this time.

Coordination of Benefits (COB) : E. DeRosa reminded the Board that HIPAA required that the IHC plans be renewable even after a covered person becomes eligible for coverage under Medicare. In order that a person may not receive duplicative benefits, she said she included a COB provision in the IHC plans. One Committee member was very concerned with the inclusion of a COB in the HMO plan, stating that the provision did not really work. E. DeRosa said she recognized that the group COB regulation was intended for use with indemnity plans and that it did not work very well for HMO plans. However, until a better regulation is adopted, she had no alternative. She said the Department of Banking and Insurance has been working on amending the COB regulation to address coordination with HMO plans as well as other types of managed care plans. She said that once that regulation is adopted, the IHC HMO plan could be amended. She noted that the SEH HMO plan would likewise require amendment. The Board agreed that a COB provision should be included in the HMO plan, as drafted.

Coverage Under a Group Plan: S. Kelly said she believed P.L. 1997, c. 146 may have eliminated the ability of a person to waive coverage under a group plan and elect an IHC plan during the open enrollment period. The Legal Committee should look into the issue.

High Deductible Plan Text: S. Kelly was concerned that the proposed text for the high deductible options was underlined in the form draft, as if it was new text, when in fact

most had already been adopted. E. DeRosa explained the limitations of the revisions feature in the WORD software she uses. The proposal can state that the text is not new.

PUBLIC HEARING (CONTINUED)
W. Sanders asked if any person had arrived who would like to offer comments on the high deductible plan proposal. No person came forward to offer oral comments. W. Sanders closed the public hearing at 11:25 a.m.

Application Text: E. DeRosa said that the application indicates that coverage will be canceled back to the effective date if a carrier finds that a person committed fraud. She said one Committee member said coverage should be terminated as of an immediate date, but not retroactively canceled. S. Kelly said a Department Bulletin had advised that coverage could not be terminated as of the effective date unless the carrier sued. E. DeRosa said this would deviate from industry practice, but that she would revise the form if required by a Department Bulletin. *[Note: Following the meeting, staff checked with the Department. In the event of fraud, a carrier may rescind coverage back to the effective date. The only situation in which a carrier would be required to use a current cancellation date would be a situation in which the carrier refused to refund premium paid. Since a rescission restores the customer and carrier to the place they would have been as of the effective date, industry practice is to return all premiums paid, and the customer is required to pay back all benefits provided by the carrier. The forms being proposed state that rescission will be as of the effective date, as permitted by the Department.]*

Other: E. Heck said she had a forms issue she wanted to raise during Executive Session.

M. Tagliaferro Correspondence
W. Sanders asked the Board to look at the draft correspondence in the Board packets and provide any comments to E. DeRosa as soon as possible. He said both he and E. DeRosa had written numerous letters to this consumer and that staff would appreciate any comments from the Board with respect to this letter. R. Rondum noted that M. Tagliaferro had written to her as well, but that she had not responded.

Nutritional Therapy
L. Yourman said she recently received some material concerning nutritional therapy and she would forward it to the Policy Forms Committee.

[Break: 11:30 a.m.- 11:40 a.m.]

VII. Report of the Technical Advisory Committee

Rate Filings
S. Kelly said the TAC recommended that the Board find the rate filings identified on the report of the TAC (copy attached) as complete to be complete. In addition, Trustmark supplied information to enable the Trustmark filing to be found complete, so it should be moved from the Incomplete list to the Complete list.

S. Kelly said the TAC recommended that the Board find filings by Mega Life, Midwest National, Oxford and PFL, as identified on the attached TAC report, incomplete.

S. Kelly said the TAC reviewed an Exhibit J for 1995 from Principal and the report was now acceptable, leaving only one outstanding 1995 Exhibit J. She said that carrier, Mega Life, appeared to be in a refund situation.

S. Kelly said TAC reviewed the one bid for an auditor that was submitted in response to the request send out by the Board. She said the reserves of six carriers would be audited relative to the 1995 Exhibit J reports.

R. Smart offered a motion to accept the recommendations of TAC as set forth on the attached TAC Report, with the Trustmark filing being considered as part of the complete list. L. Yourman seconded the motion, and the Board voted unanimously in favor of the motion, with J. Beck abstaining with respect to the Aetna filing.

Discussion of P.L. 1997, c.146
S. Kelly explained that TAC considered the issues the Board had referred to it and that the TAC Report provided a brief summary of the conclusions.

Reimbursement based on 75% v. 115% loss ratio: As the report indicates, there was not a strong consensus among TAC members regarding the change made in the law which only allows carriers to seek reimbursement to the extent the carriers have exceeded a 115% loss ratio. One TAC member was concerned that the law had removed expenses from the loss ratio calculation. S. Kelly reported that she had put together a memo which illustrated losses for prior years, based on the use of several different levels. The amount to be reimbursed would have been less if the 115% loss ratio had been used.

J. Beck expressed concern that TAC had even considered this issue. He said the legislature had already acted and the law uses 115%. W. Sanders indicated that TAC had reviewed the issue at the request of the IHC Board. W. Sanders also explained that if the Board were to want to make some recommendations to the Commissioner regarding possible changes to the law, it was important that the appropriate committees consider various aspects of the law, particularly those about which some carriers participating in the market have been rather vocal.

R. Smart asked if anyone from Time had met with the Commissioner to discuss the changes made in P.L. 1997, c. 146. J. Majcher said that Time had not requested a meeting, but that someone from Celtic had requested a meeting.

