January 9* February 13 March 13 April 10

*These minutes are still in draft form, with handwritten amendments indicated.

DRAFT*
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
January 9, 2001

Directors Participating: Darrel Farkus (Oxford Health Insurance); Frank Giannattasio; Sandy Herman (Guardian); Sandi Kelly (Horizon Blue Cross Blue Shield of New Jersey); Jane Majcher (Department of Banking and Insurance); Mary McClure (AUSHC); Eileen Shrem; Lisa Yourman.

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

I. Call to Order

W. Sanders called the Board meeting to order at 9:55 a.m. W. Sanders announced that notice of the meeting had been sent to 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.

W. Sanders welcomed two new Directors to the IHC Board, Darrel Farkus from Oxford Health Insurance Company, recently elected to fill the vacant seat for a foreign insurer authorized to do business in New Jersey, and Frank Giannattasio, recently appointed and confirmed to serve as a consumer of health plans who is reflective of the population in the State. Board members and Board staff briefly introduced themselves.

II. Minutes

November 14, 2000

L. Yourman offered a motion to approve the draft minutes of the Open Session of the November 14, 2000 Board meeting, as amended. M. McClure seconded the motion. The Board voted in favor of the motion, with D. Farkus and F. Giannattasio abstaining.

III. Report of Staff

Expense Report

W. Sanders noted that since the Board had not met during December 2000, the expenses shown on the January 2001 expense report cover two months of expenses. The amount

* These draft notes and minutes of the New Jersey Individual Health Coverage (IHC) Program Board have not been reviewed or approved by the IHC Program Board. As a result, the contents may not accurately reflect the actions of the Board, and this draft may be subject to change and modification. Please refer to the approved minutes, when available, for the official actions of the IHC Board.

shown as payment to Deloitte & Touche represents charges for audit services performed by D&T through 11/14/00 with regard to TMG's 1996 losses and is the total billed amount. TMG will be responsible for payment of half this expense.

S. Kelly offered a motion to approve the payment of the expenses shown on the January 9, 2001 expense report. L. Yourman seconded the motion. The Board voted in favor of the motion with F. Giannattasio abstaining with respect to the entire vote and L. Yourman abstaining with respect to the reimbursement due to her.

Legislative Update

S. 13:

W. Sanders said this bill, which would require IHC carriers to offer a bare bones plan with benefits as described in the bill, was passed with amendments by the Senate on December 18, 2000. The Assembly version, A. 2791 was referred to the Assembly Health Committee on October 5, 2000 but has not yet been heard.

Health Care Financing Administration (HCFA) Issues

W. Sanders reported that he had submitted a filing to HCFA requesting recertification of New Jersey's alternative mechanism for the individual market mechanism under HIPAA. Alternative mechanism filings must be reviewed every 3 years.

W. Sanders reported that copies of HCFA Bulletins 00-05 and 00-06 were included in the Board materials for informational purposes. He said they did not have an impact on the IHC Program.

Board Officer Nomination and Elections

W. Sanders noted that Board officer nominations and elections are held during the Annual Meeting.

Chair

W. Sanders asked for nominations for Chair of the Board.

S. Kelly nominated M. McClure to serve as chair of the IHC Board. E. Shrem seconded the nomination. M. McClure indicated she would be willing to serve, if elected. No other persons were nominated.

Board vote: All in favor, with D. Farkus, F. Giannattasio and M. McClure abstaining.

Vice Chair

W. Sanders asked for nominations for Vice Chair of the Board.

E. Shrem nominated L. Yourman to serve as vice chair of the IHC Board. M. McClure seconded the nomination. L. Yourman indicated she would be willing to serve, if elected. No other persons were nominated.

Board vote: All in favor, with D. Farkus, F. Giannattasio and L. Yourman abstaining.

Enrollment Reports 3Q 2000
J. Petto said that enrollment data was included in the Board materials. She said there had been a 2,708 life decrease in enrollment as compared to 2Q 2000.

Rule proposal
W. Sanders said that the rule proposal to revise the Carrier Market Share and Net Paid Loss Report (Exhibit K) had been filed and that the comment period had expired. He said no comments were submitted to the proposal and that the Board could vote to adopt the changes, as proposed, if it so desired. S. Kelly suggested a minor modification to the definition of "non-group persons" to more closely track other changes made in the proposal.

DAG E. Heck asked that the Board delay voting to adopt until after Executive Session.

