**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 10, 2005**

Directors participating: Darrel Farkus (Oxford); Sandi Kelly (Horizon BCBSNJ); Mary McClure (Aetna Health); Vicki Mangiaracina (DOBI); Eileen Shrem; Lisa Yourman (arrived at 10:00).

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 9:50 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.

Minutes

April 6, 2005 Joint Committee Meeting (TAC and Legal)
S. Kelly offered a motion to approve the Open Session minutes of the April 6, 2005 Joint Committee meeting, as amended. V. Mangiaracina seconded the motion. The Board voted unanimously in favor of the motion.

[L. Yourman arrived.]

April 12, 2005 Board Meeting
S. Kelly offered a motion to approve the Open Session minutes of the April 12, 2005 Board meeting, as amended. M. McClure seconded the motion. The Board voted in favor of the motion, with L. Yourman abstaining.

III. Election

W. Sanders reported that ballots for the carrier seat for an HMO were submitted. He noted that Aetna Health, Inc. was running for the seat, unopposed. By a vote of 8 -0 Aetna Health, Inc. was elected to continue to serve on the IHC Board.

IV. Report of Staff

Meeting Schedule
W. Sanders reported that an additional meeting was noticed for May 24, 2005. Due to lack of availability of a meeting room in the Mary Roebling Building, the meeting would be held at the Attorney General's Office located across from the train station.

Legislative Report
W. Sanders briefly discussed A. 3359, S. 544 and A. 4008.

Regulatory Report
W. Sanders said the high deductible health plan adoption was filed with the Office of Administrative Law and had been posted on the web site.

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

Staff Person
M. McClure observed that Board staff has been understaffed for close to two years since the Board did not hire a full-time person to replace J. Petto following her resignation. She recommended that the Board speak with the Department about hiring a full-time staff person. Several Board members concurred.

S. Kelly proposed a resolution to hire a full-time staff person. L. Yourman seconded the motion. The Board voted in favor of the motion, with V. Mangiaracina abstaining.

V. Loss Assessment Discussion

M. McClure reminded the Board that the Board discussed a few loss assessment methodologies during its meeting in January 2005, one being the "fill the hole" methodology and the other being the "adjusted net earned premium methodology." At that time, she said Aetna supported the "fill the hole" methodology. In light of the HealthNet decision, M. McClure said Aetna has reevaluated its position and believes the "fill the hole" methodology would not withstand a court challenge. She said Aetna believes the "adjusted net earned premium" methodology the Department supported in January is the only methodology discussed by the Board that would survive a court challenge. Therefore, she said Aetna will vote in favor of full reimbursement to carriers using the "adjusted net earned premium" methodology.

VI. Report of the Legal Committee

W. Sanders said the Legal Committee considered the draft Advisory Bulletin on the filing and reporting procedures for riders that amend a Basic and Essential Healthcare Services Plan (B&E Plan) and recommended some changes regarding the comparison of the B&E Plan with rider to a standard plan.

S. Kelly said Horizon believed the reporting requirements contained in the Bulletin should be revised. For example, she said Horizon believed the estimated incurred claims data should be collected only semi-annually, not quarterly as in the draft bulletin due to "run-out" issues. She said Horizon was concerned with being able to successfully collect some of the information the Bulletin requests. Since the HINT enrollment form does not include questions that would provide necessary information, carriers would have to seek information on a supplemental form. She suggested that use of a supplemental form would result in some persons failing to respond to the questions and expressed concern as to how incomplete data could impact a determination that adverse selection exists.

The Board agreed to ask TAC to review the claims reporting concern Horizon raised.

VII. Report of the Operations and Audit Committee

M. McClure said the Operations Committee considered making some additional reimbursements to carriers who sought reimbursement for 1997/1998 losses whose loss audits have been completed. The additional payments would bring their total payments thus far to 96% of the Exhibit K amount or the audit amount, whichever is less.

V. Mangiaracina offered a motion to accept the recommendation of the Operations and Audit Committee to pay additional reimbursement totaling $1,768,542 to: Celtic Life, Manhattan National, National Casualty, Principal Mutual and Washington National. M. McClure seconded the motion. The Board voted unanimously in favor of the motion.