Paid v. incurred claims: E. DeRosa reported that the majority of the members of TAC favored the use of incurred claims as opposed to paid claims. The Department was the dissenting voice on TAC. R. Vehec explained that the use of incurred claims would create difficulty in terms of reconciliation of reserves. He noted that while there are methodologies for reserve calculation, the numbers were not exact. He said that a carrier

could seek reimbursement for a 2-year period, then seek an exemption in a succeeding 2-year period, and thus there would be no reconciliation of reserves. He said that in a stable environment, incurred claims and paid claims should be the same. However, if business is increasing, the incurred amount will be greater than the paid amount. If business is declining, the paid loss amount will be a larger number than the incurred loss amount. R. Vehec suggested that the need to audit carriers would be even greater if losses were based on incurred claims. He also noted that reporting to the Board would likely be delayed by at least 6 months if the Board were required to use incurred claims data.

L. Yourman noted that a change to an incurred claims basis would be changing the rules. Since inception of the Program, loss reimbursement had been based on paid claims. She suggested it may not be fair to change the rules.

L. Specht suggested the Board may want to look at chapters 145 and 146 in New York. She also said if the IHC Act were to require the use of an incurred claims number that the 115% should be reduced, perhaps to a number in the 90 to 100% range.

R. Smart wondered if the use of paid claims in the law may have been an oversight since earlier drafts seemed to have used an incurred claims basis.

The Board asked that TAC re-visit the issue of paid v. incurred claims. TAC should look at the incurred claim percentage level, establish a definition for incurred claims and consider the concerns R. Vehec expressed with the use of incurred claims. Six Board members agreed to this assignment to TAC.

<u>2-Year Calculation Period</u>: S. Kelly explained that TAC believed the approach used for the original one -year basis would apply to a 2-year calculation period as well. If a carrier enters the market after the date for seeking an exemption under the 1-year basis, that carrier may not seek to be exempt until the next near. In a similar manner, if a carrier enters the market after the date established for seeking exemptions under the 2-year method, that carrier may not seek an exemption until the following 2-year period. Non-exempt carriers that enter the market after the beginning of the 2-year period would be able to seek reimbursement for losses for less than a 2-year period.

<u>Second Tier Assessment</u>: S. Kelly said that TAC would forward an issue to the Legal Committee concerning whether P.L. 1997, c. 146 altered the mechanism for a redistribution of losses among non-exempt carriers following the granting of full or partial exemptions to those carriers entitled to full or partial exemptions.

Vice Chair
S. Kelly said that B. Sobus (Aetna USHealthCare) agreed to serve as vice chair of TAC.

S. Kelly offered a motion to name B. Sobus as vice chair of TAC. L. Yourman seconded the motion, and the Board voted unanimously in favor of naming B. Sobus as vice chair of TAC, with J. Beck abstaining.

VIII. Report of the Marketing Committee

E. Shrem asked the Board members to take note of the report from Cox Communication Partners which was included in the Board packets. She also commented on the news releases included in the Board packets.

E. Shrem asked if the Board would be permitted to release a press release regarding the October Open Enrollment. She recalled that L. Moskowitz had opposed such a press release last year. She said she would like to get a release out for the 1997 October Open Enrollment Period. She said the Committee would discuss the suggestion made earlier in the meeting to release a press release describing the elimination of Plan A and the low deductible options.

E. Shrem suggested that the Board could include press releases on the WEB.

E. Shrem said it was essential that the Task Order be finalized so that work could be done on the Buyer's Guide insert, to discuss the changes that were effective September 1, 1997. She expressed concern that work on this time sensitive insert had been delayed until a task order was provided and approved by the Board. She asked that the Board approve the task Order, in advance. Several Board members commented that there was not need to delay critical work if the cost were not too great. T. Cox said the job would not exceed $1000, and would probably be around $750.

E. Shrem offered a motion that the Board authorize the task order for Cox Communication Partners and Backes Graphic Productions to work on the insert to the Buyer's Guide. R. Smart seconded the motion and the Board voted unanimously in favor of the motion.

R. Rondum complimented the activities report prepared by Cox.

IX. Report of the Operations Committee

J. Majcher said the Committee met to discuss Performance Report Certifications. The Certification must be provided by all carriers that seek reimbursement of losses. She said that the Committee asked Deloitte & Touche for an opinion regarding the usefulness of the Certifications as well as any suggestions to perhaps modify the requirement. J. Majcher said DAG E. Heck was asked to research how the Board could enforce a requirement that a carrier provide a performance report certification.

J. Majcher said no member on the Committee agreed to serve as vice chair.

X. Executive Session

S. Kelly offered a motion to end Open Session and begin Executive Session. L. Yourman seconded the motion and the Board voted unanimously in favor of the motion.

[1:10 p.m. - 2:18 p.m.]

XI. Final Business and Close of Meeting

W. Sanders explained that one of the topics discussed during executive session were the policy forms changes.

E. Shrem offered a motion to propose the draft changes to the IHC policy forms. L. Yourman seconded the motion and the Board voted unanimously in favor of the motion.

E. Shrem offered a motion to close the meeting. L. Yourman seconded the motion and the Board voted unanimously in favor of closing the Board meeting.
[The meeting adjourned at 2:20 p.m.]

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 October 8, 1997

Directors Participating VIA Teleconference: D. Cieslik (Blue Cross and Blue Shield of New Jersey); R. Rondum; E. Shrem; R. Smart (Mutual of Omaha); L. Specht (Prudential); L. Yourman

Director Participating in Person: J. Majcher (Department of Banking and Insurance)

Others Participating: E. DeRosa, IHC Program Assistant Director; DAG E. Heck (DOL) *(via teleconference);* W. Sanders, Interim Executive Director

I. Call to Order

J. Majcher called the Board meeting to order at 11:00 a.m. E. DeRosa announced that notice of the special meeting had been published in three New Jersey newspapers and posted at the Department of Banking and Insurance and the Office of the Secretary of State in accordance with the Open Public Meetings Act. E. DeRosa took roll call. A quorum was present, when considering both teleconference participation and in person participation.