IV. Report of TAC

Rate Filings
S. Kelly said that TAC reviewed four rate filings, with one from Aetna Life, two from Horizon (indemnity and HMO) and one from Oxford.

S. Herman offered a motion to find the rate filings as complete. L. Yourman seconded the motion. The Board voted in favor of the motion with S. Kelly abstaining with respect to the filings from Horizon, M. McClure abstaining with respect to the filing from Aetna Life and D. Farkus abstaining with respect to the filing from Oxford. F. Giannattasio abstained from voting on all of the filings.

Refund Plans for 1999
S. Kelly said that TAC considered the Loss Ratio Report filings for 1999. While there are still some carriers that have not yet submitted the filing, TAC was prepared to make a recommendation concerning the filings received thus far. Three carriers reported loss ratios that were below 75%. The carriers are Horizon Blue Cross Blue Shield; National Casualty; and National Health. Each carrier submitted a Refund Plan, as required, and in the plan agreed to send refunds within 45 days after the date the Board approves the refund plan. She said the total amount to be refunded, based on filings received thus far, was $1,334,887.

E. Shrem offered a motion to approve the refund plans. L. Yourman seconded the motion. The Board voted in favor of the motion with S. Kelly abstaining with respect to the Horizon filing, and F. Giannattasio abstaining from the entire vote.

V. Meeting Time

W. Sanders said that some Board members have suggested that it would be helpful if the meeting time were moved back until 10:00 a.m. Board members agreed to the later start time.

VI. Executive Session

W. Sanders said the Board had to discuss Executive Session minutes and to receive advice from counsel and asked for a motion to begin Executive Session.

L. Yourman offered a motion that the Board begins Executive Session. E. Shrem seconded the motion. The Board voted in favor of beginning Executive Session.

W. Sanders said the Board would have a very short discussion in Open Session following the Executive Session.

[Executive Session: 10:30 a.m.– 11:00 a.m.]

VII. Final Business and Close of Meeting

L. Yourman offered a motion that the Board adopt modifications to Exhibit K to address the manner in which Medicare+Choice premium should be reported and to include separate lines for premium for each of the two years in the two-year calculation period. M. McClure seconded the motion. The Board voted in favor of the motion with F. Giannattasio abstaining from the vote.

w/ changes upon adoption.

W. Sanders asked for a vote to authorize him to sign the contract and engagement letters with Deloitte & Touche (D&T).

E. Shrem offered a motion to authorize W. Sanders to sign the contract and engagement letters with D&T. J. Majcher seconded the motion. The Board voted in favor of the motion with F. Giannattasio abstaining from the vote.

E. Shrem offered a motion to adjourn the Board meeting. S. Kelly seconded the motion. The Board voted unanimously in favor of accepting the motion. The meeting adjourned at 11:05 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
February 13, 2001

Directors Participating: Darrel Farkus (Oxford Health Insurance); Frank Giannattasio; Sandy Herman (Guardian); Sandi Kelly (Horizon Blue Cross Blue Shield of New Jersey); Gale Simon (Department of Banking and Insurance)(arrived at 10:20); Mary McClure (AUSHC).

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

I. Call to Order

W. Sanders called the Board meeting to order at 10:03 a.m. W. Sanders announced that notice of the meeting had been sent to 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 copy of the Revised IHC Program 2001 Meeting Schedule was included in the Board materials and specified the meeting time as having been changed from 9:30 a.m. to 10:00 a.m.

II. Minutes

January 9, 2001

S. Kelly offered a motion to approve the draft minutes of the Open Session of the January 9, 2001 Board meeting, as amended. M. McClure seconded the motion. The Board voted unanimously in favor of the motion.

III. Report of Staff

Expense Report

S. Herman offered a motion to approve the payment of the expenses shown on the February 13, 2001 expense report. F. Giannattasio seconded the motion. The Board voted unanimously in favor of the motion.

Legislative Update

W. Sanders said the Board materials included an article from the Star Ledger that reported on a recently signed law that requires HMOs to accept the rulings of an appeal. Previously, the appeal rulings were non-binding.

W. Sanders said the Administrative Procedures Act (APA) had been amended and now requires that agencies intending to file proposals must post notice of intended actions on a quarterly basis. The amendment to the APA takes effect in June 2001.

