FINAL
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
August 9, 2005

Directors participating: Darrel Farkus (Oxford); Sandi Kelly (Horizon BCBSNJ); Ulysses Lee (Guardian); Vicki Mangiaracina (DOBI); Mary McClure (Aetna Health).

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

I. Call to Order

W. Sanders called the meeting to order at 9:50 a.m. He announced that notice of the meeting had been published in two newspapers and posted at the Department of Banking and Insurance ("DOBI"), the DOBI website, and the Office of the Secretary of State in accordance with the Open Public Meetings Act. A quorum was present.

II. Minutes

June 6, 2005
M. McClure offered a motion to approve the Open Session minutes of the June 6, 2005 Board meeting, as amended. V. Mangiaracina seconded the motion. The Board voted unanimously in favor of the motion.

June 28, 2005
V. Mangiaracina offered a motion to approve the Open Session minutes of the June 28, 2005 Board meeting, as amended. S. Kelly seconded the motion. The Board voted unanimously in favor of the motion.

III. Report of Staff

Expense Report
V. Mangiaracina offered a motion to approve the payment of the expenses on the August expense report. M. McClure seconded the motion. The Board voted unanimously in favor of the motion.

Status of Readoption
W. Sanders said Acting Governor Codey extended the expiration of N.J.A.C. 11:20-2.17 until December 31, 2005 to afford additional time for dialog on the loss assessment methodology. W.

Sanders said that as a result of the extension, N.J.A.C. 11:20-2.17 was not included in the proposed readoption with amendments.

W. Sanders said he was working on preparing a separate proposal of N.J.A.C. 11:20-2.17 using the loss assessment methodology the Board voted to use so a proposal would be ready to file, as may be appropriate.

M. McClure suggested that it would be good to consider issuing a Bulletin to IHC member carriers to advise them of the status of the loss assessment.

Legislative Report
W. Sanders briefly summarized two Federal bills, HR 525 and HR 2355.

W. Sanders reported that S. 1912 and A. 3379 passed the Senate and the Assembly. The bills, which provide participation credit for Medicaid coverage in the small employer market, had been sent to the Governor for signature.

Good Faith Effort to Market the Basic and Essential Healthcare Plan (B&E Plan)
M. McClure recused herself with respect to the B&E marketing report filing from Aetna Life Insurance Company, citing a conflict of interest since the matter related to a filing submitted by her employer, Aetna Health, Inc.

E. DeRosa referred to her memo and attachments of August 1, 2005. She said N.J.A.C. 11:20-22.6(c) sets forth the standards for marketing in good faith. Carriers must send a copy of the application that lists the B&E Plan among the plan choices. Carriers must send evidence of at least one marketing effort. Carriers must send a certification regarding lists of plan choices.

E. DeRosa referred to the information in her memo that identifies what Aetna Life Insurance Company submitted. She explained that copies of the marketing efforts Aetna Life Insurance Company provided were attached to her memo to enable Board members to review the marketing efforts.

E. DeRosa said Aetna Life Insurance Company provided the information required to demonstrate that it marketed in good faith. She noted, however, that while the report was due May 1, 2005, Aetna Life Insurance Company did not submit the filing until June 29, 2005.

S. Kelly offered a motion to refer Aetna Life Insurance Company's late filing to enforcement for action, noting that the filing that was submitted late but included the necessary information and therefore should be approved. V. Mangiaracina seconded the motion. The Board voted unanimously in favor of the motion.

E. DeRosa said that Celtic Life Insurance Company had still not submitted a marketing report. She also noted that the carrier has not filed rates for the Basic and Essential Health Care Plan since 2003. She reminded the Board that Celtic also failed to file the required marketing report in 2004.

S. Kelly offered a motion to refer the matter of Celtic's non-compliance to enforcement for action. V. Mangiaracina seconded the motion. The Board voted unanimously in favor of the motion.

Reasonable and Customary Charges
W. Sanders reported that the SEH Board briefly discussed reviewing the regulation that requires carriers to use the 80th percentile of the Prevailing Healthcare Charges System and that the SEH Board would be interested in seeking information from both Ingenix and Medicare, which uses RBRVS data. The IHC Board expressed a similar interest. W. Sanders asked if any of the carriers might have a contact at CMS that would be able to speak on RBRVS.

D. Farkus suggested that the Medical Society might be interested in discussions of a reasonable and customary standard.

IV. Report of the Operations and Audit Committee

W. Sanders said the Operations and Audit Committee met to discuss the Executive Order 41 and the Protective Life and Fortis audits.

Executive Order 122 and Certification Required by Executive Order 41
W. Sanders said that the Committee considered the certification required by Executive Order 41 and that the Committee suggested that staff write to the Governor's Authorities Unit to seek clarification on audit committee member compliance in light of the independence standards set forth in Executive Order 122. W. Sanders said that at least one member serving on the Committee must have accounting or auditing experience. U. Lee agreed to check if Guardian would like to name someone with those qualifications to replace Sandy Herman who retired from Guardian.

Protective Life
W. Sanders said the Legal Committee also reviewed a submission that Protective Life's counsel submitted in July 2005. He said the Committee noted that the submission failed to include a concise statement listing the material facts in dispute as required by N.J.A.C. 11:20-20.2(a)iv.

M. McClure offered a motion to write a letter to Protective Life to request that Protective Life provide a concise statement listing the material facts in dispute. D. Farkus seconded the motion. The Board voted unanimously in favor of the motion.

Fortis
W. Sanders reported that he had received a message from D&T which he understood as indicating that completion of the Fortis audits would require the Board and Fortis to come to an understanding on what may be considered as premium and claims, and that D&T then could test the validity of the submission and draw a conclusion. D&T noted that a limitation on access to documents could mean that D&T could not complete the audits.

[Break: 10:56 a.m. – 11:05 a.m.]

V. Report of the Legal Committee

W. Sanders reported that counsel for Celtic submitted an overly broad OPRA request. He said he would be speaking with the requestor to ask that the requestor specify the documents being requested.

VI. Report of the Technical Advisory Committee

E. DeRosa said TAC met to consider one rate filing and a rate compliance issue.

E. DeRosa said S. 1781/A. 3116 imposed a 1% assessment on the premiums of HMOs. A. 4402 continues this assessment and also amends N.J.S.A. 26:2J-47 to provide that (except for federally underwritten business) an HMO may not recoup this assessment of 1% of premium through additional premiums or charges.