Some members of the Board participated by telephone conference. A speaker phone was used so that members of the public could hear the board members participating via teleconference. W. Sanders asked that Board members announce their names before speaking.

W. Sanders explained that the purpose of this special meeting was to allow the Board to consider a request for a hearing made by CIGNA HealthCare.

II. Executive Session

D. Cieslik offered a motion that the Board enter into Executive Session for the purpose of receiving legal advice. E. Shrem seconded the motion. The Board voted unanimously in favor of entering Executive Session.

[Executive Session: 11:05 a.m. - 12:20 p.m.]

III. Final Business and Close of Meeting

R. Rondum commented on the characterization of Public Members in part three of the letter brief of CIGNA. She said she took personal offense to such characterization. R. Rondum noted that the Public Members serving as Directors of the IHC Board have diverse interests and backgrounds and vote as consumers, and agents. She said the Public Members have served on the Marketing Committee and are capable of judging the success of a corporate marketing strategy from the information provided by the corporation. R. Rondum continued by stating that the consumers are not the strategic planners nor the delivery vehicles of the product. She said they are, however, the final, undisputed judges of the promotion success of the marketing plan.

E. Shrem agreed with the comments made by R. Rondum and added that the Public Members who serve as Board Members are not compensated for such service.

W. Sanders reported that the Board received legal advice concerning the CIGNA request for a hearing. He said that the case does not meet the Administrative Procedures Act definition of a “contested case” since a hearing on such a matter is not required by constitution nor by statute.

W. Sanders explained that the Board noted there were several outstanding issues concerning the information CIGNA presented, and that the Board would request that CIGNA furnish additional information. W. Sanders noted that while the Board did not believe it was required to seek and review such additional information within a fixed period of time defined by law, that the Board would ask that CIGNA waive any time periods that may exist, given the fact that the Board only meets for regular meetings on a monthly basis.

D. Cieslik offered a motion that the Board advise CIGNA that the case was not a contested case, and ask CIGNA to provide some additional information, and waive any time frames that may apply to the Board in terms of responding. L. Yourman seconded the motion. The Board voted unanimously in favor of the motion.

R. Rondum offered a motion to close the Board meeting. J. Majcher seconded the motion. The Board voted unanimously in favor of closing the Board meeting.
[The meeting adjourned at 12:30 p.m.]

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 October 14, 1997

Directors Participating: J. Beck (Aetna USHealthCare) *(arrived at 9:40 a.m.);* S. Kelly (Blue Cross and Blue Shield of New Jersey); J. Majcher (Department of Banking and Insurance); E. Shrem; R. Smart (Mutual of Omaha); L. Specht (Prudential); L. Yourman

Others Participating: E. DeRosa, IHC Program Assistant Director; DAG E. Heck (DOL); W. Sanders, Interim Executive Director

I. Call to Order

J. Majcher called the Board meeting to order at 9:33 a.m. W. Sanders announced that notice of the meeting had been published in three New Jersey newspapers and posted at the Department of Banking and Insurance and the Office of the Secretary of State in accordance with the Open Public Meetings Act. A quorum was present.

II. Minutes

S. Kelly said she believed the minutes should indicate that the withdrawal regulation would be revised to state that carriers must advise customers that there is a special Open Enrollment Period which occurs during the 60 days surrounding the cancellation of a plan. The Board agreed that it had discussed the fact that customers must be advised of the special Open Enrollment opportunity, but disagreed that it had agreed with S. Kelly that the Withdrawal Regulation was the appropriate place to specify the requirement that carriers give notice of the Open Enrollment opportunity.

J. Majcher offered a motion to approve the minutes of the Open Session of the September 9, 1997 Board meeting, as amended. R. Smart seconded the motion and the Board voted unanimously in favor of approving the minutes.

III. Report of the Interim Executive Director

Expense Report

J. Majcher offered a motion to approve the payment of the expenses shown on the September 9, 1997 expense report. L. Yourman seconded the motion and the Board voted unanimously in favor of approving the payment of the expenses shown on the expense report.

Enrollment Data
W. Sanders reported that preliminary 2nd quarter 1997 enrollment data was available. The number of contracts remained close to level, decreasing only from 97,706 as of the end of the 1st quarter to 97,236 at the end of the 2nd quarter. The number of covered lives decreased from 168,262 to 165, 238. The number of persons covered by pre-reform plans decreased by about 1,000. He noted that the SEH 2nd quarter 1997 enrollment remained level, as it was reported, but noted that a new, large carrier in the SEH market had mis-reported during the 1st quarter, so considering the correction to the 1st quarter data, there was actually a slight increase in enrollment from the 1st to the 2nd quarter.

E. Shrem asked if there were any reports that showed the shift from carrier to carrier. She suggested it would be useful information. W. Sanders said the data, as compiled, does not show shifts, but that staff could look into compiling such data.

Rulemaking
W. Sanders said he spoke with A. Weiss at DOHSS. She advised him that there was no immediate need for the well child care rider since the new KidsCare Program would initially be part of Medicaid. During a later phase of the Program, they may be interested in using the IHC forms. W. Sanders said she agreed to notify him if the need to develop a well child rider should arise.

The proposal to specify the naming of PPO and POS plans was being considered again by TAC prior to TAC recommending that it be adopted. No written comments were received in response to the proposal.

He suggested that adoption of outstanding proposals to modify Exhibits K and Q, the Carrier Market Share and Net Paid Loss Report and the Certification of Compliance should be withheld due to further modification to both exhibits necessitated by changes required by P.L. 1997, c. 146 and the changes made to the standard plans.

W. Sanders reported that when staff sends carriers disks with the new forms, carriers will be asked to sign a form indicating the carrier has received the disk.

W. Sanders reported that the Withdrawal Regulation was still being reviewed by Governor's counsel. S. Kelly asked when it may be effective. W. Sanders speculated it may be early December.