VIII. Report of the Technical Advisory Committee

Rate Filings

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

S. Kelly said TAC considered two rate filings from Oxford, one for HMO plans effective July 2005 and the other for SCA plans, effective August 2005. She said TAC recommended that the filings be found complete subject to clarification. She said TAC noted Oxford included some data in the filings that was inconsistent with data in the Annual Statement filing.

L. Yourman offered a motion to find the Oxford filings complete, subjected to clarification. V. Mangiaracina seconded the motion. The Board voted unanimously in favor of the motion.

S. Kelly said TAC discussed the draft of subchapter 12 and recommended some changes.

[Break: 12:40 p.m. – 12:50 p.m.]

IX. Discussion of Draft Regulations and Draft Policy Forms

Subchapter 12
The Board reviewed draft subchapter 12 and suggested reorganizing the sections discussing when a person may purchase an individual plan to create sections to address movement at any time and movement only during open enrollment period. The Board agreed to seek input from TAC regarding whether a person with HMO coverage should be able to move to an HMO plan with a lower copayment at any time.

[E. Shrem left the meeting at 12:55 p.m.]

X. Executive Session

W. Sanders said the Board would need to move to Executive Session to receive advice from counsel and review Executive Session minutes.

M. McClure offered a motion to begin Executive Session to receive advice from counsel and review minutes. S. Kelly seconded the motion. The Board voted unanimously in favor of the motion.

[Executive Session: 12:56 p.m. – 1:07 p.m.]

XI. Discussion of Draft Regulations and Draft Policy Forms (Continued)

E. DeRosa asked Board members to provide comments on the latest draft policy forms no later than May 19, 2005.

L. Yourman asked if the plans would cover all kinds of diabetic supplies. She also asked about coverage for nebulizer kits and similar disposable supplies essential to the delivery of a prescription medication.

L. Yourman expressed concern that the prescription drug benefit for HMO coverage has no maximum out of pocket. She suggested that using a higher maximum out of pocket such as $10,000 or $20,000 would be better than no maximum out of pocket.

S. Kelly offered a motion to retain the 50% benefit for prescription drugs without a maximum out of pocket. M. McClure seconded then motion. The Board voted in favor of the motion with L. Yourman opposed.

XII. 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 2:08 p.m.

MINUTES OF THE MEETING OF THE
NEW JERSEY INDIVIDUAL HEALTH COVERAGE PROGRAM BOARD
AT THE OFFICES OF THE
ATTORNEY GENERAL'S OFFICE
TRENTON, NEW JERSEY
May 24, 2005

Directors participating: Darrel Farkus (Oxford); Sandi Kelly (Horizon BCBSNJ); Ulysses Lee (Guardian) (arrived at 9:55 a.m.); Mary McClure (Aetna Health); Vicki Mangiaracina (DOBI); Eileen Shrem.

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 9:37 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 the Board would consider the following during the meeting:

- Draft Advisory Bulletin on issuing riders to amend a Basic and Essential Healthcare Services Plan
- Draft readoption regulation
- Draft policy forms

II. Draft Advisory Bulletin

S. Kelly said TAC reviewed the reporting requirements in the draft Bulletin on riders to amend the Basic and Essential Healthcare Services Plan and recommended that the quarterly reporting be modified to address paid claims rather than incurred claims, and recommended that annual reporting be included to provide information on incurred claims.

III. Regulation Discussion

S. Kelly said TAC considered whether a member with an HMO plan should be permitted to move to a lower copayment HMO plan at any time and recommended that such movement be limited to the open enrollment period. The Board agreed. Such a restriction on movement must be included in subchapter 12. The Board agreed.

S. Kelly noted that the old subchapter 12 addressed some eligibility issues and what rating tier a consumer could apply for and expressly stated that a carrier could not force a consumer to purchase in one tier as opposed to another. She suggested that such text might be added to the new subchapter on eligibility.

[break: 11:25 a.m. – 11:35 a.m.]

IV. Policy Forms Discussion

E. DeRosa reviewed the policy forms changes included in the most recent drafts. She reviewed the deductible and copayment options the Board previously decided to eliminate, and the deductible and copayment options the Board previously decided to add.

Since the schedule pages in the forms include variable text to accommodate all possible copays and deductibles, the Board suggested it would be helpful to also include schedules that illustrate the plans carriers must offer. E. DeRosa said subchapter 3 specifically identifies what must be offered as opposed to what may be offered but agreed it might be helpful to actually illustrate the required offerings.