TAC discussed enforcing the anti- pass-through provision by:
1) Requiring a certification of compliance with A. 4402; and
2) Analyzing the pattern of loss ratios, expense ratios, and profit margins in filings.

E. DeRosa said TAC recommended that the certification should specifically state that the assessment is not being passed through and it should also state how the assessment is being funded. (For example, by a reduction in profit margin, or outside of the premium entirely such as through investment income or reduction in surplus).

E. DeRosa said TAC recommended that the Board consider issuing an Advisory Bulletin to advise carriers of the means by which HMOs can demonstrate that the assessment is not being passed through. She said TAC also recommended that the rate filing regulation be amended to require the certification including a statement as to the source of the funding for the assessment.

Both M. McClure and S. Kelly voiced concern with TAC reviewing loss ratios. Both believed a certification stating that the assessment was not being passed through should suffice. E. DeRosa noted that certifications have not proven to be useful if they cannot be corroborated. She noted that carriers certify that they are issuing standard plans, yet when she receives copies of plan provisions in connection with the review of complaints, the text the carrier has issued is not always standard plan text. W. Sanders noted similar difficulties with the Exhibit K certifications.

The Board asked who is responsible for enforcing compliance with the anti-pass through requirement. The Legal Committee will consider this question.

U. Lee recused himself with respect to the rate filing from Health Net, citing a conflict of interest since the matter related to a filing submitted by Health Net, with whom his employer, Guardian, has a joint venture.

E. DeRosa said TAC considered a rate filing from HealthNet. She said she requested and received the clarification TAC identified and therefore TAC recommended that the filing be found complete.

D. Farkus offered a motion to find the Health Net rate filing complete. M. McClure seconded the motion. The Board voted unanimously in favor of the motion.

VII. Executive Session

W. Sanders said the Board would need to go into Executive Session to review minutes and receive advice from counsel. He said the Board would not conduct any more business following Executive Session.

D. Farkus offered a motion to begin Executive Session for the purpose of reviewing minutes and receiving advice from counsel. M. McClure seconded the motion. The Board voted unanimously in favor of the motion.

[Executive Session: 11:37 a.m. – 12:00 noon]

VIII. Close of Meeting

S. Kelly offered a motion to adjourn the Board meeting. D. Farkus seconded the motion. The Board voted unanimously in favor of the motion.

The meeting adjourned at 12:00 noon.

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 13, 2005

Directors participating: Darrel Farkus (Oxford); Sandi Kelly (Horizon BCBSNJ); Ulysses Lee (Guardian); Vicki Mangiaracina (DOBI); Mary McClure (Aetna Health); Eileen Shrem.

Others present: Ellen DeRosa, Deputy Executive Director; DAG Karyn Gordon (DOL) DAG Eleanor Heck (DOL); Rosaria Lenox, Program Accountant; Wardell Sanders, Executive Director.

I. Call to Order

W. Sanders called the meeting to order at 9:33 a.m. He announced that notice of the meeting had been published in two newspapers and posted at the Department of Banking and Insurance ("DOBI"), the DOBI website, and the Office of the Secretary of State in accordance with the Open Public Meetings Act. A quorum was present.

II. Minutes

August 9, 2005
M. McClure offered a motion to approve the Open Session minutes of the August 9, 2005 Board meeting. V. Mangiaracina seconded the motion. The Board voted unanimously in favor of the motion.

III. Executive Session

M. McClure said the Board needed to discuss a Horizon litigation issue in Executive Session.

E. Shrem offered a motion to enter Executive Session. M. McClure seconded the motion. The Board voted unanimously in favor of the motion.

S. Kelly, DAG E. Heck and Board staff recused themselves from the meeting at 9:37 a.m.

[Executive Session: 9:37 a.m. – 9:57 a.m.].
S. Kelly, DAG E. Heck and Board staff returned to the meeting at 9:57 a.m., S. Kelly remained recused from discussion of Horizon's motion.

IV. Consideration of Horizon's Motion to Settle the Record

V. Mangiaracina reported that the Board considered Horizon's motion to settle the record in its appeal of the Board's adjustment of Horizon's request for reimbursement of losses for 1993 and 1994. She said Horizon requested that certain documents be included in the statement of items comprising the record.

V. Mangiaracina offered a motion to deny Horizon's request to include certain documents in the statement of items comprising the record because the Board determined that the documents were neither related to the matter under consideration nor were they documents the Board considered when it made its decision following the OAL hearing in 2003 and 2004. U. Lee seconded the motion. The Board voted unanimously in favor of the motion.

V. Report of Staff

Expense Report
V. Mangiaracina offered a motion to approve the payment of the expenses on the September 2005 expense report. E. Shrem seconded the motion. The Board voted unanimously in favor of the motion.

Basic and Essential Health Care Services Plan (B&E Plan) Rider Filing
Oxford Health Insurance Company

D. Farkus recused himself with respect to the rider filing from Oxford Health Insurance Company, citing a conflict of interest since the matter related to a filing submitted by his employer, Oxford Health Plans, Inc.

E. DeRosa said Oxford submitted a rider to include additional benefits in its EPO version of the B&E plan. She noted that there were some minor technical changes required for the rider, but that the main point of concern was that the filing stated that rates had not yet been filed, and in fact, no rate filing for the rider had been received. She referred the Board to N.J.A.C. 11:20-22.5(b) which requires carriers to file a certification which includes a statement that rates have been submitted.

M. McClure offered a motion to disapprove the B&E Rider filing since a rate filing had not been made. V. Mangiaracina seconded the motion. The Board voted unanimously in favor of the motion.

Informational Materials
W. Sanders briefly identified the informational materials that were included in the Board packets.

Fee Profile
W. Sanders reported that a representative from Ingenix agreed to come to a Board meeting to present information on the PHCS fee profile.

M. McClure offered to find out if anyone at Aetna with expertise concerning RBRVS would be willing and available to come to a Board meeting to present information on this data.

Financial Statements
R. Lenox presented financial statements and responded to questions posed by various Board members. She said Deloitte & Touche would be coming in to audit the financial statements. The Board commended R. Lenox for her work in preparing the financial statements.

2Q05 Enrollment Reports
E. DeRosa explained that the enrollment reports, as distributed to the Board, may have to be modified based on information staff requested from one of the carriers. W. Sanders said any updates to the reports would be provided as soon as they were available.