W. Sanders said the DOBI's proposed regulations on specified disease plans was still in the comment period. Comments may be made until March 7, 2001. S. Kelly noted that coverage under a specified disease plan would not be considered as creditable coverage.

Withdrawals from Individual Market

E. DeRosa said QualMed Plans for Health first submitted a request to withdraw from the IHC market last fall. Various pieces of information were lacking from the filing and E. DeRosa said she wrote to the company and advised them of what was required. A revised filing was submitted and also lacked required information. E. DeRosa said the most recent filing included all required information and that the sample notices provide the information required by the regulation. She said the staff recommendation would be to approve the withdrawal filing. She noted that QualMed Plans for Health operated only in two of the southern counties and had minimal enrollment.

M. McClure offered a motion that the Board accept the staff recommendation and approve the withdrawal filing from Qual Med plans for Health. D. Farkus seconded the motion. The Board voted in favor of the motion with F. Giannattasio and S. Herman abstaining.

E. DeRosa noted that Mutual of Omaha, although not a carrier that sold IHC plans, had a fairly substantial block of individual plans that were issued prior to August 1, 1993. As required under HIPAA, Mutual of Omaha notified the Commissioner of its intention to withdraw from the pre-reform individual market. The existing plans will be non-renewed subject to notice, as required. E. DeRosa reported that staff had received a fair number of calls from covered persons who had received the notification concerning withdrawal. She said she was sharing this information with the Board for informational purposes. No Board action was required.

Exhibit K Filings (Market Share and Net Paid Gain/Loss Report)

W. Sanders said the Exhibit K or non-member certification filing is due by March 1, 2001. He said that the web site included copies of the Exhibit K and non-member certification along with filing instructions.

Outreach

W. Sanders said he spoke at NJ Association of Health Underwriters meetings in Parsippany and in Monmouth/Ocean. In addition, he reported that he spoke at a meeting of the Monmouth/Ocean Development Council. He noted that the presentations focused largely on small employer group coverage issues.

Rulemaking Changes

W. Sanders said he shared the following suggestions with the Legal Committee but wanted to have some feedback from the Board before proceeding to draft a rule proposal.

1. The Loss Ratio Filing requirements should be expanded to include a requirement that carriers that are required to make refunds must send a certification to

confirm that all refunds have been sent. He noted the DOBI indicated it would be including a similar requirement with respect to SEH loss ratio filings.

2. The Loss Ratio Filing requirements should be amended to specify that carriers providing refunds do not need to send out refunds of less than $1.00. He noted that this had been the Board's practice. Amending the regulation in this regard would conform the regulation to practice. He noted that a refund amount might be a matter of cents and that the Board's practice had prevented carriers from having to cut a check for an amount such as $.14.
3. The Rate Filing requirements should be expanded to require that carriers provide a copy of the renewal letter that would accompany the notice of a rate adjustment. In the process of investigating inquiries it has come to the attention of staff and DOBI that some carriers have incorrectly characterized the role of the Board and/or DOBI in terms of a rate increase. For example, some letters advising consumers of an IHC rate increase have stated that the increase was approved by the DOBI. The copy of the renewal letter would simply be an additional item to be included in the informational filing. Several members of the Board suggested that staff should look at the renewal letters when the rate filings are received to give the carrier ample time to make any necessary adjustments. The Board agreed to issue an Advisory Bulletin to let carriers know of the Board's concerns with providing misinformation to consumers.
4. W. Sanders said that the Board's regulations prohibit a person from changing from an indemnity plan to an HMO except during the Open Enrollment Period which occurs in October of each year. He said that staff has gotten many calls from consumers who just received notice of a rate increase and wanted to switch to an HMO because the coverage was less expensive. Since the regulation prohibits moving to a richer plan except during the open enrollment period, the consumer must wait. W. Sanders noted that consumers are simply looking for a lower cost option and HMO coverage is less expensive than indemnity coverage in spite of the fact that the HMO coverage is richer. He suggested that consumers should be able to move to a lower cost plan when the rates for existing coverage increase. The Board asked that TAC consider whether allowing consumers to switch to a lower rate plan when the rates for existing coverage increase would present any selection issues.
5. W. Sanders noted that the IHC Board had voted previously to disband the Policy Forms Committee. The regulations, however, still state that such a Committee may be formed. To conform the regulation to practice, he suggested that the reference to the Policy Forms Committee should be deleted. W. Sanders said that L. Yourman, who could not be present at the Board meeting due to illness, had asked that the Board reconsider reconstituting the Policy Forms Committee. The Board discussed the matter but agreed not to reconstitute the Committee. W. Sanders asked Board members to submit any policy forms recommendations, in writing, to E. DeRosa.
6. W. Sanders noted that the regulations had not been updated since the Prevailing Healthcare Charges System data ceased being published by HIAA and became available though Ingenix. The regulation should refer to Ingenix.
7. W. Sanders said a fair number of consumers have complained about the timing of the Open Enrollment Period. Many carriers do not have January rates available in October, when consumers are supposed to be able to make Open Enrollment decisions. How can a person make an educated decision in October, about coverage to be effective in January, if one of the most important factors in a decision, rates, are not yet available? He suggested either moving the Open Enrollment Period to November or extending it for 60 days, and thus cover