E. DeRosa noted that since HMO carriers must cover bariatric surgery as a result of HMO regulations, the draft indemnity forms also cover bariatric surgery. The Board agreed there could be selection against HMO coverage if it were covered only in the HMO but not in the indemnity coverage.

S. Kelly reported that she received information from the claims area at Horizon regarding L. Yourman's inquiry concerning whether the plans cover nebulizers and disposable supplies such as cartridges to deliver medications. She said such items are covered.

E. DeRosa said she was drafting a revised certification of compliance to address the amended policy forms. She said Exhibit L which is used for enrollment reporting would be revised to capture the cost sharing of the amended plans.

W. Sanders said the Legal Committee considered the draft Advisory Bulletin on riders to amend a Basic and Essential Healthcare Services Plan (B&E Plan) and recommended some changes regarding the comparison of the B&E Plan with rider to a standard plan.

D. Farkus recused himself with respect to the discussion of the PHCS fee profile citing a conflict of interest since the matter related to Ingenix which owns the PHCS profile and is owned by United Health Group, which is the parent of his employer, Oxford.

M. McClure expressed concern that the PHCS profile is being influenced by doctor billing and therefore may not provide a fair indication of a reasonable charge for the various services. She said the RBRVS assigns relative values to services depending on the nature and complexity of the service. She said Medicare uses RBRVS. While she said Aetna would not recommend paying at the same level as Medicare pays, Aetna would recommend using 125% of RBRVS.

S. Kelly also supported using RBRVS and said Horizon believed 115% of RBRVS would provide appropriate payment. S. Kelly said Horizon recommends using 100% of the Medicare DRG for hospital charges.

E. DeRosa asked if Horizon and Aetna could provide some comparative information regarding how 115% or 125% of RBRVS to the current requirement that carriers use the 80th percentile of PHCS. She noted that a fair number of consumer inquiries deal with the fact that a provider's charge exceeded the allowance established using the 80th percentile of PHCS often leaving consumers with large balance billing charges. From a consumer perspective it would be very helpful to know if using 115% or 125% of RBRVS would result in even greater consumer liability.

V. Executive Session

W. Sanders said the Board would need to move to Executive Session to receive advice from counsel.

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 the motion.

[Executive Session: 2:20 p.m. – 2:45 p.m.]

VI. Discussion of Draft Regulations and Draft Policy Forms (Continued)

W. Sanders reminded the Board that at the May 10, 2005 meeting M. McClure said Aetna Health, Inc. was going to support using the "adjusted net earned premium" method to calculate loss assessments for 1997 and forward. Given the position Aetna is now taking on the assessment methodology, W. Sanders noted the Board appears to be at an impasse, lacking the necessary five votes for any one methodology.

V. Mangiaracina noted that the Commissioner must review and approve the Plan of Operation, and the assessment methodology is contained in the Plan of Operation. She said that if the Board continues to be at an impasse with respect to the loss assessment methodology the Commissioner would propose the Plan of Operation and would use the "adjusted net earned premium" methodology.

The Board asked the Legal Committee to consider whether modified community rated lives covered under Basic and Essential Healthcare Services plans should be included in the calculation of non-group person lives.

VII. Horizon Filings

W. Sanders said the Board received both a rate filing and a rider filing from Horizon shortly before the May 24, 2005 meeting. The filings, which relate to the Basic and Essential Healthcare Services Plan and a rider would be discussed during the June 6, 2005 meeting.

VIII. Close of Meeting

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

The meeting adjourned at 3:25 p.m.

DRAFT*
MINUTES OF THE MEETING OF THE
NEW JERSEY INDIVIDUAL HEALTH COVERAGE PROGRAM BOARD
AT THE OFFICES OF THE
NEW JERSEY DEPARTMENT OF BANKING AND INSURANCE
TRENTON, NEW JERSEY
June 6, 2005

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

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

Others present: Ellen DeRosa, Deputy Executive Director; DAG Eleanor Heck (DOL); Wardell Sanders, Executive Director; Neil Vance (Chief Actuary Life and Health DOBI).