Noting that the enrollment reports show new enrollment in the Basic and Essential Health Care Services Plans (B&E Plans), E. Shrem suggested that it would be helpful to include an article in the *Insurance Reporter* regarding the availability of the B&E Plans with various riders. E. DeRosa suggested that any article should also provide some general information on individual market rules.

VI. Report of the Operations and Audit Committee

W. Sanders said the Operations and Audit Committee met to discuss Executive Order 122 and loss audits.

Fortis
W. Sanders reported that Deloitte & Touche (D&T) continued to review the status of the Fortis audit. However, given the fundamental disagreement between Fortis and the Board regarding reporting requirements, W. Sanders said D&T indicated it was unlikely Fortis would sign a management representation letter certifying the financials are consistent with reporting requirements. W. Sanders said the Committee asked D&T to provide written guidance on the steps D&T could take with respect to the Fortis audits.

Other Loss Audits
M. McClure said the audit reports for both Manhattan National and National Casualty had been issued. She said D&T completed the auditing work for MetLife for 97/98 and 99/00 and the only outstanding item was a representation letter for 97/98. With respect to Aegon audits, D&T was

reviewing whether a contract in another engagement would violate independence standards. M. McClure said D&T was contacting UICI to schedule the audit UICI requested in light of the fact the agreed-upon procedures did not support loss reimbursement.

Executive Order 122
W. Sanders said that the Order allows staff to serve as a conduit of information and that decision-making must remain with the Board.

Reimbursement Request
W. Sanders said L. Yourman requested reimbursement for a DSL line. He said the Committee awaited supporting documentation for the request before making any recommendation as to whether reimbursement would be appropriate.

VII. Report of the Legal Committee

W. Sanders reported that the Legal Committee discussed information recently provided by CMS that stated that if a person with individual coverage subsequently becomes eligible for group coverage, the person must be permitted to retain individual coverage. W. Sanders noted that eligibility for group coverage has been a basis for termination of an individual plan. He said the Committee believed that if an individual elects to retain the individual plan while also being covered under a group plan, that the group plan would be the primary plan and the individual plan would coordinate as secondary.

The Board would like the Legal Committee to discuss how the requirement should be implemented, given that the current regulations state an individual plan must be terminated when a person covered under the plan becomes eligible for group coverage. Should the Board issue a Bulletin?

W. Sanders said the Legal Committee considered a draft bulletin on the 1% HMO assessment, 05-IHC-04. He said the Committee was concerned with a requirement that carriers certify where the 1% assessment funding was coming from, and that the Bulletin was revised to remove this requirement from the certification.

M. McClure opposed the Board sending out a Bulletin on the 1% assessment prior to the Department formally issuing a Bulletin. D. Farkus favored the Department issuing a Bulletin to address all markets, including the individual market.

VIII. Report of the Technical Advisory Committee

S. Kelly said TAC considered a rate filing from Celtic. She said the filing was deficient in many regards, including the necessary certification. She said TAC recommended that the filing be found incomplete.

V. Mangiaracina offered a motion to find the Celtic rate filing incomplete. E. Shrem seconded the motion. The Board voted unanimously in favor of the motion.

S. Kelly said TAC reviewed the first quarterly report on B&E activity from AmeriHealth. She said TAC believed the report did not evidence migration from standard plans to the B&E plan with rider.

[Break: 11:30 a.m. – 11:37 a.m.]

S. Kelly said TAC considered the draft bulletin on the 1% assessment. Although TAC did not recommend changes, she said she favored deleting the fourth paragraph that requires a rate filing to state how the assessment is being funded. M. McClure reiterated her position that the Board should not issue a Bulletin until after the Department has issued a Bulletin. D. Farkus said he believes consideration of the 1% HMO assessment is entirely a Department issue.

The Board agreed to postpone issuing a Bulletin on the 1% HMO assessment.

IX. Executive Session

W. Sanders said the Board would need to go into Executive Session to review minutes and receive advice from counsel. He said the Board would not conduct any more business following Executive Session.

E. Shrem offered a motion to begin Executive Session for the purpose of reviewing minutes and receiving advice from counsel. V. Mangiaracina seconded the motion. The Board voted unanimously in favor of the motion.

[Executive Session: 11:50 a.m. – 12:35 p.m.]

X. Close of Meeting

V. Mangiaracina offered a motion to adjourn the Board meeting. E. Shrem seconded the motion. The Board voted unanimously in favor of the motion.

The meeting adjourned at 12:35 p.m.

FINAL
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 11, 2005

Directors participating: Darrel Farkus (Oxford); Sandi Kelly (Horizon BCBSNJ); Ulysses Lee (Guardian); Vicki Mangiaracina (DOBI); Mary McClure (Aetna Health).

Others present: Ellen DeRosa, Deputy Executive Director; DAG Eleanor Heck (DOL); Rosaria Lenox, Program Accountant; Wardell Sanders, Executive Director.

I. Call to Order

W. Sanders called the meeting to order at 9:40 a.m. He announced that notice of the meeting had been published in two newspapers and posted at the Department of Banking and Insurance ("DOBI"), the DOBI website, and the Office of the Secretary of State in accordance with the Open Public Meetings Act. A quorum was present.

II. Minutes

September 13, 2005
M. McClure offered a motion to approve the Open Session minutes of the September 13, 2005 Board meeting, as amended. V. Mangiaracina seconded the motion. The Board voted unanimously in favor of the motion.

III. Report of Staff

Expense Report
S. Kelly offered a motion to approve the payment of the expenses on the October 2005 expense report. M. McClure seconded the motion. The Board voted unanimously in favor of the motion.

Basic and Essential Health Care Services Plan (B&E Plan) Rider Filing
Oxford Health Insurance Company

D. Farkus recused himself with respect to the rider filing from Oxford Health Insurance Company, citing a conflict of interest since the matter related to a filing submitted by his employer, Oxford Health Plans, Inc.

E. DeRosa said Oxford submitted a revised rider to amend its EPO version of the B&E plan. The revisions addressed necessary minor technical changes required for the rider. Since the revised filing included a certification as required by N.J.A.C. 11:20-22.5(b) stating that rates had been submitted, E. DeRosa said the filing included all of the required information.

S. Kelly offered a motion to approve the B&E Rider filing. V. Mangiaracina seconded the motion.

With the recusal of D. Farkus, a quorum of the Board was not present, and therefore the Board could not take action to vote on the rider filing.