W. Sanders said the packets included a copy of the recent adoption of changes to the high deductible plan text that could be used with an MSA.

WEB Site
W. Sanders reported the SEH Board had inquired as to whether it would be possible to determine how may visitors came to the Board's WEB site. The DOBI can measure the number of visitors to the DOBI Home Page. He reported the following activity for the 6-day period from October 1 - October 6, 1997:
DOBI Home Page 2596 visitors

Health Boards	369 visitors
IHC Rates	194
SEH Rates	72

He said a conservative estimate of visitors may be about 2000 visitors per month. Thus, the WEB page may be a very effective outreach tool. He said the IHC rate page is updated only quarterly. L. Yourman volunteered to input the rates monthly. She noted the value of having current data available.

S. Kelly said staff should have E-mail capabilities. W. Sanders said he would look into it.

Bulletin on P.L. 1997 c, 146 and HCQA
W. Sanders said he completed his draft of the bulletin on P.L. 1997 c, 146 and the HCQA. He reported that E. DeRosa suggested some changes which he would incorporate and then he would provide the draft to the Legal Committees of both Boards for review and comment.

Consumer Calls
W. Sanders said he and E. DeRosa continued to receive calls on rate increases, particularly the Trustmark rate increase. The DOBI has also been handling these calls. The volume of calls has started to decrease, however.

Interest Calculation
W. Sanders reported that P. Lechner has been working on the calculation of the amount of interest due to BCBSNJ, Time and National Casualty.

1996 Assessment
W. Sanders reported that work on the assessment will begin after the interest has been calculated.

1995 Loss Audits
W. Sanders said the Manhattan National audit, which is not a full audit, was near completion. The BCBSNJ audit is not complete.

Outreach
W. Sanders reported he spoke at the following events:

9/23/97	South Jersey Health Underwriters
9/30/97	Commissioner's Life/Health Underwriters Advisory Board
10/1/97	Health Affairs Committee of the NJ Business and Industry Association

W. Sanders reported he filmed a segment for a 1/2 hour cable show called "Financial Matters" which will air on November 11, 1997 at 8:30 a.m. on CTN cable TV stations. The host invited him to return for another segment to be filmed in March, 1998. He reported he also did a radio interview with Gene Dillard, a freelance correspondent who

sells his pieces to a number of radio stations including NJ 101.5, WHYY the NPR station in Philadelphia, and KYW, a Philadelphia all news AM radio station.

IV. Report of the Technical Advisory Committee

S. Kelly directed the Board to the TAC report in the Board packets. The TAC recommended that the Board find the seven filings specified on the report as complete.

R. Smart offered a motion that the Board find the rate filings specified on the attached copy of the TAC report as complete. L. Yourman seconded the motion and the Board voted unanimously in favor of the motion, with S. Kelly abstaining with respect to the BCBSNJ filings.

S. Kelly said TAC recommended that the Board contract with Apex Management to perform the calculated reserve audits for 1995. She noted this was the only bidder. Apex had done the audits for 1993.

R. Smart offered a motion that the Board contract with Apex Management to perform the calculated reserve audits for 1995. J. Majcher seconded the motion, and the Board voted unanimously in favor of the motion.

V. Report of the Marketing Committee

E. Shrem noted that the packets contained a copy of the new insert for the Buyer's Guide. She said the Committee would be reviewing the Task Orders provided by Cox and Backes for the new Buyer's Guide, the logo and the brochure.

W. Sanders noted that the packets also contained a copy of the press release sent out to discuss the October Open Enrollment Period.

E. Shrem noted that a report from Cox was in the Board packets.

VI. Executive Session

S. Kelly offered a motion that the Board begin Executive Session. R. Smart seconded the motion and the Board voted unanimously in favor of the motion.

[Executive Session: 10:35 a.m. - 11:15 a.m.]

VII. Report of the Policy Forms Committee

L. Curry reported that the Committee met on October 9, 1997 to discuss two sets of written comments to the policy forms proposal: BCBSNJ and First Option Health Plan

L. Curry directed the Board to the issue raised by E. DeRosa in her October 9, 1997 distribution to the Board. Specifically, L. Curry asked the Board to consider the issue of

direct access to an OB/GYN in a POS plan. She said the Committee recommended that direct access be allowed since it would be more customer-friendly. L. Curry noted that the prior POS text contained an option so that carriers could limit self-referral to an OB/GYN to once per year, or could allow direct access for non-surgical gynecological care and routine pregnancy care. The forms, as proposed, which borrow the POS language from the SEH forms, allow no choice, so all carriers must allow direct access.

S. Kelly noted that BCBSNJ had a closed block of POS business which allows self-referral only once per year. Since the proposal repeals the prior PPO and POS text, she asked what would happen to this closed block. E. DeRosa suggested this change should be considered no differently than any other change to the standard plans. That is, she believed the carrier would have to update the forms to be consistent with the new text.

The Board asked the Legal Committee to consider the responsibility of carriers to modify closed blocks of business when the Board has adopted forms changes.

S. Kelly offered a motion that the Board allow carriers an option in the POS text to either limit self-referral to the OB/GYN to once per year, or to allow direct access for non-surgical gynecological care and routine pregnancy care. R. Smart seconded the motion, with the Board voting in favor of the motion, 5 -2 (L. Yourman and E. Shrem opposed the motion.)

L. Curry said another issue raised by a commenter was the confusion customers may experience as a result of the change to the termination provision when a person becomes eligible for Medicare. As a result of HIPAA, a carrier may no longer terminate an individual when he or she becomes eligible for Medicare. The Committee did not believe the policy forms required clarification. However, the Committee believed the Buyer's Guide should clearly explain the option to retain IHC coverage now available to Medicare eligible persons who already had an IHC plan. She said the Senior Services Health Unit should be advised of this option. E. DeRosa reported that she had already spoken with staff from the Health Unit.