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 said the Board would consider the following during the meeting:

- Horizon filing of a Basic and Essential Health Care Services Plan (B&E Plan) rider (policy form and rates)
- B&E Plan Rider bulletin
- Proposed Readoption with Amendments, including Policy Forms

II. B&E Filings

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

E. DeRosa referred the Board to her memo of June 3, 2005 with a staff recommendation on the Horizon policy forms filing. She explained that Horizon previously certified it was using the specimen B&E policy form. In the new filing, Horizon used the specimen form to create an Exclusive Provider Organization (EPO) version of the B&E Plan. E. DeRosa said the changes Horizon made to the specimen plan were appropriate for the creation of an EPO product. She recommended that the Board approve Horizon's forms filing for the EPO B&E Plan. E. DeRosa noted that the Legal Committee considered the uniform modification provisions of HIPAA and believes a carrier can uniformly modify an indemnity B&E Plan to become an EPO B&E Plan. Thus, Horizon would not need to maintain the indemnity version of the B&E Plan beyond the non-renewal of inforce plans.

E. DeRosa said the filing also included a rider to increase the benefits of the EPO B&E Plan. She summarized the benefits the rider adds. Responding to a question as to whether the B&E Plan plus rider would create a plan comparable to a standard plan, E. DeRosa said it would not since the rider adds limited benefits. E. DeRosa said Horizon provided the benefit comparison being considered as a requirement in the B&E Rider bulletin. She recommended that the Board approve the rider.

M. McClure offered a motion to approve the EPO B&E plan and the increasing rider as submitted by Horizon Blue Cross Blue Shield. E. Shrem seconded the motion. The Board voted unanimously in favor of the motion.

E. DeRosa said TAC considered the rate filing and had several questions and therefore was recommending that the filing be found incomplete. She said she contacted Horizon following the TAC meeting. Horizon provided information to respond to the questions which she said she forwarded to TAC members for review. E. DeRosa said she received responses from the TAC members all of whom said the responses addressed the concerns. Therefore,

E. DeRosa said the TAC recommendation to find the filing incomplete was no longer the recommendation.

The Department's actuary, Neil Vance, acknowledged that Horizon provided responses to the questions TAC identified. He said the Department welcomes additional products in the individual market. He said the Department is concerned with the rates, not with the product. N. Vance said the rate filing specifies a 12.3% profit margin which the Department believes to be excessive. He said the Department could not endorse a rate filing with such a large profit margin for a product priced to a 75% loss ratio.

N. Vance said overall profit margins in the commercial market over the past couple of years have been around 4%. He noted that profit margins in the individual market have been a bit higher than 4%.

N. Vance said the existing B&E Plan is a community rated pure indemnity plan. He said Horizon offered the B&E Plan at a price comparable to a standard indemnity product even though the benefits in the B&E Plan are significantly less than in the standard plans. With the new rate filing as a point of comparison, N. Vance said it became clear that the rates for the existing product were excessive and gave examples of the rates for the B&E Plan with rider. He noted even for the older ages, the rates are lower than the existing B&E plan rates. N. Vance said nine people bought the existing B&E Plan and he said he believed there should be some adjustment as a result of the excessive rates.

L. Yourman asked if the Board can challenge a 12.3% profit margin. She recalled that the Board refused to add a maximum out of pocket to prescription drug coverage as a consumer protection fearing it would increase rates by 1% – 3%, yet a carrier can set rates assuming a 12.3% profit. L. Yourman expressed concern that a carrier would consider a profit margin of 12.3% which is well in excess of the profit margins used by other carriers in the commercial market.

N. Vance said there is a difference between a carrier pricing to 75% as a minimum loss ratio versus using 75% as an exact target. N. Vance said the rates in the rate filing were too high. He said there was no justification for a 12.3% profit margin and that Horizon could reduce the rates without impairing their financial condition.

III. Executive Session I

W. Sanders said the Board would need to move to Executive Session to receive advice from counsel.

[S. Kelly recused herself from the meeting.]

L. Yourman offered a motion to begin Executive Session to receive advice from counsel. V. Mangiaracina seconded the motion. The Board voted unanimously in favor the motion.

[Executive Session: 10:23 a.m. – 10:30 a.m.]

