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
May 8, 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 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 quorum was present.

II. Minutes

April 10, 2001

S. Kelly offered a motion to approve the draft minutes of the Open Session of the April 10, 2001 Board meeting, as amended. J. Majcher 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 May 8, 2001 expense report. J. Majcher 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 the deadline for filing rule proposals with the Office of Administrative Law under

the old process would be June 15, 2001. If the proposal cannot be submitted by that date, it will be subject to the new process for filing rule proposals, a process the Board previously discussed.

Legislative Update

W. Sanders briefly discussed A.2791, which would require carriers in the individual market to offer a "bare bones" plan. He noted that the sponsors of the bill believe that the low cost associated with a bare bones plan would make insurance more accessible to individuals who do not have the means to afford the existing standard plans. He noted that the bare bones plan would not be subject to pure community rating, but would rather be rated using a 3.5:1 rate band, where factors of age, gender and geographic location would be permissible rating factors.

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 and that the Preliminary Notice of Assessment was supposed to be released by May 1, 2001. However, as the data carriers reported on Exhibit K was cross-checked against other data submitted by the carriers, a significant number of reporting discrepancies were noted. W. Sanders said he contacted the carriers for explanations of the discrepancies, and corrected filings, as appropriate. He reported that there were still some outstanding net earned premium issues to be resolved. He suggested that if the remaining discrepancies could be resolved in advance of the June Board meeting that the Board may want to hold a special meeting to consider the Preliminary Notice of Assessment so it could be released before the June Board meeting.

W. Sanders noted that carriers would have 30 days from the date of the Preliminary Notice of Assessment in which to file requests for an exemption.

Fortis: Calculation of Net Investment Income

W. Sanders said that Fortis reported approximately $4.2 million in losses for 1999/2000, where that loss amount was calculated using the methodology for net investment income calculation Fortis has argued was appropriate. Fortis agreed to perform the calculation of the losses using the methodology set forth in the Board's regulation, and using the Board's interpretation of the phrase "inception to date." Using the Board's methodology for calculation of net investment income, Fortis's loss amount for 1999/2000 would be approximately $1.2 million.

Date for July Board Meeting

W. Sanders noted that Good Faith Marketing Report filings are due July 1, 2001. In order to give the Marketing Committee ample time for the review of those filings prior to the July Board meeting, he suggested that it would be helpful to delay the

July meeting until later in the month. The Board agreed. The July meeting will be held on July 31, 2001.

Other

DAG E. Heck reported that her office would be moving to another location in Trenton.

IV. Report of the Operations Committee

M. McClure reported that the Operations Committee met the prior day and considered the status of the audits and agreed upon procedures for the 1997/1998 and 1999/2000 assessment cycles. She reported that the Committee discussed an aspect of the Celtic audit that indicated there were approximately $1.6 million in network fees that had been reported as claims, over the 4-year period. She said the Committee asked Scott Sanders of Deloitte & Touche (D&T) to find out what Celtic means by "network fees," and that the Board would then determine whether such fees are reported as claims for the purposes of statutory reporting.

M. McClure said that some of the carriers had failed to provide D&T with all of the requested information. She said the Committee directed W. Sanders to write to those carriers to remind them of the necessity of cooperating with the audit as a prerequisite for any reimbursement. M. McClure said the Committee suggested that the Board not pay 80% of the requested amount prior to completion of the audits as had been done in the past. The Committee believed that withholding any payment until completion of the audits would create incentive for carriers to cooperate with the audits.

M. McClure said the Committee also considered the 1996 audit report of Clarica (formerly TMG). She said TMG originally sought approximately $3.1 million in reimbursable losses. As a result of the audit, the reimbursable loss amount was reduced to approximately $2.8 million. Clarica signed the management representation letter, which signaled Clarica's agreement with the audit report.

S. Kelly offered a motion that the Board accept the 1996 audit report of TMG. J. Majcher seconded the motion. The Board voted in favor of the motion, with D. Farkus and L. Yourman abstaining.