October and November. The Board asked TAC to consider whether moving or lengthening the Open Enrollment period would have any adverse consequences.

Subject to advice from TAC on a couple of issues, the Board agreed with the suggested changes to the regulations.

IV. Report of TAC

Rate Filings

S. Kelly said that TAC considered a rate filing but that additional information was not yet provided. Rather than discuss the filing during this meeting it would be held until the following meeting.

Loss Ratio Filings for 1999

S. Kelly said that TAC was concerned that some carriers had still not provided the required loss ratio filing for 1999. The filing was due August 15, 2000. The Board agreed that if a carrier's filing has not been provided by February 20, 2001 that the carrier should be referred to Enforcement.

E. DeRosa said she had spoken with several of the tardy carriers. She said that some were confused by the fact that Exhibit K is only due every two years. Others said they used the services of a TPA and were having difficulty securing the data.

S. Kelly offered a motion to refer to Enforcement any carriers that have not filed a 1999 Loss Ratio Report by February 20, 2001. M. McClure seconded the motion. The Board voted unanimously in favor of the motion.

Modified Community Rating Analysis

S. Kelly said the attachment to the TAC Report was the result of TAC's further study of the effects of moving to a modified community rating rate basis. She said it was being provided to the Board on an informational basis. It was prepared in response to a request from the Commissioner for some data in a variety of forms.

S. Herman asked if the annual enrollment report data would indicate whether there has been a migration from younger to older covered persons. S. Kelly noted that the data is provided for all covered persons and is not tied to the age of the primary insured.

The Board agreed the data, as attached to the TAC report should be released to the Commissioner.

V. Report of the Operations Committee

W. Sanders said the Committee discussed the 1996 Reimbursable Loss Audit of Clarica (formerly TMG).

[D. Farkus recused himself from the meeting.]

W. Sanders said TMG had issued a prescription drug rider to amend the prescription drug coverage contained in the standard IHC plans. The rider was not a standard rider and was not permitted to be used. Clarica has advised Deloitte & Touche (D&T)

that it was trying to hire a programmer who would be able to back out all of the prescription drug rider premium and claims, and then re-adjudicate the claims such that the drugs would be covered subject to the terms of the standard plan. Clarica has not had success hiring such a programmer. Scott Sanders of D&T advised the Operations Committee that the process could be accomplished manually but that it would take time.

S. Herman said that the easiest thing to do would be to remove all prescription drug claims. He noted that using this approach, Clarica would not be reporting the re-adjudicated amount for the prescription drug claims.

The Board agreed that W. Sanders should write to Clarica and give Clarica 30 days in which to either "clean up" all the prescription drug claims (i.e. back out prescription drug premium and payments under the prescription drug rider and re-adjudicate according to the terms of the plan) or back out prescription drug premium and all prescription drug claims on the cases that were issued the rider.

[D. Farkus returned to the meeting.]

VI. Committee Membership

W. Sanders explained that since the Board has 9 members, a Committee with membership of 5 Board members or more would constitute a quorum.

TAC

M. McClure offered a motion to retain existing membership on TAC. S. Herman seconded the motion. The Board voted unanimously in favor of the motion.

Committee membership is as follows:
Horizon BCBSNJ
AetnaUS Healthcare
DOBI
Guardian
Celtic (not Board member)

Legal

D. Farkus said Oxford would like to participate on this committee.
S. Kelly offered a motion to add Oxford to the existing membership of the Legal Committee. M. McClure seconded the motion. The Board voted unanimously in favor of the motion.