IV. B&E Filings (Continued)

M. McClure offered a motion to find the Horizon rate filing for the B&E EPO plan and the rider complete. U. Lee seconded the motion. The motion did not carry. (3

votes in favor: M. McClure, U. Lee, D. Farkus; 2 votes opposed: V. Mangiaracina, L. Yourman; 1 abstention: E. Shrem)

DAG E. Heck confirmed that N.J.A.C. 11:20-2.5(d)1 requires a majority of Board members present at the meeting is required for such a motion to carry.

V. B&E Rider Bulletin

V. Mangiaracina offered a motion to issue Advisory Bulletin 05-IHC-03 on riders that amend the Basic and Essential Healthcare Services Plan. M. McClure seconded the motion. The Board voted unanimously in favor of the motion.

[Break: 10:45 a.m. – 10:55 a.m.]

VI. Policy Forms Exhibits

E. DeRosa reviewed the policy forms exhibits and discussed changes since the last draft of the policy forms with the Board.

L. Yourman requested that specific text be added to the forms to address coverage for various disposable supplies such as insulin pump cartridges and the insulin pump itself. S. Kelly said such items are already covered. She said Horizon covers such items under the durable medical equipment covered charge.

E. DeRosa said the specimen B&E policy form was updated to reflect all the non-covered charge type changes that were made to the standard plans. She noted that carriers using the specimen form will have to update their policy form when the Board adopts the proposed amendments. Carriers that filed their own B&E forms will be required to file new forms.

VII. Regulation Text

Operations and Audit Committee Recommendations
W. Sanders said the Operations and Audit Committee recommended that the regulation include a $20.00 de minimis amount for the payment of an assessment invoice, whether it is a combined loss and administrative assessment or just an administrative or just a loss assessment.

W. Sanders said the Committee believed two years would be ample time for timely completion of a loss audit.

Legal Committee Recommendations
W. Sanders said the Legal Committee recommended that Medicare Advantage and Medicare +Choice be counted in non-group target setting and satisfaction.

W. Sanders said the Legal Committee recommended that B&E enrollment, regardless of whether the plan is rated on a community rated or a modified community rated basis be counted in non-group target setting and satisfaction.

W. Sanders said the Legal Committee considered whether a market withdrawal during a two-year calculation period should preclude a carrier from seeking reimbursement for losses incurred during the period. He said the Committee recommended that absence of premium during the period, not withdrawal, should be the factor to preclude reimbursement of losses.

Determination of Reasonable and Customary Charge
W. Sanders reported that a representative from Ingenix, the company that owns the PHCS fee profile gave a presentation to a number of persons from the Department.

D. Farkus recused himself from the discussion of the PHCS profile citing a conflict of interest since the matter related to Ingenix which owns the PHCS profile and Ingenix is owned by United Health Group, which is the parent company of his employer, Oxford.

M. McClure reported that the RBRVS schedule is available for free on the internet. She acknowledged that using 125% of RBRVS would produce benefit payments that are lower than those produced using the 80th percentile of PHCS. She said she learned 125% of RBRVS would be about 57% of the 80th percentile of PHCS.

M. McClure said Aetna is concerned with how benefits are to be paid to non-network providers in instances where the members are responsible only for network level cost sharing. E. DeRosa noted that N.J.A.C. 11:22-5.6 requires carriers to pay various ancillary providers in a network hospital (e.g., anesthesiologists) such that the member pays only the network cost sharing.

V. Mangiaracina said that any change from using the 80th percentile of PHCS is a major change that requires significant research and consideration. Further, since the SEH Program also requires the use of the 80th percentile of PHCS it would make sense for both Boards to consider the issue at the same time.

M. McClure said RBRVS helps deal with inflation caused by billing practices. S. Kelly said the IHC Program plans should not continue to provide richer coverage than large group plans in terms of how the reasonable and customary charge is determined.

S. Kelly briefly discussed the chart Horizon compiled showing cost to charges for hospital bills. She said Horizon recommended that carriers not be required to pay hospitals actual charges.

After some discussion, the Board agreed to consider the reasonable and customary standard in conjunction with the SEH Board at a later date.

VIII. Executive Session II

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

[Executive Session: 1:22 p.m. – 1:45 p.m.]

IX. Policy Forms and Regulation Text

V. Mangiaracina offered a motion to propose Appendix Exhibits A, B, C, D, E, F, J, K and L. L. Yourman seconded the motion. The Board voted unanimously in favor of the motion.