Celtic Life Insurance Company B&E Marketing Report
E. DeRosa summarized the filing requirements for a marketing report as follows:

- Send a copy of the application that shows B&E is listed
- Send evidence of at least one marketing effort

- Send a certification

E. DeRosa summarized the filing as submitted by Celtic Life Insurance Company in light of those requirements.

E. DeRosa said the filing includes an application that has a box for the Basic and Essential plan. However, the application included in the filing is not the HINT form which is the form that has been required for the past couple of years. She said Celtic contacted her after receiving a letter from Enforcement and inquired about the marketing report filing. E. DeRosa said she reviewed each of the requirements for the filing and specifically noted that the Board would look to make sure the B&E product was listed on the HINT form.

E. DeRosa said Celtic submitted a brochure that includes information on the B&E plan and noted some of that information is not correct. She said significant information in the brochure regarding the program and the standard plans is out of date and incorrect. She said the brochure does not include rates or any other information that would associate it with the 2004 period.

E. DeRosa reported that the filing also failed to include the required certification.

S. Kelly offered a motion to disapprove the Celtic Life Insurance Company Basic & Essential plan marketing report for 2004. V. Mangiaracina seconded the motion. The Board voted unanimously in favor of the motion.

Fee Profile
W. Sanders reported that a representative from Ingenix agreed to come to present information on the PHCS fee profile to both the IHC and SEH Boards and had proposed several dates for the presentation. W. Sanders said he would schedule the meeting based on the availability of Board members.

Legislative Update
W. Sanders said S.2236 passed and would allow a full-cost buy-in to NJ FamilyCare to provide coverage for children above 350% of the Federal Poverty Level.

Outreach
W. Sanders and E. DeRosa briefly discussed of their speaking engagements since the September Board meeting.

IV. Report of the Operations and Audit Committee

W. Sanders said the Operations and Audit Committee met and discussed various agreed-upon procedures (AUPs) and audits.

AUPs
M. McClure said the Metropolitan Life draft AUP for 99/00 was issued to Metropolitan and we await the management representation letter. She said Mega Life and Midwest AUPs were completed, but both carriers requested full audits. She said Aegon also requested a full audit.

M. McClure said Deloitte & Touche (D&T) provided a memo stating the additional information Protective Life provided on July 15, 2005 did not appear to provide any information related to the items identified as exceptions in the draft report. She said D&T would seek a management representation letter, and once received, would issue a final AUP report.

Audits
M. McClure said the Metropolitan Life draft audit for 97/98 was issued to Metropolitan Life and we await the management representation letter.

V. Report of the Legal Committee

W. Sanders said the Committee received a copy of the United States Life reply brief to the Appellate Division regarding 1993 – 1996 loss assessments.

W. Sanders said the Committee considered a draft bulletin regarding guaranteed renewability in instances where an individual becomes eligible for coverage under a group plan. The Board suggested some amendments to the bulletin text.

D. Farkus requested that the Department consider amending its regulation on coordination of benefits to allow coordination with individual coverage.

V. Mangiaracina offered a motion to issue the advisory bulletin, as revised. U. Lee seconded the motion. The Board voted unanimously in favor of the motion.

VI. Report of the Technical Advisory Committee

S. Kelly said TAC considered a revised rate filing for the Basic and Essential plan from Celtic. She said the revised filing addressed the issues for which the prior filing had been found incomplete.

V. Mangiaracina offered a motion to find the Celtic rate filing complete. M. McClure seconded the motion. The Board voted unanimously in favor of the motion.

Since the remaining filings were submitted by Board member carriers who would be recused from consideration of filings by their carriers, a quorum was not present to take action on the remaining rate filings TAC considered.

S. Kelly said TAC considered the 2004 loss ratio reports and refund plans and recommended that refund plans from CIGNA, National Health and Trustmark be approved.

M. McClure offered a motion to approve the refund plans submitted by CIGNA, National Health and Trustmark. V. Mangiaracina seconded the motion. The Board voted unanimously in favor of the motion.

VII. Executive Session

W. Sanders said the Board would need to go into Executive Session to review minutes and receive advice from counsel. He said the Board would conduct more business following Executive Session.

V. Mangiaracina offered a motion to begin Executive Session for the purpose of reviewing minutes and receiving advice from counsel. D. Farkus seconded the motion. The Board voted unanimously in favor of the motion.

[Executive Session: 10:50 a.m. – 10:57 a.m.]

VIII. Final Business and Close of Meeting

Celtic Life Insurance Company
W. Sanders said counsel for Celtic Life Insurance Company sent a letter to the Board requesting that Celtic be paid in full for 1997/1998 and 1999/2000 net paid losses. W. Sanders said the Board would send a letter identifying the amount due to Celtic, which would take into account Celtic's liability for 50% of the cost of the loss audits. Due to appeals to the loss assessments for those loss periods, the Board does not have sufficient loss assessment funds collected for these periods to allow full payment of net paid losses. W. Sanders summarized the Board's practice of reimbursing carriers to a certain percentage of the net paid loss based on the lesser of the Exhibit K amount or the audited amount. Celtic has been reimbursed a percentage of net paid losses and at this time cannot be reimbursed for the balance.

V. Mangiaracina offered a motion to advise Celtic of the amount due to Celtic and explain that the Board does not have sufficient loss assessment funds for 1997/1998 and 1999/2000 to allow full payment of Celtic's net paid losses. M. McClure seconded the motion. The Board voted unanimously in favor of the motion.

Fortis Audit
M. McClure said the Operations Committee understood from D&T that the error rates in the loss audit performed thus far have been too great to provide an audit opinion. Further, Fortis disagrees with the Board on the reporting requirements. M. McClure said the Committee recommended that the Board contact Fortis to ask that they: categorize the areas of disagreement regarding reporting requirements; quantify the differences in the exceptions found; and submit to further testing after adjustments are made. She said W. Sanders would draft the letter and share it with D&T for comments before sending to Fortis.

M. McClure offered a motion to send a letter to Fortis, as outlined above. V. Mangiaracina seconded the motion. The Board voted unanimously in favor of the motion.

CIGNA
W. Sanders said R. Lenox prepared a series of spreadsheets illustrating various ways to collect money to pay CIGNA its 27.2% exemption and interest for 1996.