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 might be a short discussion in Open Session following the Executive Session.

[Executive Session: 10:38 a.m. – 11:45 a.m.]

VI. Final Business and Close of Meeting

W. Sanders said that the Legal Committee recommended that just and NJ Kidcare Part A was considered Medicaid since it is an expansion of Medicaid, NJ FamilyCare Part A should be considered as Medicaid. Since neither NJ Kidcare Part D nor NJ FamilyCare Part D are expansions of Medicaid, enrollment in Part D of NJ KidCare and NJ FamilyCare should not be included as non-group enrollment. Since the lives do not count as Medicaid lives, the premium for KidCare Part D and FamilyCare Part D would not count as Medicaid premium in determining whether a carrier was a "member" of the IHC Program. Therefore, if a carrier largely serves in the Medicaid market and participates in Kidcare Part D and/or NJ FamilyCare Part D, the premium from Part D could make the Medicaid carrier a member of the IHC Program, depending on the volume of the Part D premium as compared to Medicaid premium. W. Sanders said the Board intends to include this guidance in its regulations.

E. Shrem offered a motion to adjourn the Board meeting. F. Giannattasio seconded the motion. The Board voted unanimously in favor of accepting the motion. The meeting adjourned at 11:50 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
June 14, 2001

Directors Participating: Loretta Curry (Horizon Blue Cross Blue Shield of New Jersey); Darrel Farkus (Oxford Health Insurance); Frank Giannattasio (arrived at 11:30 a.m.); Sandy Herman (Guardian); Jane Majcher (Department of Banking and Insurance); Mary McClure (AUSHC).

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 10:03 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 quorum was present.

II. Minutes

May 8, 2001

The Board discussed a minor change to the draft minutes. DAG E. Heck asked that a vote on the minutes be delayed until after Executive Session. The Board agreed.

V. Report of Staff

Expense Report
P. Lechner noted that the expense for the 1996 claims audit of TMG would be paid by TMG, as previously agreed to by TMG.

S. Herman offered a motion to approve the payment of the expenses shown on the May 8, 2001 expense report. M. McClure 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.

Legislative Update

W. Sanders briefly discussed S.13, which would require carriers in the individual market to offer a "bare bones" plan. He said it was heard in the Senate Banking and Insurance Committee and was voted out of Committee on June 4, 2001.

W. Sanders said that S.1769 would exempt HMOs that were established under the UMDNJ Flex Act from the IHC assessment. M. McClure asked if the Board would comment on this bill. W. Sanders reminded the Board that any comments it might want to make to the Legislature would have to be sent through the Department. He said he would give a copy of the bill to Board members. Additionally, he said he planned to attend the hearing on the bill that was scheduled for that afternoon, and would advise the Board of the outcome of the hearing.

United States Life Order

W. Sanders noted that the Board materials included a copy of the Order that had been issued to United States Life relative to its appeal of loss assessments for years 1993 through 1997/1998.

Clarica Withdrawal

E. DeRosa reported that Clarica (formerly TMG) filed a request to withdraw from the IHC market. E. DeRosa noted that the filing was unique since Clarica had had neither premium nor enrollment since approximately 1997. Since there were no inforce plans, no notice to policyholders and producers would be needed. E. DeRosa said the recommendation of staff was to find the filing acceptable.

J. Majcher offered a motion to accept the withdrawal filing from Clarica. L. Curry seconded the motion. The Board voted in favor of the motion, with D. Farkus abstaining.

VI. Report of the Technical Advisory Committee (TAC)

E. DeRosa said TAC met twice since the last Board meeting to consider Certification of Non-Group Persons filings during one meeting, and rate filings during a second meeting.

Certification of Non-Group Persons

E. DeRosa reminded the Board that carriers that had requested conditional exemptions for the 1999/2000 calculation period were required to submit a Certification of Non-Group Persons by March 1, 2001. She said that the requirements for the Certification starting in 1999/2000 required carriers to certify to enrollment on a quarterly basis. She said that as a result, it was easy not just to compare the data to enrollment data on Exhibit K, but also to compare the Certification's enrollment information to quarterly enrollment data as provided on Exhibit L. She said HMO carriers also report enrollment to the Managed Care Bureau of the Department of Banking and Insurance and that she used that data for comparison purposes as well. E. DeRosa said she contacted carriers that reported inconsistent data and asked them to address the inconsistencies.