Committee membership is as follows:
Horizon BCBSNJ
Aetna US Healthcare
DOBI
Oxford

Marketing

D. Farkus said Oxford would like to participate on this Committee. M. McClure said Aetna US Healthcare would designate a new representative to serve on the Committee.
M. McClure offered a motion to add Oxford to the existing membership of the Marketing Committee. F. Giannattasio seconded the motion. The Board voted unanimously in favor of the motion.

Committee membership is as follows:
Eileen Shrem
Horizon BCBSNJ
Aetna US Healthcare
Oxford

Operations

W. Sanders said that although Lisa Yourman could not be present for the Board meeting, she wanted the Board to know of her interest in serving on the Operations Committee. F. Giannattasio said he would be interested in serving on the Operations Committee. S. Kelly said Horizon would be willing to give up its position on the Operations Committee.

Board members voted for four members for the Operations Committee. Ballot results were as follows:

DOBI:	6 votes
Aetna USHealthcare:	5 votes
Guardian:	5 votes
F. Giannattasio:	6 votes
L. Yourman:	1 vote
Horizon:	1 vote

Committee membership is as follows:
DOBI
Aetna USHealthcare
Guardian
F. Giannattasio

VII. Other

W. Sanders said a copy of the Advisory Bulletin Log was included in Board materials.

W. Sanders said Fortis expressed an interest in meeting with the Operations Committee to discuss Net Investment Income issues relative to the 1997/1998 Exhibit K filing. Since Operations Committee members are already in Trenton for the IHC Board meeting, the best time seemed to be following the March IHC Board meeting. The Board asked that before agreeing to a meeting, however, W. Sanders should advise Fortis that the Committee is only willing to meet if Fortis provides information concerning its position prior to the meeting so the Committee has an opportunity to review it and if the information is different than that already provided to the Board.

VIII. Executive Session

W. Sanders said the Board had to discuss Executive Session minutes and to receive advice from counsel and asked for a motion to begin Executive Session.

G. Simon offered a motion that the Board begins Executive Session. D. Farkus seconded the motion. The Board voted in favor of beginning Executive Session.

W. Sanders said there would not be any discussion in Open Session following the Executive Session.

[Break: 11:35 a.m. – 11:45 a.m.]
[Executive Session: 11:45 a.m.– 12:10 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
March 13, 2001

Directors Participating: Darrel Farkus (Oxford Health Insurance); Frank Giannattasio; Sandy Herman (Guardian); Sandi Kelly (Horizon Blue Cross Blue Shield of New Jersey); Jane Majcher (Department of Banking and Insurance); Mary McClure (AUSHC); Eileen Shrem.

Others Participating: Ellen DeRosa, Deputy Executive Director; DAG Eleanor Heck (DOL); Pearl Lechner, Program Accountant; Wardell Sanders, Executive Director.

I. Call to Order

W. Sanders called the Board meeting to order at 10:00 a.m. W. Sanders announced that notice of the meeting had been sent to 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

February 13, 2001

J. Majcher offered a motion to approve the draft minutes of the Open Session of the February 13, 2001 Board meeting, as amended. M. McClure seconded the motion. The Board voted in favor of the motion, with E. Shrem abstaining.

VIII. Report of Staff

Expense Report
S. Kelly offered a motion to approve the payment of the expenses shown on the March 13, 2001 expense report. D. Farkus seconded the motion. The Board voted unanimously in favor of the motion.

IHC Regulation Update
W. Sanders said that Governor's Counsel was still reviewing the draft rule proposal that would allow for $5,000 and $10,000 deductible options for plan A/50.

Exhibit K Filings (Market Share and Net Paid Gain/Loss Report)
W. Sanders said that Exhibit K or non-member certification filings were due by March 1, 2001. He reported that a number of filings had not yet been received. For the 1997/1998 assessment period, there were 104 member carriers. To date, only 26 carriers filed Exhibit K stating that they were IHC Program members. W. Sanders said that carriers that sold IHC plans during 1999/2000 had filed Exhibit K, as required. He said he was contacting carriers that had failed to file either an Exhibit K or a non-member certification.

Spreadsheet of Losses
W. Sanders said the total reported losses for 1999/2000 was $9,369,864.08. He noted that carriers that reported losses have experienced decreasing enrollment. By way of comparison, he noted that losses paid for 1997/1998 totaled $29,771,141.52.