W. Sanders said the Legal Committee was divided as to when the payment to CIGNA must be made. He said the majority of members believed payment was not required at this time. He said there was no consensus as to how the interest should be collected.

W. Sanders commented that if the Board were to bill for an $800,000 assessment there would likely be challenges and there would not be sufficient money to pay CIGNA. If the Board were to do a full interim reconciliation, then there may be enough to pay CIGNA. He said there would be three classes of creditors: CIGNA; carriers due money for net paid losses; and carriers due money because they paid more than their liability as a result of reconciling events.

M. McClure suggested that the Board should do a reconciliation of the 1996 assessment, including changes in net earned premium, CIGNA's exemption and loss audit information. D. Farkus agreed.

V. Mangiaracina said there was no question in her mind that the Board must pay CIGNA now. She noted that if the money were available in an account the Board would not have hesitated to make payment. S. Kelly disagreed, saying Horizon did not read the Court's order as requiring payment now.

U. Lee noted that the Board was considering doing an interim reconciliation using a methodology the Board did not agree to use for 1996.

The Board recognized three issues to be resolved:

- How to treat NYLCare for the 1996 period. Should it be exempt or non-exempt?
- What methodology to use for the reconciliation of the 1996 assessment?
- Whether CIGNA is due payment now or should payment be made when all outstanding matters involving the 1996 loss assessment have been resolved.

Close of Meeting

M. McClure offered a motion to adjourn the Board meeting. S. Kelly seconded the motion. The Board voted unanimously in favor of the motion.

The meeting adjourned at 12:45 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
November 7, 2005

Directors participating: Darrel Farkus (Oxford); Sandi Kelly (Horizon BCBSNJ); Ulysses Lee (Guardian); Vicki Mangiaracina (DOBI); Eileen Shrem; Mary Taylor (Aetna Health).

Others present: Ellen DeRosa, Deputy Executive Director; DAG Eleanor Heck (DOL); Rosaria Lenox, Program Accountant; Wardell Sanders, Executive Director.

I. Call to Order

W. Sanders called the meeting to order at 9:35 a.m. He announced that notice of the meeting had been published in two newspapers and posted at the Department of Banking and Insurance ("DOBI"), the DOBI website, and the Office of the Secretary of State in accordance with the Open Public Meetings Act. A quorum was present.

W. Sanders said David Mannis of CIGNA and Julie Tatonni of Windels Marx Lane & Mittendorf, representing United States Life, requested the opportunity to briefly address the Board.

II. Presentations

J. Tattoni reported that Windels Marx Lane & Mittendorf represents United States Life in the appellate process. She urged the Board not to return any monies to CIGNA as such payment would require the Board to bill for an assessment to collect the money. She stated that the loss assessment regulation awaits legislative action. Further, she said a fundamental fairness argument should lead the Board to delay any assessment billing pending a determination as to whether the Supreme Count decision on the invalidated assessment methodology has only prospective application or whether it also has retroactive application.

In response to a question, J. Tattoni said her firm also represents Fortis and Guardian, but she stated her presentation to the Board was made only on behalf of United States Life.

D. Mannis said the Court ordered the Board to calculate the amount due to CIGNA. He asked that the Board comply with the decision and issue an order to CIGNA stating the amount due to CIGNA. He acknowledged that the decision did not expressly state that the Board must pay the amount immediately. Although, he said CIGNA requests that such immediate payment be made. He suggested that the loss assessment for 1996 took place long ago, and it was such prior assessment that necessitates the payment due to CIGNA. Therefore, funding the payment to be made to CIGNA should not be viewed as a new loss assessment. He suggested that the money could be collected as part of an administrative assessment.

III. Report of Staff

Expense Report

V. Mangiaracina offered a motion to approve the payment of the expenses on the November 2005 expense report. M. Taylor seconded the motion. The Board voted unanimously in favor of the motion.

Basic and Essential Health Care Services Plan (B&E Plan) Rider Filing
Oxford Health Insurance Company

D. Farkus recused himself with respect to filings from Oxford Health Insurance Company, citing a conflict of interest since the matter related to a filing submitted by his employer, Oxford Health Plans, Inc.

E. DeRosa said Oxford submitted a revised rider to amend its EPO version of the B&E plan. The revisions addressed necessary minor technical changes required for the rider. Since the

revised filing included a certification as required by N.J.A.C. 11:20-22.5(b) stating that rates had been submitted, E. DeRosa said the filing included all of the required information.

M. Taylor offered a motion to approve the B&E Rider filing. E. Shrem seconded the motion. The Board voted unanimously in favor of the motion.

Oxford Refund Plan
E. DeRosa said the Board had been unable to vote to approve the Oxford refund plan for 2004 during the last Board meeting due to lack of a quorum. She reminded the Board that the amount to be refunded was $402,376.

S. Kelly offered a motion to approve the Oxford refund plan for 2004. V. Mangiaracina seconded the motion. The Board voted unanimously in favor of the motion.

Fee Profile
W. Sanders reported that a representative from Ingenix will present information on the PHCS fee profile to both the IHC and SEH Boards on November 21, 2005 beginning at 9:30 a.m.

Legislative Update
W. Sanders said a bill to address coverage for lead treatment, removing the first dollar benefit, as well as Assemblyman Cohen's bill to reform both the individual and small employer markets, would possibly be considered during the lame duck session.

W. Sanders said a Federal bill was introduced that would broaden eligibility for funding assistance for high risk pools. He reminded the Board that the IHC mechanism did not qualify under prior standards, but indicated that with broadened eligibility, the IHC mechanism could possibly be eligible. W. Sanders noted that Senator Enzi introduced a Federal, revised association health plan bill.

Outreach
W. Sanders briefly discussed of his speaking engagements since the October Board meeting.

IV. Report of the Legal Committee

W. Sanders said the Legal Committee met and discussed several issues.

Draft Rule Adoption
W. Sanders said the Legal Committee believed no legal issues were raised in the adoption.

Comment submitted by Windels Marx Lane & Mittendorf on Rule Proposal
W. Sanders reported that the Committee recommended sending a letter to Windels Marx referring to the Board's minutes of the June 6, 2005 meeting in addition to responding to the comment by indicating the rule comment was beyond the scope of the proposal.

NJ FamilyCare Full Cost Buy-In
W. Sanders said the Committee recommended that premium earned for the NJ FamilyCare full cost buy-in would be net earned premium for purposes of Exhibit K reporting.