S. Kelly said she believed the draft response to BCBSNJ comment 10 should be revised. She suggested that item two of the instruction section of the application form should refer the applicant to the information given in item five. The Board agreed.

E. DeRosa noted that the effective date for the adoption would be January 1, 1998. However, she recommended that the Board allow carriers to begin to use the new forms prior to January 1, 1998. The Board agreed. E. DeRosa said she would prepare a Bulletin to discuss this option which would accompany the disks carriers would be sent, containing the adopted text.

L. Yourman offered a motion to adopt the policy forms proposal. E. Shrem seconded the motion and the Board voted unanimously in favor of the motion.

VIII. Close of Meeting

R. Smart offered a motion to adjourn the meeting. J. Majcher seconded the motion, and the Board voted unanimously in favor of the motion. *[The meeting adjourned at 11:55 a.m.]*

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
November 12, 1997

Directors Participating: L. Curry (Blue Cross and Blue Shield of New Jersey); J. Majcher, Chair (Department of Banking and Insurance); R. Rondum; R. Smart (Mutual of Omaha); L. Yourman

Others Participating: E. DeRosa, IHC Program Assistant Director; DAG E. Heck (DOL); W. Sanders, Interim Executive Director

A quorum was not present at the time the meeting was scheduled to commence. While the Board awaited the arrival of members who had been delayed, the Board invited Katherine Swartz and Deborah Garnick to present their preliminary findings concerning the first four years of the Individual Health Coverage Program.

I. Presentation of Preliminary Report to the Board (Harvard Brandeis Study)

K. Swartz began by stating that the regulations governing the IHC Program were very sophisticated and that they believed that overall, the IHC Program had been successful. She stated that the Board may want to consider some fine-tuning at this juncture, noting that all programs require evaluation and subsequent adjustment. She thanked those persons who cooperated with the study and particularly thanked R. Smart, K. O'Leary and E. DeRosa for their efforts in support of the study.

K. Swartz summarized the five key findings as follows:
1. a market for individual health coverage was created;
2. adverse selection may not have occurred;
3. most new contractholders had prior health coverage;
4. most enrollees compared plans among carriers; and
5. most enrollees were satisfied.

She noted these were remarkable achievements.

Question and Answer Period

R. Rondum noted there had been an undercurrent of fear that the report could be dismissed because of old data. She was pleased that the fear was unfounded. R. Rondum also expressed pleasure with the emphasis the report gives to the Health Access Program. Lastly, she suggested that the report should recognize the impact the consumer Board members have had on coverage.

K. Swartz said that they recognized that the IHC Program was not run by the Department of Banking and Insurance, rather, it has been run by concerned parties, both carriers and consumers. She said the New Jersey model was a terrific example for other states and making the interested parties the regulatory body lent to the success of the Program.

L. Curry asked if they had any indication as to why the Health Access enrollees seemed to have a greater level of satisfaction than non-Health Access enrollees. D. Garnick said that one satisfaction type question persons had been asked was whether they would recommend the Program to family and friends. A "yes" response indicated satisfaction. She suspected Health Access persons were perhaps glad to have been covered under the subsidized program.

The Board thanked K. Swartz and D. Garnick for coming to present this preliminary report. Both K. Swartz and D. Garnick expressed an interest in returning to present the final findings which they hoped to have completed in the spring of 1998.

[Break: 10:35 a.m. - 10:45 a.m.]

I. Call to Order

J. Majcher called the Board meeting to order at 10:45 a.m. W. Sanders announced that notice of the meeting had been published in three New Jersey newspapers and posted at the Department of Banking and Insurance and the Office of the Secretary of State in accordance with the Open Public Meetings Act. A quorum was present.

II. Minutes

October 8, 1997

J. Majcher offered a motion to approve the minutes of the Open Session of the October 8, 1997 Board meeting, as amended. R. Smart seconded the motion and the Board voted in favor of approving the minutes, with one abstention (L. Curry). [The motion carried based on the affirmative votes of a majority of those present.]

October 14, 1997
J. Majcher offered a motion to approve the minutes of the Open Session of the October 14, 1997 Board meeting. L. Yourman seconded the motion and the Board voted in favor of approving the minutes, with one abstention (R. Rondum). [The motion carried based on the affirmative votes of a majority of those present.]

III. Report of the Technical Advisory Committee

E. DeRosa reported that TAC considered a number of rate filings as set forth on the Report of the Technical Advisory Committee, copy attached. She noted that the clarification the TAC requested from CIGNA had been received. The TAC recommended that the rate filings of the 10 listed carriers be found complete.

R. Smart offered a motion to find the rate filings shown on the Report of TAC as complete. L. Yourman seconded the motion. The Board voted unanimously in favor of the motion, with L. Curry abstaining with respect to the BCBSNJ filing.

E. DeRosa explained that the rate filings from MEGA Life and Mid-West included rates for all plans and deductibles. TAC broke out the rates for the $1500 and $2250 deductibles which could be used for MSA plans since neither of these carriers appropriately responded to requests for clarification of the rate filings for these high deductible plans. TAC did not believe it necessary to find the entire filing incomplete simply due to the high deductible component, and thus recommended that the non-high deductible portion be found complete and only the high deductible portion be found incomplete.

R. Smart offered a motion to find the rate filing for the high deductible (MSA) plans of MEGA Life and Mid-West incomplete. J. Majcher seconded the motion. The Board voted unanimously in favor of the motion.

E. DeRosa reported that the outstanding 1995 Loss Ratio Report had been received. Since the loss ratio was less than 75%, the carrier submitted a refund plan. E. DeRosa explained that $22,888 would be refunded. The recommendation to approve the refund plan was subject to MEGA confirming that the $22,888 would not be reduced by any managed care expenses.