W. Sanders explained that Fortis calculated its reported losses using its method of calculating net investment income. He said Fortis agreed to calculate the loss amount using the method consistent with the Board's interpretation of its regulations.

S. Kelly asked if it would be necessary for carriers that are not seeking reimbursement to report net investment income on Exhibit K. P. Lechner said that it would be helpful if the carriers reported net investment income so that the Board would have a record as to the net investment income as of a specific moment in time.

W. Sanders said that carriers that filed for reimbursement would be required to submit a Performance Report by April 1, 2001.

Minimum Enrollment Targets
W. Sanders said the minimum enrollment targets for 2001/2002 would hopefully be sent out around May 1, 2001.

TMG 1996 Loss Audit
W. Sanders said Scott Sanders of Deloitte & Touche (D&T) reported that TMG responded to all outstanding requests. W. Sanders said that D&T hoped to have the audit completed within the next few weeks. W. Sanders explained that TMG backed out all prescription drug rider claim payments, about $100,000. By backing out those claims payments, no carrier paying an assessment would be providing reimbursement for such claims.

IX. Report of TAC

Rate Filings
S. Kelly said that TAC considered three rate filings, one each from Celtic, Horizon and National Health and that TAC recommended that the filings be found complete.

J. Majcher offered a motion to accept the recommendation from TAC and finding the filings from Celtic, Horizon and National Health as complete. S. Herman seconded the motion. The Board voted in favor of the motion with S. Kelly abstaining from the vote with respect to the Horizon filing.

Open Enrollment Period issues

S. Kelly said that TAC considered whether the annual October Open Enrollment Period should be moved ahead to November to give consumers a better chance of knowing what the rates for a January 1 effective date might be. She said TAC did not believe there would be any problem with moving the period ahead one month. She said TAC suggested that rate sheets showing January rates should be available in November so consumers could make informed decisions regarding the plans they are considering. The rate sheets would have a caveat noting that the consumer should check with the carriers to make sure the rates have not been changed. F. Giannattasio expressed concern that the consumers would not know the exact rates that would be in effect for a January 1 effective date. The Board agreed that the Open Enrollment period should be moved ahead to November and that January rates should be made available with the suggested caveat.

S. Kelly explained that the Open Enrollment period is the only time a consumer who has an existing IHC plan may elect to upgrade to a richer IHC plan. According to the IHC Board's regulations, moving from a non-HMO plan to an HMO plan would be considered to be an upgrade and thus could only occur during the Open Enrollment Period. Although rates for HMO coverage tend to be less expensive than rates for some non-HMO coverages, the coverage under the HMO plan is richer than coverage under the non-HMO plan. She said TAC considered whether someone who is covered under an non-HMO plan and gets a rate increase should be allowed to switch to the cheaper HMO plan. She reported that TAC did not favor allowing consumers to be allowed to switch to an HMO plan from a non-HMO plan at any time other than the Open Enrollment Period due to adverse selection. E. DeRosa said TAC gave an example of selection against the HMO. The HMO covers maternity care subject to a single $25 copayment. Thus, a consumer could move to the HMO just to have the maternity charges covered and then switch back to the non-HMO plan. E. DeRosa commented that the only time selection would occur in this instance would be if the person happened to get the rate increase under the non-HMO plan at the same time as the person needed coverage for maternity.

D. Farkus said he believed consumers would make a decision to move to the HMO based purely on economic factors. He said he believed consumers should be permitted to move to the HMO to be able to get a less expensive rate.

S. Kelly noted that TAC also believed there would be selection against the non-HMO carriers. TAC suggested that the people who would move to the HMO would be the healthier lives and thus the remaining pool of insured under indemnity coverage would further erode possibly causing increased rates.

There was some Board discussion suggesting that a person could be required to move to a less expensive non-HMO plan first, and only when there are no other non-HMO options, move to the HMO.

The Board asked TAC to please discuss the issue again. The Board agreed to discuss the issue further during the April Board meeting.

V. Executive Session

W. Sanders said the Board had to discuss Executive Session minutes and to receive advice from counsel and asked for a motion to begin Executive Session.

S. Herman offered a motion that the Board begins Executive Session. J. Majcher seconded the motion. The Board voted in favor of beginning Executive Session.

W. Sanders said there would not be any discussion in Open Session following the Executive Session.

[Break: 11:40 a.m. – 11:45 a.m.]
[Executive Session: 11:45 a.m.– 12:10 p.m.]