In response to a question, W. Sanders said the Committee did not consider how lives enrolled in the full cost buy-in would affect enrollment targets or the satisfaction of those targets.

Transition to Maximum Out of Pocket Provisions
E. DeRosa explained that when a person is issued a new plan the person is entitled to deductible credit for charges incurred during the same calendar year, but no coinsurance credit is extended. When the Board adopts the revised standard plans, carriers will be required to issue new plans. For a consumer who may already have satisfied the coinsurance cap under a current plan, providing only deductible credit would require the person to again satisfy coinsurance requirements. She noted that depending on the cost sharing of the plan, a person could have to again incur thousands of dollars of charges before meeting the maximum out of pocket.

E. DeRosa said the Committee considered the impact to consumers of the transition from coinsurance cap and coinsured charge limit provisions to maximum out of pocket provisions as exist in the plans as proposed, and whether and how the Board could require carriers to provide credit for coinsurance as plans are reissued. E. DeRosa explained that the Committee discussed promulgating a rule that would require carriers to provide coinsurance credit when the Board requires reissue of a new plan.

E. DeRosa said that after the Legal Committee meeting she drafted a regulation that would require carriers to provide coinsurance credit in the situation described above. The coinsurance credit would be addressed using a new rider, called a Plan Update Rider. The Board was asked to review the draft regulation and rider and provide comments to E. DeRosa by November 21, 2005.

V. Readoption

W. Sanders said Acting Commissioner Don Bryan approved the proposed amendments to Plan of Operation, N.J.A.C. 11:20-2.1 through -2.16.

E. DeRosa said the Board received written comments from Oxford Health Plans and from Windels Marx Lane & Mittendorf on behalf of Guardian Life Insurance Company. She reviewed each of the comments, as summarized in the draft readoption along with the draft responses. The Board concurred with the draft responses.

E. DeRosa asked the Board to provide direction regarding the Operative Date for the standard plan amendments. The Board discussed using July 1, 2006 for the policy forms as that delayed date would allow ample time for carriers to update their materials.

S. Kelly said Horizon noted that the definition of a “federally defined eligible individual” did not include a qualification found in HIPAA, namely that there has not been a significant break in coverage of 63 or more days. The Board agreed to delay consideration of this comment until after Executive Session.

[Break: 11:45 a.m. – 11:50 a.m.]

VI. Executive Session I

E. Shrem offered a motion to begin executive Session to receive advice from counsel. V. Mangiaracina seconded the motion. The Board voted unanimously in favor of the motion.

VII. Report of the Technical Advisory Committee

M. Taylor recused herself with respect to a rate filing from Aetna, citing a conflict of interest since the matter related to a filing submitted by her employer, Aetna Health Inc.

S. Kelly said TAC considered a rate filing for plans A/50 – D from Aetna Life Insurance Company. She said TAC requested some additional information, but the filing could be found complete subject to Aetna providing the information.

S. Kelly said TAC considered a request from Aetna Health Inc. to extend the HMO rates. She said TAC recommended that the request be accepted.

E. Shrem offered a motion to find the Aetna Life rate filing complete subject to receipt of the additional information. V. Mangiaracina seconded the motion. The Board voted unanimously in favor of the motion.

E. Shrem offered a motion to find the request for an extension of the Aetna HMO rates complete. V. Mangiaracina seconded the motion. The Board voted unanimously in favor of the motion.

S. Kelly recused herself with respect to a rate filing from Horizon, citing a conflict of interest since the matter related to a filing submitted by her employer, Horizon Blue Cross Blue Shield of New Jersey.

E. DeRosa said TAC considered a rate filing for the HMO plans from Horizon. She said TAC requested some information regarding the source of funding for the 1% HMO assessment, but the filing could be found complete subject to Horizon providing the information.

V. Mangiaracina offered a motion to find the Horizon HMO rate filing complete subject to receipt of the additional information. E. Shrem seconded the motion. The Board voted unanimously in favor of the motion.

S. Kelly said TAC considered a rate filing from Celtic Life for plans A/50 – D and recommended that it be found complete.

E. Shrem offered a motion to find the Celtic Life rate filing complete. V. Mangiaracina seconded the motion. The Board voted unanimously in favor of the motion.

D. Farkus recused himself with respect to a rate filing from Oxford, citing a conflict of interest since the matter related to a filing submitted by his employer, Oxford Health Plans.

S. Kelly said TAC considered a rate filing from Oxford for the basic and essential plan with a rider and subject to receipt of some information, recommended that the filing be found complete.

E. Shrem offered a motion to find the Oxford rate filing complete subject to receipt of clarifying information. M. Taylor seconded the motion. The Board voted unanimously in favor of the motion.

S. Kelly said TAC considered a refund plan as submitted by Fortis to refund $279 and recommended that it be approved.

M. Taylor offered a motion to approve the Fortis refund plan. E. Shrem seconded the motion. The Board voted unanimously in favor of the motion.

VIII. Readoption

The Board again discussed S. Kelly's comment on the definition of a "federally defined eligible individual." The Board determined that the issue should be considered by the Legal Committee. If the Legal Committee believes an amendment is warranted, the amendment could be included in the proposal the Board had previously discussed to address coordination of benefits with a group plan.

M. Taylor offered a motion to adopt the readoption with amendments, using a July 1, 2006 operative date for the policy forms and portions of the regulation related to the policy forms, and a February 1, 2006 operative date for all other portions of the regulation. E. Shrem seconded the motion. The Board voted unanimously in favor of the motion.

IX. 1996 Exemption and Assessment Calculation

M. Taylor recused herself with respect to discussion of the exemption status of NYLCare, citing a conflict of interest since the matter related to an entity acquired by her employer, Aetna Health, Inc.

W. Sanders reminded the Board that in 1996 it voted to deny the exemption requests of CIGNA and NYLCare for failure to demonstrate that they marketed the standard IHC plans in good faith. He noted that while CIGNA challenged the denial and prevailed when the requirement to demonstrate good faith marketing was invalidated, NYLCare did not challenge the Board's action. In order to work with the 1996 assessment spreadsheets, the Board must determine whether NYLCare should be granted an exemption in light of the invalidation of the good faith marketing requirement.

V. Mangiaracina offered a motion to continue to consider NYLCare as non-exempt in light of NYLCare's failure to raise a timely challenge of the denial of the exemption. E. Shrem seconded the motion. The Board voted unanimously in favor of the motion.