E. DeRosa said TAC reviewed the Certification of Non-Group Persons data that was used to calculate the percentage of non-group person target satisfaction. She said TAC recommended that the Board accept the Certifications as submitted by the seven carriers identified on the TAC report.

M. McClure offered a motion to accept the recommendation of TAC and accept the Certification of Non-Group persons filings from the listed carriers. L. Curry seconded the motion. The Board voted separately on each carrier's filing.

Aetna US HealthCare:	**4 in favor, 1 abstaining (M. McClure)**
AmeriHealth:	**5 in favor**
CIGNA:	**5 in favor**
Guardian:	4 in favor, 1 abstaining (S. Herman)
Horizon:	**4 in favor, 1 abstaining (L. Curry)**
Oxford:	**4 in favor, 1 abstaining (D. Farkus)**
United:	**5 in favor**

Rate Filings

E. DeRosa said TAC reviewed a number of rate filings, as listed on the TAC report. She said TAC recommended that all be found complete. She noted that one filing included rates for plan options that the Board had discontinued. She said TAC asked that staff write to the carrier to seek an explanation for the inclusion of those rates.

S. Herman offered a motion to accept the recommendation of TAC and find the rate filings listed on the TAC report as complete. M. McClure seconded the motion. The Board voted separately on each carrier's filing.

Aetna Life:	**4 in favor, 1 abstaining (M. McClure)**
Horizon (two filings):	**4 in favor, 1 abstaining (L. Curry)**
Oxford (two filings):	4 in favor, 1 abstaining (D. Farkus)
United (two filings):	5 in favor

VII. Executive Session A

W. Sanders said the Board would need to move into Executive Session to discuss advice from counsel. He said Open Session would resume following a brief Executive Session.

D. Farkus offered a motion to begin Executive Session. M. McClure seconded the motion. The Board voted unanimously in favor of the motion.

[Executive Session: 10:40 a.m. – 11:05 a.m.]

[Break 11:05 a.m. – 11:15 a.m.]

VIII. Report of the Operations Committee

W. Sanders said the Committee considered the DRAFT Notice of Preliminary Assessment for the 1999/2000 calculation period. He provided the Board with an explanation of the nature of the data appearing in each column of the spreadsheet.

W. Sanders explained that carriers whose names are in italics typeface are carriers from whom he is awaiting information.

Fortis Benefits and Fortis Insurance reported information to the IHC Program that differed significantly from information reported to the "Under 50 Program." He said he requested, but has not yet received, an explanation of the discrepancy.

HealthNet (formerly Foundation) has indicated that it believed it was an exempt carrier. W. Sanders said the Board did not receive any exemption request from this carrier in response to any of the three opportunities the Board extended to carriers. Further, he said the carrier did not submit a Certification of Non-Group Persons.

John Alden reported information to the IHC Program that differed significantly from information reported to the "Under 50 Program." He said he requested, but has not yet received, an explanation of the discrepancy.

New York Life reported negative net earned premium. W. Sanders said he asked Bob Vehec, an actuary with the DOBI, to advise as to whether negative premium can be appropriate.

Trustmark excluded premium attributable to a "minimum premium plan" and W. Sanders said he was seeking clarification as to why Trustmark believed such premium should not be considered as net earned premium.

United States Life failed to include premium from "excess of loss coverage" on Exhibit K.

M. McClure noted that Prudential Insurance Company was assigned a target in spite of the fact that Prudential was never in the IHC market and withdrew from the health market in New Jersey. E. DeRosa explained that the targets are set based on each carrier's percentage of net earned premium. Since Prudential reported net earned

premium on the 1999/2000 Exhibit K, Prudential was assigned a target number of non-group lives. E. DeRosa explained that the assigning of a target does not obligate a carrier to participate in the IHC market so as to enroll the target number of lives. As an alternative to entering the market and enrolling non-group lives, a carrier may elect to pay an assessment for reimbursable losses incurred by those carriers that do enroll non-group person lives.