VI. Close of Meeting

M. McClure offered a motion to adjourn the Board meeting. J. Majcher seconded the motion. The Board voted unanimously in favor of accepting the motion. The meeting adjourned at 12:05 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
April 10, 2001

Directors Participating: Frank Giannattasio; Sandy Herman (Guardian); Sandi Kelly (Horizon Blue Cross Blue Shield of New Jersey); Jane Majcher (Department of Banking and Insurance); Patricia Mastrangelo (Oxford Health Insurance); Mary McClure (AUSHC); Eileen Shrem; Lisa Yourman.

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

I. Call to Order

W. Sanders called the Board meeting to order at 10:05 a.m. W. Sanders announced that notice of the meeting had been sent to 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

March 13, 2001

E. Shrem offered a motion to approve the draft minutes of the Open Session of the March 13, 2001 Board meeting, as amended. S. Herman seconded the motion. The Board voted in favor of the motion, with L. Yourman abstaining.

X. Report of Staff

1996 TMG Reimbursable Loss Audit
W. Sanders reported that he expected that the 1996 reimbursable loss audit report of TMG would be completed shortly and that the Board could vote on the audit during the May 2001 meeting.

Expense Report
E. Shrem offered a motion to approve the payment of the expenses shown on the April 10, 2001 expense report. L. Yourman seconded the motion. The Board voted unanimously in favor of the motion.

IHC Regulation Update

W. Sanders said that Governor's Counsel was still reviewing the draft rule proposal that would allow for $5,000 and $10,000 deductible options with Plan A/50. He said that as of two weeks ago it appeared the review would be completed very soon. E. Shrem and Joe Camargo suggested that W. Sanders should supply Governor's Counsel with a copy of the enrollment report that shows enrollment steadily declining. Such data would further substantiate the need for the high deductible options.

Exhibit K Filings (Market Share and Net Paid Gain/Loss Report)

W. Sanders said that the due date for carriers to file either an Exhibit K or a Non-Member Certification filing was March 1, 2001. He reported that in spite of follow-up, a few filings had still not yet been received. He said he was pursuing the carriers that had not yet filed the report.

Performance Reports

W. Sanders noted that carriers that are seeking reimbursement for losses paid in 1999/2000 were required to file a performance report by April 1, 2001. He said that several carriers had not yet made the required filing. W. Sanders said he would send the reports to the Operations Committee for review.

Certification of Non-Group Persons

E. DeRosa said that carriers that requested an exemption from the reimbursable loss assessment for 1999/2000 were required to file a Certification of Non-Group Persons. She noted that most of the carriers that were required to file the Certification failed to do so on a timely basis. In addition, she reported that she was checking the enrollment information provided on the Certification against enrollment data included on Exhibit K and on the Quarterly Enrollment reports, and noted some significant discrepancies. She said she would write to each carrier that submitted information that is inconsistent with other information and request that the discrepancies be explained, or that a corrected Certification of Non-Group Persons be submitted.

M. McClure suggested that it would be helpful to provide carriers with a template of the certification. E. DeRosa said that she could do that for the next two-year calculation period. She noted that the regulation provides the exact language a carrier must use in the Certification, so the template would merely state text already given in regulation.

Fortis: Net Investment Income Calculation

W. Sanders said Fortis agreed to calculate the loss amount using the method consistent with the Board's interpretation of its regulations and that the calculation was to have been provided prior to the Board meeting. He said the calculation was not received.

1997/1998 and 1999/2000 Reimbursable Loss Audit Status Report

W. Sanders said Scott Sanders of Deloitte & Touche would be providing monthly status reports of the progress of the reimbursable loss audits for 1997/1998 and 1999/2000. The first status report was included in the Board materials. He explained that "AUP" as shown on the status report means Agreed Upon Procedures being performed in lieu of a full audit for those carriers whose requested reimbursement was less than $1 million.

Enrollment Reports

J. Petto said the Board materials included a series of enrollment memos for 2Q, 3Q and 4Q 2000. Due to some reporting errors, she cautioned the Board that the data contained in each memo would not "foot out" down the page.

J. Petto said she compiled enrollment data by age and gender and included a copy of the comparison in the Board materials. She noted the decrease in enrollment for persons less than 50 years of age. The Board agreed that the comparison data should be provided to the Commissioner.