[E. Shrem left the meeting.]

The Board considered what action it could take to respond to the Court's direction to calculate the amount due to CIGNA. M. Taylor and S. Kelly supported calculating the reconciliation for 1996 using the best information available to the Board.

X. Executive Session II

W. Sanders said the Board would need to go into Executive Session to receive advice from counsel. He said the Board would conduct more business following Executive Session.

M. Taylor offered a motion to begin Executive Session for the purpose of receiving advice from counsel. S. Kelly seconded the motion. The Board voted unanimously in favor of the motion.

[Executive Session: 1:20 p.m. – 1:45 p.m.]

XI. Final Business and Close of Meeting

CIGNA Request
M. Taylor said D. Mannis requested two things:

- That the Board provide an accounting of the amount due to CIGNA for the 1996 loss assessment; and
- Consideration of an extraordinary event for extraordinary circumstances resulting in the Board issuing an administrative assessment to fund the liability to CIGNA.

V. Mangiaracina offered a motion that the Board prepare an accounting for the amount due to CIGNA based on the Board not having set aside the correct amount, and calculate interest on that amount due. M. Taylor seconded the motion. The Board voted in favor of the motion, with one abstention, U. Lee.

Close of Meeting
D. Farkus offered a motion to adjourn the Board meeting. S. Kelly seconded the motion. The Board voted unanimously in favor of the motion.

The meeting adjourned at 1:55 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 13, 2005

Directors participating: Sandi Kelly (Horizon BCBSNJ); Ulysses Lee (Guardian); Amy Sawyer (Oxford); Eileen Shrem; Gale Simon (DOBI); Mary Taylor (Aetna Health); Lisa Yourman (arrived at 9:55 a.m.).

Others present: Ellen DeRosa, Deputy Executive Director; DAG Eleanor Heck (DOL); Rosaria Lenox, Program Accountant; Wardell Sanders, Executive Director.

I. Call to Order

W. Sanders called the meeting to order at 9:40 a.m. He announced that notice of the meeting had been published in two newspapers and posted at the Department of Banking and Insurance ("DOBI"), the DOBI website, and the Office of the Secretary of State in accordance with the Open Public Meetings Act. A quorum was present.

W. Sanders announced that Steven Lenox was confirmed by the Senate to fill the seat for representative of organized labor. Due to a prior commitment, W. Sanders said S. Lenox was unable to attend the December meeting. W. Sanders also announced that Vicki Mangiaracina returned to the Division of Law at the Attorney General's Office. He said Assistant Commissioner Gale Simon would serve on the Board as the Commissioner's designee.

II. Minutes

M. Taylor offered a motion to accept the open session minutes of the October 11, 2005 Board meeting. S. Kelly seconded the motion. The Board voted in favor of the motion with E. Shrem abstaining.

III. Report of Staff

Expense Report
S. Kelly offered a motion to approve the payment of the expenses on the December 2005 expense report. M. Taylor seconded the motion. The Board voted unanimously in favor of the motion.

Enrollment Reports 3Q05
W. Sanders noted an increase in the Basic and Essential Health Care Plan enrollment and decrease in enrollment in the standard plans. The net result was a decrease of 817 covered lives.

Fee Profile
W. Sanders reported that a representative from Milliman and Robertson will give a presentation on the RBRVS profile that is used by Medicare. In addition, he said a firm named Concentra has asked to offer a presentation on their profile.

Legislative Update
W. Sanders said a bill that would reform both the individual and small employer markets was reported out of the Senate Commerce Committee on December 12, 2005, with amendments. He discussed the key elements of the bill.

W. Sanders said a bill to address coverage for lead treatment, removing the first dollar benefit was reported out of the Senate Commerce Committee on December 12, 2005, with amendments.

W. Sanders said a bill that would allow dependents to be covered until age 30 was reported out of the Senate Commerce Committee on December 12, 2005, with amendments.

IV. Report of the Legal Committee

W. Sanders said the Legal Committee met and discussed several issues.

NJ FamilyCare Full Cost Buy-In
W. Sanders said the Committee determined that lives enrolled in the full cost buy-in are not to be considered as non-group lives and therefore would not affect enrollment targets or the satisfaction of those targets.

Definition of "federally defined eligible individual"
W. Sanders said the Committee recommended that the definition of "federally defined eligible individual" be amended to address the stipulation that during the 18 months of prior coverage there can be no significant break in coverage (more than 63 days).

Can a federally qualified HMO carrier sell only one indemnity plan using an affiliate's indemnity license?
W. Sanders said the Committee believed that while the federally qualified HMO carrier can satisfy its obligation to sell standard plans by selling just the HMO plan, if an affiliated carrier elects to sell indemnity coverage, that affiliate is required to offer all of the standard plans.

Draft proposal of N.J.A.C. 11:20-2.17
W. Sanders said the Committee considered the draft regulation which uses the adjusted net earned premium method. He noted that the adjusted net earned premium method was the methodology the Board voted to propose in July 2005 before the Governor extended the expiration of N.J.A.C. 11:20-2.17. In sending the regulation to Governor's Counsel, W. Sanders said he would need to identify those parties that would be adversely affected by the regulation. Several Board members said he should state that partially exempt carriers would be adversely affected, as compared to the old methodology.

V. Report of the Technical Advisory Committee

Rate Filings
S. Kelly said TAC considered a rate filing from AmeriHealth for the standard HMO plan and the Basic and Essential Plan with and without the riders and recommended that the filing be found complete, subject to the carrier providing information on the funding of the 1% HMO assessment.

M. Taylor offered a motion to find the AmeriHealth filing complete, subject to clarification. E. Shrem seconded the motion. The Board voted unanimously in favor of the motion.

A. Sawyer recused herself with respect to rate filings from Oxford and United, citing a conflict of interest since the matter related to a filings submitted by her employer, Oxford, and the parent of her employer, United.

S. Kelly said TAC considered a rate filing for plans A/50 – D from Oxford and recommended that the filing be found complete.

S. Kelly said TAC considered a rate filing for the Basic and Essential Plan from United and recommended that the filing be found complete, subject to the carrier providing some additional information.

S. Kelly said TAC considered a rate filing for the HMO Plan and Plans A/50 – D from United and recommended that the filing be found complete, subject to the carrier providing some additional information.

M. Taylor offered a motion to find the Oxford and United rate filings complete, with the United filings subject to receipt of the additional information. E. Shrem seconded the motion. The Board voted unanimously in favor of the motion.