W. Sanders said that as a result of the outstanding issues the Board would delay releasing the Preliminary Notice of Assessment. He said he was hopeful that the outstanding issues could be resolved within the next couple of weeks. If that occurs, he suggested that the Board could meet via teleconference to vote on the preliminary Notice of Assessment rather than delay the vote until the July Board meeting which would not be until July 31, 2001.

M. McClure said the Operations Committee also considered the status of the reimbursable loss audits being performed by Deloitte & Touche (D&T). She commented that the audits seemed to be progressing with the exception of the audit of Protective Life. Protective Life has not responded to D&T's requests for information. She noted that there is an outstanding issue with Celtic concerning a network fee issue. She said Celtic was putting together an explanation of the fee.

W. Sanders said all carriers, except Principal, seeking reimbursement for 1999/2000 reimbursable losses provided the required Performance Report. Principal has advised that it cannot certify to numbers on the report until after completion of the audit.

W. Sanders said that HealthNet checked off on Exhibit K that it was an exempt carrier. He said that the Board did not have a record of having received an exemption request. He said that he would write to HealthNet to request evidence that it had filed a request for an exemption.

VII. Executive Session B

W. Sanders said the Board needed to receive advice from counsel and consider a personnel matter and asked for a motion to begin Executive Session.

J. Majcher offered a motion that the Board begin Executive Session. F. Giannattasio seconded the motion. The Board voted in favor of beginning Executive Session.

W. Sanders said there might be a short discussion in Open Session following the Executive Session.

[Executive Session: 11:50 a.m. – 12:22 p.m.]

VIII. Final Business and Close of Meeting

Minutes (Continued)

J. Majcher offered a motion to approve the draft minutes of the Open Session of the May 8, 2001 Board meeting, as amended. F. Giannattasio seconded the motion. The Board voted unanimously in favor of the motion.

D. Farkus offered a motion to adjourn the Board meeting. F. Giannattasio seconded the motion. The Board voted unanimously in favor of accepting the motion. The meeting adjourned at 12:22 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
July 31, 2001

Directors Participating: Robert Benkert (Oxford Health Insurance); Sandi Kelly (Horizon Blue Cross Blue Shield of New Jersey); Frank Giannattasio; Sandy Herman (Guardian); 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, Joanne Petto, Assistant Director.

I. Call to Order

E. DeRosa called the Board meeting to order at 10:05 a.m. She 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. Executive Session A

E. DeRosa said the Board would need to have a brief Executive Session to receive advice from counsel before discussing any of the issues listed on the Agenda. She said the Board would conduct Open Session business immediately following the Executive Session.

S. Herman offered a motion that the Board begin Executive Session. S. Kelly seconded the motion. The Board voted in favor of the motion.

[Executive Session A: 10:06 a.m. – 10:35 a.m.]

III. Minutes

June 14, 2001

S. Herman offered a motion to approve the Open Session minutes from the June 14, 2001 Board meeting, as amended. M. McClure seconded the motion. The Board voted in favor of the motion, with E. Shrem abstaining.

IV. Report of Staff

Expense Report

P. Lechner explained the reasons for some of the large expenses noted on the July 31, 2001 expense report.

S. Kelly offered a motion to approve the payment of the expenses shown on the July 31, 2001 expense report. F. Giannattasio seconded the motion. The Board voted in favor of the motion, with E. Shrem abstaining with respect to reimbursement to be paid to her.

Enrollment Data for 1Q2001

J. Petto noted the decrease in enrollment as experienced by both the IHC and the SEH Programs for first quarter 2001. In response to an inquiry from F. Giannattasio regarding why people may be dropping coverage, M. McClure noted that a Robert Wood Johnson-funded survey studying the individual market may disclose some of the reasons. E. Shrem commented on the rate increases. S. Kelly commented that the Board has attempted to take action intended to retain lives in the IHC market, by recommending modified community rating, and the high deductible plans.