R. Smart offered a motion to approve the refund plan from MEGA Life. J. Majcher seconded the motion. The Board voted unanimously in favor of the motion.

E. DeRosa said the Board proposed a change to N.J.A.C. 11:20-3.1(d). No comments were received. TAC recommended that the regulation be adopted. This regulation addressed the manner in which a carrier must designate PPO and POS plans. The plan must be named based on the out-of-network benefit level.

L. Curry offered a motion to adopt the amendments to N.J.A.C. 11:20-3.1(d). J. Majcher seconded the motion. The Board voted unanimously in favor of adopting the amendments to the regulation.

E. DeRosa called the Board's attention to the new carrier on the November rate sheet - Guardian. She noted that Guardian entered the market with PPO plans in addition to the indemnity plans.

IV. Report of the Interim Executive Director

Expense Report

L. Curry offered a motion to approve the payment of the expenses shown on the November 12, 1997 expense report. J. Majcher seconded the motion. The Board voted unanimously in favor of the motion, with R. Rondum abstaining with respect to reimbursement due to her.

Rulemaking

W. Sanders said the text of the adopted policy forms has been provided to carriers. Notice of the adoption was sent to interested parties.

W. Sanders said he contacted Governor's Counsel to inquire about the adoption of the Withdrawal Regulation but had not received a reply.

Legislative Activity

W. Sanders said A. 3253 was introduced on November 6, 1997. This bill would change the effective date for the change to the loss reimbursement mechanism as set forth in P.L. 1997, c. 146 from January 1, 1997 to January 1, 1998. He said a companion Senate bill would be introduced.

W. Sanders said A. 3188, also introduced on November 6, 1997, would allow consumers to sue carriers for medical malpractice in connection with network based plans.

2nd Quarter 1997 Enrollment Data

W. Sanders reported that there was a slight decrease in IHC enrollment. He said that the combined IHC and SEH enrollment still exceeded 1 million persons.

Market Conduct Study

W. Sanders said the Department of Banking and Insurance completed a market conduct examination of a carrier that participates in the IHC and SEH programs. He noted that the examination of the IHC business disclosed that the carrier was not providing the required Outline of Coverage. He noted that the study required no action by the Board.

Web Site - DOBI Home Page
W. Sanders reported that during the month of October there were 769 visitors to the information of the Health Boards, 449 visitors to the IHC rates data and 139 visitors to the SEH rate comparison data.

He said corrections were recently made to SEH data. W. Sanders reported that the IHC rates information was updated quarterly. It takes about 6 hours to input the rates. He reported that the data from the rate comparison sheets cannot simply be transferred to the WEB site and must be re-input. He will look into whether staff could input the data for the WEB page and then use that data for the hard copy rate sheets.

HMO Performance Report
W. Sanders reported that the Department of Health and Senior Services (DOHSS) just released the first HMO Performance Report. A representative from DOHSS will come to the December Board meeting to discuss the report. The Board may want to refer to the report in the Buyer's Guide. J. Majcher said the Commissioner of Health and Senior Services said the report indicated that HMO carriers had not been providing the maintenance care they should be providing.

CIGNA
W. Sanders reported that CIGNA provided a response to the Board's request for information. It was received November 5, 1997 and would be reviewed by the appropriate Committees.

Insurance Reporter
W. Sanders said he was asked for any information to be included in the Insurance Reporter. Ideas must be provided by November 26, 1997.

Correspondence
W. Sanders called the Board's attention to two letters he wrote which were included in the Board packets. In both cases, he refuted incorrect information concerning the IHC Program.

1997 Assessment
W. Sanders reported he and P. Lechner just completed the SEH assessment and would now focus on the IHC assessment.

1996 Loss Audits
W. Sanders said he just received a report from Deloitte & Touche regarding the status of the 1996 loss audits which he would forward to the Operations Committee.

He said a letter of understanding for the 1996 loss audits would be reviewed by the Attorney General's Office and the Operations Committee.

Outreach

The SEH Marketing firm, Wenzel and Company placed an article in Chambers of Commerce publications. Although the focus of the article was the SEH Program, it did mention the IHC Program and provided the toll-free number.

Meeting date for December 1997
W. Sanders said that attendance at the NAIC meeting by two Board members may pose a quorum problem for the December 9, 1997 meeting. The Board selected the following alternate dates: December 11, 1997 or December 18, 1997.

The proposed 1998 meeting schedule would need to be revised for the December meeting as it was scheduled for the same time as the NAIC meeting in December 1998.

V. Executive Session

R. Smart offered a motion that the Board begin Executive Session for the purpose of receiving Legal Advice and to consider other matters. J. Majcher seconded the motion and the Board voted unanimously in favor of moving into Executive Session.

[Executive Session: 11:30 a.m. - 1:10 p.m.]

VI. Close of Meeting

R. Smart offered a motion to adjourn the Board meeting. L. Yourman seconded the motion. The Board voted unanimously in favor of adjourning the Board meeting.
[The meeting adjourned at 1:11 p.m.]

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
December 4, 1997

Directors Present: J. Majcher, Chair (Department of Banking and Insurance)

Directors Participating Via Telephone Conference: J. Beck (Aetna USHealthcare); R. Rondum; E. Shrem; L. Specht (Prudential); L. Yourman

Others Participating: W. Sanders, Executive Director; DAG Eleanor Heck; Robert Vehec, Department of Banking and Insurance

I. Emergency Meeting

W. Sanders announced that Board members had been convened to consider holding an emergency meeting. He noted that the Board was faced with an emergent

matter regarding Blue Cross and Blue Shield of New Jersey's appeal of the 1993 and 1994 loss audits.