S. Kelly said TAC considered a rate filing from CIGNA for the HMO plan and the Basic and Essential Plan and recommended that the filing be found incomplete. E. DeRosa said she contacted CIGNA after TAC met and requested the necessary information. She said CIGNA provided the information. Of the four TAC members, two reviewed the filing and advised her that the additional information was sufficient to find the filing complete. In response to a question, E. DeRosa said one of the members who had a chance to review the additional information was Neil Vance, the Department's actuary.

G. Simon offered a motion to find the CIGNA HMO and Basic and Essential rate filing complete. E. Shrem seconded the motion. The Board voted unanimously in favor of the motion.

Basic and Essential Quarterly Reports (3Q05)
S. Kelly said TAC believed it necessary to continue to monitor enrollment data. Since about 10% of the new enrollment AmeriHealth reported indicated they previously had IHC plans, she said TAC believed there was a potential for selection. E. DeRosa said TAC made a similar observation with the Horizon report, where 141 persons who had previous coverage stated they came from IHC plans.

S. Kelly suggested that the self-reported information on prior coverage may not be providing the information the Board is seeking. For example, if a person is asked if he or she previously had individual coverage the person may respond yes, even if that coverage terminated a year ago.

The Board asked E. DeRosa to request copies of the inquiries AmeriHealth and Horizon sends to Basic and Essential policyholders in order to compile the information for the quarterly report.

[Break: 11:07 a.m. – 11:16 a.m.]

VI. Report of the Operations and Audit Committee

M. Taylor said the Audit Committee met with auditors from Deloitte & Touche regarding the program audits. The auditors will begin to review the program books in January. She said the initial RFP covered 1996 through 1999 and the new RFP will cover 2000 through 2005.

VII. Executive Session

W. Sanders said the Board would need to go into Executive Session to receive advice from counsel and consider draft executive session minutes. He said the Board would conduct more business following Executive Session.

E. Shrem offered a motion to begin Executive Session for the purpose of receiving advice from counsel and reviewing minutes. L. Yourman seconded the motion. The Board voted unanimously in favor of the motion.

[Executive Session: 11:25 a.m. – 12:25 p.m.]

VIII. Final Business and Close of Meeting

Proposal of N.J.A.C. 11:20-2.17
M. Taylor offered a motion to propose N.J.A.C. 11:20-2.17, as drafted. E. Shrem seconded the motion. By roll call vote the Board voted in favor of the motion, with U. Lee abstaining and S. Kelly noting that while Horizon voted in favor of the proposal, the proposal does not reflect Horizon's position.

Windels Marx Letter
U. Lee recused himself from consideration of a letter written by Windels Marx citing a conflict of interest since the letter was written on behalf of Guardian, his employer.

W. Sanders said the December 5, 2005 letter from Windels Marx asked two questions: Did the Board take final agency action on treatment of the 1993 – 1996 assessments during the June 6, 2005 Board meeting, and has the Board taken final agency action at any other time on the treatment of the 1993 – 1996 loss assessments as a result of the Court decision. W. Sanders said the simple answers to both questions was no.

S. Kelly offered a motion to respond to the December 5, 2005 letter with negative responses to both questions. L. Yourman seconded the motion. The Board voted unanimously in favor of the motion.

CIGNA Request
W. Sanders said he received an email from David Mannis of CIGNA at 5:14 p.m. the evening before the Board meeting stating that CIGNA wants the Board to either issue an Order or a Resolution regarding the amounts owed to CIGNA relating to its 1996 loss assessment in addition to the letters the Board already provided to CIGNA.

M. Taylor offered a motion to deny CIGNA's request for an Order or Resolution, and instead re-send the previous letter and spreadsheets in which the Board advised CIGNA of the principal amount ($803,259), the interest ($237,571.07) and state in the cover letter the amount owed to CIGNA, as reflected on the spreadsheet previously provided to CIGNA. G. Simon seconded the motion.

U. Lee said he would prefer to send CIGNA a letter, correct the amount shown in the email from D. Mannis and simply refer CIGNA to the attachment the Board previously provided the CIGNA.

M. Taylor amended her motion to state that the Board should send CIGNA a letter; correct the incorrect information contained in the email from D. Mannis, and refer CIGNA to the spreadsheet that was previously provided. G. Simon seconded the amended motion. The Board voted unanimously in favor of the amended motion.

1996 Reconciliation

M. Taylor said she believed the Board should issue an interim reconciliation assessment to collect the money due to CIGNA using the 1996 assessment methodology, removing the good faith marketing requirement penalty for CIGNA and run the numbers using the most current net earned premium information for all carriers.

U. Lee said that although the Court's ruling technically did not speak to 1996, the methodology used in 1996 was the same as that used in 1997/1998 which the Court invalidated. He said the Board would be advised to use the adjusted net earned premium method.

A. Sawyer noted that there have been numerous acquisitions and mergers since 1993 making it exceptionally difficult to track liability for various carriers. Since the Court only addressed 1997/1998 and forward, she believed the Board should be guided by that direction.

S. Kelly offered a motion to use the existing 1996 assessment methodology for an interim reconciliation. L. Yourman seconded the motion. By roll call vote, the Board voted in favor of the motion with 6 votes in favor and one opposed, U. Lee.

L. Yourman offered a motion to issue the interim reconciliation, for the 1996 loss assessment, with adjustments for the audits, approved appeals, and to CIGNA's status as a partially exempt carrier. M. Taylor seconded the motion. By roll call vote, the motion did not carry, with 4 votes in favor and 3 opposed, A. Sawyer, S. Kelly and U. Lee.

The Board agreed to table to discussion until the January Board meeting. R. Lenox will provide a copy of the reconciliation to Board members prior to the January Board meeting.

Other

L. Yourman posed a question regarding the reform legislation discussed earlier in the meeting. She noted one of the features of the bill would require all carriers that sell in the small employer market to also sell in the individual market. She asked what would happen if a carrier had withdrawn from the individual market and the 5-year ban on re-entry had not yet been satisfied. The Board noted that her point posed an interesting question. The Board agreed to consider it, if the bill were passed.

Close of Meeting

E. Shrem offered a motion to adjourn the Board meeting. A. Sawyer seconded the motion. The Board voted unanimously in favor of the motion.

The meeting adjourned at 1:00 p.m.