Legislative Update

E. DeRosa said that S.1769 would exempt HMOs that were established under the UMDNJ Flex Act from the IHC assessment. She said that W. Sanders provided a copy of the bill to Board members after the June meeting. E. DeRosa asked if Board members wished to comment on the bill. S. Kelly said she did not think it appropriate to let carriers out of the IHC assessment. Other Board members agreed. The Board asked that staff draft a letter for the consideration of the Board during the September Board meeting to express the Board's opposition to the bill.

E. DeRosa said that P.L. 2001, c.130 terminated the subsidy for any remaining persons covered under IHC plans through Health Access and that such persons would be eligible for coverage under NJ FamilyCare. She said that unless the members purchase IHC coverage on their own, the loss of the subsidy would lead to further decreases in IHC enrollment.

[Break: 10:52 a.m. – 11:00 a.m.]

V. Report of the Marketing Committee

E. DeRosa said the Marketing Committee met at the offices of the Department of Banking and Insurance on July 11, 2001 and again on July 26, 2001 to consider the 1999/2000 Good Faith Marketing Reports. Although the filing of the reports was delayed until July 2, 2001 due to the fact that July 1 fell on a Sunday, one carrier, CIGNA, failed to file the report on a timely basis. She said four carriers enrolled less than 50% of the assigned target of non-group persons for 1999/2000, and each of the four carriers filed reports.

E. DeRosa referred the Board to the Report of the Marketing Committee that included the Committee's recommendations as well as a copy of the regulation, N.J.A.C. 1:20-9.6 and the review checklist that the Committee used to evaluate the reports. She explained that the checklist simply lists the requirements set forth in the regulation. E. DeRosa reported the findings of the Committee with respect to each of the Good Faith Marketing reports.

CIGNA

E. DeRosa said that CIGNA ran a series of eight different ads in various major and local newspapers in New Jersey and some business journals, during both 1999 and 2000, and all of these ads specifically addressed the availability of individual health coverage in New Jersey.

E. DeRosa said the Committee recommended that the Board accept the CIGNA 1999/2000 Good Faith Marketing report because the report demonstrated that CIGNA undertook a significant media advertising campaign, in proportion to its minimum enrollment share, in direct support of sales of standard individual health benefit plans in New Jersey.

J. Majcher offered a motion to accept the recommendation of the Marketing Committee and accept the 1999/2000 Good Faith Marketing report submitted by CIGNA. F. Giannattasio seconded the motion. The Board voted unanimously in favor of the motion.

Guardian

[S. Herman recused himself from the meeting for the consideration of the Guardian report.]

E. DeRosa said Guardian ran an ad that specifically addressed the availability of individual coverage in New Jersey in a range of newspapers and magazines in New Jersey and in the metropolitan area during both 1999 and 2000. In addition, she said Guardian reported use of the web site, various consumer materials, and a press release, all of which specifically addressed individual coverage in New Jersey.

E. DeRosa said the Committee recommended that the Board accept the Guardian 1999/2000 Good Faith Marketing report because the report demonstrated that Guardian undertook a significant media advertising campaign, in proportion to its

minimum enrollment share, in direct support of sales of standard individual health benefit plans in New Jersey.

E. Shrem offered a motion to accept the recommendation of the Marketing Committee and accept the 1999/2000 Good Faith Marketing report submitted by Guardian. M. McClure seconded the motion. The Board voted in favor of the motion, with F. Giannattasio abstaining.

[S. Herman returned to the meeting.]

Oxford

[R. Benkert recused himself from the meeting for the consideration of the Oxford report.]

E. DeRosa stated that the Oxford representative on the Marketing Committee likewise recused himself from the Committee's review and discussions of the Oxford report.