E. Shrem said that the Registered Health Underwriter text she was using to prepare for an exam discussed community rating and stated that community rating was harmful to the market.

XI. Report of TAC

Rate Filings

S. Kelly said that TAC considered one rate filing, from Fortis and that TAC recommended with a vote of 5-0 that the filing be found complete.

S. Kelly offered a motion to accept the recommendation from TAC and finding the filing from Fortis as complete. S. Herman seconded the motion. The Board voted in favor of the motion.

1999 Refund Plan

S. Kelly said TAC reviewed an additional refund plan for 1999, from CNA, and recommended that the refund plan be approved. She said the refund amount was $12,127.

M. McClure offered a motion to approve the refund plan for 1999 submitted by CNA. F. Giannattasio seconded the motion. The Board voted unanimously in favor of the motion.

Open Enrollment Period issues

S. Kelly said that TAC again considered whether the Open Enrollment period should be the only time a consumer who has an existing non-HMO plan may elect to upgrade to an HMO plan. According to the IHC Board's current regulations, moving from a non-HMO plan to an HMO plan would be considered to be an upgrade and thus could only occur during the Open Enrollment Period. She said TAC recognized that any decision regarding a change to this regulation would be a policy decision to be made by the Board. TAC discussed what protections might be useful in the event the Board would decide to allow movement from a non-HMO plan to an HMO plan at a time other than the fixed Open Enrollment Period.

S. Kelly said TAC believed one alternative to allowing movement from a non-HMO to an HMO in the event of a rate increase would be to create a second open enrollment period. With two opportunities for enrollment, a consumer who receives a notice of a rate increase would have to wait no more than 6 months to move to the HMO plan.

S. Kelly said TAC believed another safeguard might be to allow consumers to switch from a non-HMO plan to an HMO plan only during the month coincident with the rate increase. Thus, a consumer who receives a rate increase effective May 1 could not decide in July to switch from the non-HMO plan to the HMO plan.

S. Kelly said TAC also considered whether a change in rate due to a change in family status should generate an opportunity to switch from a non-HMO plan to an HMO plan. She said TAC did not view a change in rate due to the addition of one or more family members to be a rate increase and therefore movement should not be allowed at that time. P. Lechner suggested that a consumer who gets married or has a child is likely to want an HMO at that time since HMO coverage encourages well care.

L. Yourman said she would be concerned with a rule that would not give a consumer ample time to secure the HMO coverage. She said that if an application were received in late March the carriers would not be able to provide an April 1 effective date. E. DeRosa explained that the IHC regulations require a carrier to accept an application and premium as late as March 31 and still give an April 1 effective date.

S. Herman suggested that the Board should look into redefining what constitutes an upgrade. He noted that to a consumer, HMO coverage is not richer than non-HMO coverage since HMO coverage restricts consumers to use of the HMO network for non-emergency care. He expressed concern, however, that a consumer might switch to the HMO for less expensive rates then switch back to the non-HMO when he or she is sick and wants to use providers outside the network. He asked if there could be some restriction on movement back to a non-HMO plan following the switch to the HMO plan. W. Sanders said he would send that issue to the Legal Committee for consideration.

The Board agreed to consider that a consumer should be allowed to switch from a non-HMO plan to an HMO plan at any time, with a restriction being imposed on movement back to the non-HMO plan, if the Legal Committee finds that such a restriction would be permissible. W. Sanders should draft the necessary rule proposal.

V. Executive Session

W. Sanders said the Board had to receive advice from counsel and asked for a motion to begin Executive Session.

E. Shrem offered a motion that the Board begin Executive Session. L. Yourman seconded the motion. The Board voted in favor of beginning Executive Session.

W. Sanders said there would not be any discussion in Open Session following the Executive Session.

[Break: 11:20 a.m. – 11:35 a.m.]
[Executive Session: 11:35 a.m.– 12:20 p.m.]

VII. Final Business and Close of Meeting

M. McClure offered a motion to issue an order to United States Life in response to its appeal of the 1993, 1994, 1995, 1996 and 1997/1998 assessments, agreeing to stay the appeal pending the outcome of CIGNA's appeal of the Board's Readoption with Amendments. S. Kelly seconded the motion. The Board voted unanimously in favor of the motion.

E. Shrem offered a motion to adjourn the Board meeting. L. Yourman seconded the motion. The Board voted unanimously in favor of accepting the motion. The meeting adjourned at 12:20 p.m.