E. Shrem offered a motion that the Board hold an emergency meeting. R. Rondum seconded the motion, and the motion was approved unanimously by roll call vote.

W. Sanders announced that as soon as possible following the calling of the meeting, notice of the meeting would be prominently posted in the Office of the Secretary of State, the Department of Banking and Insurance, and sent to three newspapers of general circulation in accordance with the Open Public Meetings Act.

W. Sanders indicated that the Open Public Meetings Act required the Board to publicly announce and place in the minutes the following statements: (1) The normal notice requirements of the Open Public Meetings Act had not been met; (2) An unexpected, important, emergent matter had arisen involving litigation issues in the matter currently before the Office of Administrative Law regarding the 1993 and 1994 audits of Blue Cross and Blue Shield's losses which required immediate consideration by the Board; (3) The failure by the Board to act could compromise the Board's position in the litigation; (4) The emergent matter could not have been foreseen by the Board at the time when the required notice could have been provided; (5) Notice of the meeting would be provided as soon as possible following the meeting; and (6) The meeting would be limited to the specific matter of urgency for which the emergency meeting was convened.

II. Executive Session

J. Majcher offered a motion that the Board begin Executive Session for the purpose of discussing litigation issues relating to Blue Cross and Blue Shield's appeal of its 1993 and 1994 loss audits. E. Shrem seconded the motion and the motion was approved unanimously by roll call vote.

[Executive Session: 3:15 p.m.. - 3:45 p.m.]

III. Close of Meeting

E. Shrem offered a motion to adjourn the Board meeting. J. Majcher seconded the motion. The Board voted unanimously in favor of adjourning the Board meeting.
[The meeting adjourned at 3:45 p.m.]

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 December 11, 1997

Directors Participating: Sandy Kelly (Blue Cross and Blue Shield of New Jersey); William Kramer (Aetna U.S. HealthCare); Ritamarie Rondum; Eileen Shrem; Gale Simon (Department of Banking and Insurance); Lee Ann Specht (The Prudential); Rebecca Smart (Mutual of Omaha).

Others Participating: Ellen DeRosa, Deputy Executive Director; DAG Eleanor Heck (DOL); Joanne Petto, Assistant Director; Wardell Sanders, Executive Director

I. Call to Order

W. Sanders called the Board meeting to order at 9:40 a.m. He announced that notice of the meeting had been published in three New Jersey newspapers and posted at the Department of Banking and Insurance and the Office of the Secretary of State in accordance with the Open Public Meetings Act. A quorum was present.

II. HMO Report Card

N. Shapiro and F. Presciani (Department of Health and Senior Services) stated that this was the first in a series of quality measurements for HMOs. The purpose of the HMO Report Card is to: a) provide consumer and business communities with the information necessary to make an informed choice; b) encourage HMO quality practices; and c) enable DOHSS, in a monitoring role, to review the quality of care provided. Information for the study was derived from the HEDIS datasets and from the CAP Surveys.

The HMO Report Card was widely published and is available on request, and through the DOHSS web site. E. Shrem stated the carriers should be notified that improvement was needed by all carriers in Customer Service. E. Shrem requested copies of the Report Card and suggested additional distribution options. A copy was forwarded to Cox Communications Partners for informational purposes. R. Rondum suggested that the Bill of Rights should be in the actual contract as well as in the handbook. G. Simon stated that there is no regulation requiring this inclusion. W. Kramer and R. Smart replied that more members read the handbook than the actual contract. As required by the Health Care Quality Act, a proposal has been made to gather similar information on all other managed care plans.

III. Introduction of Joanne Petto

W. Sanders introduced J. Petto to the Board who began as a new staff member of the IHC and SEH Programs. He reported that J. Petto came to the Programs with an impressive background in health care, insurance, and hospital administration.

IV. Minutes

November 11, 1997

S. Kelly questioned whether the required outline of coverage mentioned in the Market Conduct Study had been forwarded to the Legal Committee for consideration. W. Sanders will follow-up with G. Simon on the regulation or statute that requires the outline of coverage.

S. Kelly offered a motion to approve the minutes of the Open Session of the November 11, 1997 Board meeting. R. Smart seconded the motion and the Board voted in favor of approving the minutes, with one abstention (E. Shrem). [The motion carried based on the affirmative votes of a majority of those present.]

December 4, 1997

E. Shrem offered a motion to approve the minutes of the Open Session of the December 4, 1997 Board meeting. R. Rondum seconded the motion and the Board voted in favor of approving the minutes, with two abstentions (R. Smart and S. Kelly). [The motion carried based on the affirmative votes of a majority of those present.]

V. Report of Executive Director

Expense Report

S. Kelly offered a motion to approve the payment of the expenses shown on the November 12, 1997 expense report. R. Smart seconded the motion. The Board voted unanimously in favor of the motion, with individuals abstaining with respect to their own reimbursements.

Rulemaking

W. Sanders said the amendment for naming managed care plans (where out-of-network benefits govern plan designation) will be published in the New Jersey Register on January 5, 1998.

W. Sanders said that he contacted Governor's Counsel to inquire about the adoption of the Withdrawal Regulation but had not received a reply. R. Smart observed that carriers have the right to withdraw from the market, with or without the regulations, by raising their rates.

Legislative Activity
W. Sanders said there was an Assembly Health Committee hearing scheduled for December 11, 1997 on **A. 3253**. This bill would change the effective date for the change to the loss reimbursement mechanism as set forth in P.L. 1997, c. 146 from January 1, 1997 to January 1, 1998. He said a companion Senate bill would be heard on December 15, 1997.

S. Kelly inquired about KidCare (Children First portion of the Access Program). W. Sanders reported that he spoke representatives from DOHSS who stated that no action was required by the IHC Board at this time.

3rd Quarter 1997 Enrollment Data
W. Sanders reported that J. Petto was in the process of completing and analyzing the enrollment reports.