E. DeRosa noted that the Board's regulations provide two means carriers may use to satisfy the standards of good faith marketing. The two carriers whose reports were previously discussed chose to rely upon advertising, promotion and marketing efforts. Oxford's report did not demonstrate the use of any advertising, promotion or marketing efforts in support of the sale of individual plans in New Jersey. However, the report did demonstrate that it used insurance producers to market the

individual plans in New Jersey. Oxford provided copies of materials provided to producers to encourage them to sell individual coverage and also provided specific information concerning the payment of commissions.

E. DeRosa said the Committee recommended that the Board accept the Oxford 1999/2000 Good Faith Marketing report because the report demonstrated that Oxford undertook a significant efforts, in proportion to its minimum enrollment share, to educate licensed insurance producers about its standard individual health benefit plans in NJ and offered to pay competitive commission schedules for the sales of such plans and competitive rates.

J. Majcher offered a motion to accept the recommendation of the Marketing Committee and accept the 1999/2000 Good Faith Marketing report submitted by Oxford. E. Shrem seconded the motion. The Board voted unanimously in favor of the motion.

[R. Benkert returned to the meeting.]

United Healthcare

E. DeRosa said United Healthcare provided information concerning the use of its web site that was used to market individual coverage. She said the Committee noted that information on individual health coverage was prominently included on the site and that the site provides easy access to detailed information on individual coverage.

In addition, United Healthcare's brand ads contained a toll free number and the web address. Upon calling the toll free number the Committee learned that the first option a caller hears is an inquiry as to whether the caller is interested in individual coverage. The Committee noted that after only a short time of listening to prompts to direct the caller to information on individual coverage in New Jersey, the automated portion of the call ceased and the caller was connected to a person who was able to answer questions and ready to mail information.

E. DeRosa said the Committee recommended that the Board accept the United Healthcare 1999/2000 Good Faith Marketing report because the report demonstrated that United Healthcare undertook a significant marketing campaign, in proportion to its minimum enrollment share, in direct support of sales of standard individual health benefit plans in New Jersey.

J. Majcher offered a motion to accept the recommendation of the Marketing Committee and accept the 1999/2000 Good Faith Marketing report submitted by United Healthcare. E. Shrem seconded the motion. The Board voted unanimously in favor of the motion.

VI. Presentation from Ivan Punchatz, Esq.

E. DeRosa said that Mr. Ivan Punchatz, outside counsel for HealthNet, requested the opportunity to address the IHC Board. *[S. Herman left his seat at the Board table and went to sit with the audience.]*

Mr. Punchatz said he had come to speak on behalf of PHS and QualMed Plans for Health to address the issue of whether HealthNet should be granted an exemption for 1999/2000 even though the HealthNet request was submitted late. [Note:

HealthNet is the new name of the parent company of PHS and QualMed Plans for Health.]

Mr. Punchatz said he provided written information concerning why the Board should grant the exemption request submitted by his client. He said the request HealthNet submitted met the substantive standards of the requirement to file a request for an exemption. He acknowledged that the request had been filed late. However, he stated that denying the exemption request solely due to the fact it was not filed within 30 days of the date the Board notified carriers of the revised target of non-group person would be punitive and would result in a sharing of program losses that he characterized as not being equitable. Mr. Punchatz said that other program members would get a "windfall" and the reduced assessment liability would not be "earned."

Mr. Punchatz continued saying that any carrier sitting on the Board that would benefit from the denial of HealthNet's request for an exemption should recuse itself from any discussion and vote on whether the filing should be accepted.

Mr. Punchatz said that if the Board votes to grant the exemption it would be based on what HealthNet has done. If the Board denies the request, the denial would not be based on the marketplace but rather on an admitted error of his client. He noted that the Board kept changing the date for filing the request for an exemption, noting that carriers were asked to file three separate times.

Mr. Punchatz explained how the error occurred. He said the person who filed the request for the 1997/1998 period was no longer working for the company. He said Tom Messer said he called Ellen DeRosa on June 21, 2000 and that E. DeRosa told Mr. Messer HealthNet had an exemption. He contends that the requirement to file a request for an exemption in response to the Board's June 23, 2000 Advisory Bulletin was "buried" inside the Bulletin. The fact that HealthNet checked off on Exhibit K that it was an exempt carrier should be sufficient to show that HealthNet believed it had filed for an exemption. He said it was a simple mistake that HealthNet did not file a request for an exemption.

Mr. Punchatz speculated as to whether granting the exemption might set a precedent that other carriers might use in later years. He said he believed it would not. HealthNet sought exemptions in prior years. The "numbers" did not considerably change for this 1999/2000 period as compared to prior periods. HealthNet enrolled greater than 50% of its assigned target of non-group persons. He said HealthNet would suffer unduly if the exemption were to be denied. He said it was a question of form over substance. He repeated that other carriers would benefit from the denial of the exemption request.

Mr. Punchatz thanked the Board for its consideration and asked if there were any questions.

E. DeRosa asked Mr. Punchatz to identify the carrier members of the Board that he believed would benefit from the denial of the exemption in the form of a decreased assessment, and to explain how he believed the decrease would occur for such carriers. Mr. Punchatz said he was not familiar with the liability for each carrier and

could not say which carriers would benefit from the denial of the request. However, he said if any carriers would stand to benefit, they would know it, and should recuse themselves. E. DeRosa advised him that none of the carrier members of the IHC Board would benefit from the denial of the exemption request in the form of a reduced assessment liability.

VII. Executive Session B

E. DeRosa said the Board would need to move into Executive Session again to receive advice from counsel and to address a personnel issue. She said the Board would resume Open Session following the Executive Session.

E. Shrem offered a motion that the Board begin Executive Session. S. Kelly seconded the motion. The Board voted in favor of the motion.

[S. Herman recused himself from the meeting.]

[Executive Session: 11:40 a.m. – 12:30 p.m.]

IX. Final Business and Close of Meeting

[S. Herman recused himself from the meeting.]

E. DeRosa said the Board considered the information HealthNet and its counsel previously submitted as well as the presentation Mr. Punchatz gave earlier in the meeting. She said the IHC Board concluded the following:

Health Net failed to submit a timely written request for an exemption for the 1999/2000 two-year period in response to the October 1st Notice.

Health Net failed to submit a timely written request for an exemption for the 1999/2000 two-year period in response to the November 17th Notice.

Health Net failed to submit a timely written request for an exemption for the 1999/2000 two-year period in response to the June 23rd Notice.

Even if Ms. DeRosa had made the statements that Mr. Messer recorded in his e-mail,

such oral statements would be irrelevant in determining whether Health Net

submitted a timely written request for an exemption or in determining whether

Health Net should be granted an exemption.

Health Net's June 12, 2001 written request for an exemption for the 1999/2000 assessment cycle occurred after the close of the two-year calculation period and after the Exhibit K filings from all carriers, including those carriers seeking reimbursement, were due.

Health Net's June 12, 2001 written request for an exemption for the 1999/2000 assessment cycle and the 2001/2002 assessment cycle did not include all of the affirmative statements required by N.J.AC. 11:20-9.2(a).

The statutory provision for the loss assessment, N.J.S.A. 17B:27A-12, and the implementing regulations at N.J.A.C. 11:20-9.2 requires carriers in the individual market to elect in advance of the close of two-year cycle, and in advance of knowledge of what the losses will be in the market, whether the carrier will seek an exemption from losses.

E. Shrem offered a motion that the Board deny HealthNet's June 12, 2001 request for exemption for 1999/2000. F. Giannattasio seconded the motion. The Board voted unanimously in favor of the motion.

[S. Herman returned to the meeting.]

S. Kelly offered a motion for the Board to release the Preliminary Notice of Assessment and Notification of Non-Group person targets. J. Majcher seconded the motion. The Board voted unanimously in favor of the motion.

E. Shrem offered a motion to adjourn the Board meeting. F. Giannattasio seconded the motion. The Board voted unanimously in favor of accepting the motion. The meeting adjourned at 12:37 p.m.