1998 Board Meeting Schedules
W. Sanders said the IHC and SEH Board meeting schedules were included in the Board packets.

VI. Report of the Operations Committee

1998 Fiscal Year Budget
P. Lechner gave an overview of the 1998 fiscal year budget and stated that she added explanations to the printed budget figures where appropriate. G. Simon requested the addition of a percentage change column from prior year. R. Rondum stated, and the Board agreed, that P. Lechner should feel comfortable making changes to the budget format developed by the former Executive Director for easier reference and reconciliation. W. Sanders agreed to follow-up with G. Simon regarding procedures for reconciliation of previous years' budgets. R. Smart discussed the need to do final budget reconciliations after the assessments are completed. W. Kramer stated that he would like to see more detailed budget information and more analysis of monies spent in future budgets. He added that the reimbursements should be shown as an additional line item.

W. Kramer offered a motion to approve the 1998 fiscal year budget. R. Smart seconded the motion. The Board voted unanimously in favor of the motion, with one abstention (G. Simon).

1996 Assessment
W. Sanders walked through the calculation of the 1996 loss assessment and the fiscal year 1998 administrative assessment and stated that the reconciliation would be completed once the all the final numbers have been determined. Physicians Health Care Plan of NJ was late in the submission of its Exhibit K. Once that exhibit has been received, the assessment will be recalculated. At this time, the assessment is $46,046,824, with $38,096,165 of that amount being borne by the non-exempt carriers. Two carriers, CIGNA and NYLCare, did not meet the Good Faith Marketing requirements and were therefore not entitled to a pro-rata exemption for 1996 losses.

S. Kelly offered a motion to approve the 1996 assessment based on the expected report from Physicians Health Care Plan of NJ. L. Specht seconded the motion. The Board voted unanimously in favor of the motion, with one abstention (G. Simon).

Bank Accounts
J. Donnellan, as interim administrator, set up two accounts (checking and investment) for IHC funds. W. Sanders reported that he would like to set up sub-accounts.

R. Smart offered a motion to authorize W. Sanders to establish sub-accounts. S. Kelly seconded the motion. The Board voted unanimously in favor of the motion.

Deloitte & Touche (D&T) 1996 Loss Audit
W. Sanders reported that he would request more frequent (monthly) updates on the status of the 1996 loss audits. R. Smart asked for a status on the 1995 BCBSNJ audit with respect to Medicaid; W. Sanders indicated that he would follow-up with D&T. S. Kelly suggested that W. Sanders give D&T copies of the Board meeting schedule so the Board could anticipate more timely reports.

Deloitte & Touche Bills
Originally, these bills were to contain a 10% cap for administrative expenses. D&T now states that 10% is unfair; they are making a distinction between local audits, and audits for which they must travel. W. Sanders asked D&T for background information on the expenses. Until clarification is received on the expenses, W. Sanders recommended that billed expenses not be paid, but that billed time be paid.

S. Kelly offered a motion to approve payment to D&T for billed time. W. Kramer seconded the motion. The Board voted unanimously in favor of the motion to pay billed time.

[Break: 11:37 - 11:55 a.m.]
Deloitte & Touche Agreement
No Board action is required; this agreement is pending a review by the Attorney General's office.

VII. Report of the Technical Advisory Committee

Rate Filings
The TAC recommended that the rate filings of the 10 listed carriers on the Report of TAC, copy attached, be found complete.

R. Smart offered a motion to find the rate filings shown on the Report of TAC as complete. E. Shrem seconded the motion. The Board voted unanimously in favor of the motion.

Paid versus Incurred Losses, Two Year Refund Basis, 115% Loss Reimbursement Threshold
S. Kelly reported that TAC considered whether it would be more appropriate to consider loss reimbursement based on paid losses, as is required by the current law, or based on incurred losses. She noted that as enrollment for a carrier decreases, paid losses would increase. She reported that the majority of TAC recommended that reimbursable losses should be based on incurred losses as opposed to paid losses, and that only premiums and claims should be considered in the calculation. In addition, the refund period which P.L. 1997, c. 146 retained as a one-year period, should be modified to a two-year period, to be consistent with the two-year period for loss reimbursement. S. Kelly said that TAC recognized that both changes would require legislative action. She further reported that TAC was unable to reach a consensus regarding the 115% loss reimbursement threshold set forth in P.L. 1997, c. 146.

W. Kramer observed that the Board is not responsible for making policy; its charge is to enforce legislation and to make sure that the program runs smoothly within the law. Following a straw poll, the Board asked TAC to develop a recommendation letter to be sent to the Department of Banking and Insurance, outlining its concerns with the current law, a proposed solution, and the benefits of that solution.

VII. Report of the Marketing Committee

E. Shrem mentioned that the Cox Communications report dated December 5, 1997 was included in the Board packets. Revisions for the Buyer's Guide are in progress with an anticipated completion date of January 31, 1998.

E. Shrem stated that two underwriting associations have formed an alliance and will be voicing recommendations to legislators concerning the IHC program. A news release on the member refunds was issued on November 25, 1997.

VIII. Report on the Policy Forms Committee

There was no meeting this month, but the committee will get together to discuss a) Exhibit Q and b) comments received on the September 1, 1997 changes that became effective on January 1, 1998.

IX. Executive Session

R. Smart offered a motion that the Board move into Executive Session to discuss litigation issues. W. Kramer seconded the motion and the Board voted unanimously in favor of moving into Executive Session.

[Executive Session: 12:35 a.m. - 1:45 p.m.]

X. Close of Meeting

E. Shrem offered a motion to adjourn the Board meeting. R. Rondum seconded the motion. The Board voted unanimously in favor of adjourning the Board meeting.
[The meeting adjourned at 1:46 p.m.]