L. Yourman offered a motion to propose N.J.A.C. 11:20-2.17, as drafted (adjusted net earned premium assessment methodology beginning 1997). M. McClure

seconded the motion. The motion did not carry. (in favor: L. Yourman, E. Shrem, V. Mangiaracina, M. McClure; opposed: S. Kelly, D. Farkus, U. Lee)

U. Lee said Guardian would have supported the motion if it had addressed periods beginning in 1993.

U. Lee offered a motion to propose N.J.A.C. 11:20-2.17, with the draft modified such that the adjusted net earned premium assessment methodology begins in 1993 and continues thereafter. The motion was not seconded.

V. Mangiaracina offered a motion to use the adjusted net earned premium methodology for 1993 – 1996 and to use the adjusted net earned premium methodology for 1997 and forward. L. Yourman seconded the motion. The motion did not carry. (in favor: U. Lee; opposed: M. McClure, V. Mangiaracina, E. Shrem, D. Farkus, L. Yourman, S. Kelly)

V. Mangiaracina offered a motion to use the adjusted net earned premium methodology for 1997 and forward. M. McClure seconded the motion. The Board voted in favor of the motion. (in favor: M. McClure, V. Mangiaracina, U. Lee; E. Shrem, L. Yourman; opposed: D. Farkus, S. Kelly)

The Board discussed waiting until litigation is completed to determine what, if anything, must be done to the assessment methodology for 1993 – 1996. The Board took no action.

V. Mangiaracina offered a motion to propose Chapter 20, subject to the review of the Attorney General's Office, and if there are substantive changes, the Board must have the opportunity to consider them. L. Yourman seconded the motion. The Board voted unanimously in favor of the motion.

X. Close of Meeting

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

The meeting adjourned at 2:30 p.m.

DRAFT*
MINUTES OF THE MEETING OF THE
NEW JERSEY INDIVIDUAL HEALTH COVERAGE PROGRAM BOARD
AT THE OFFICES OF THE
NEW JERSEY DEPARTMENT OF BANKING AND INSURANCE
TRENTON, NEW JERSEY
June 28, 2005

Directors participating in Trenton: Darrel Farkus (Oxford); Vicki Mangiaracina (DOBI).

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Directors participating from other locations by phone: Sandi Kelly (Horizon BCBSNJ); Ulysses Lee (Guardian); Mary McClure (Aetna Health); Amy Wallace (Oxford); Lisa Yourman.

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. He took roll call. A quorum was present.

Due to telephone participation, W. Sanders asked that people identify themselves when speaking.

II. Request to Address the Board

W. Sanders said David Mannis of CIGNA asked for the opportunity to address the Board.

D. Mannis commented on the vote the Board took during the June 6, 2005 meeting to include in the proposed readoption of the IHC regulations an assessment methodology that he referred to as the "USLife approach." He said CIGNA would like the Board to support a delay for any proposal of an assessment methodology to allow the Legislature time to offer a legislative resolution.

D. Mannis noted that Assemblyman Cohen's bill, which was approved by the Assembly, includes an approach to the loss assessment. He said identical loss assessment language has been recommended for inclusion in the budget which must be approved by June 30, 2005.

D. Mannis said he was aware that the Board was concerned that any loss assessment methodology it proposes will lead to litigation. D. Mannis said CIGNA believes that if the Legislature, not the Board, dictates the assessment methodology, the methodology would better withstand litigation. He agreed that a challenge to any action of the Board was likely. He said CIGNA is prepared to challenge any assessment approach that suffers from defects, and which he said is not in accord with the law, such as the method the Board voted to propose during its June 6, 2005 meeting.

In response to an inquiry from L. Yourman, the Board briefly discussed the assessment methodology as included in Assemblyman Cohen's bill and suggested for inclusion in the budget. M. McClure described it as the "stop the music" approach since it would provide for no further payments to carriers who had reimbursable losses in prior periods, regardless of what the carriers had been paid thus far, and no further loss assessments would be billed for the prior years.

L. Yourman said the Board chose a method it believed addressed the requirements of the law. She invited CIGNA to provide comments during the comment period.

D. Mannis urged the Board to carve out the assessment text from the proposed readoption and proceed to propose the other parts of the regulation.

M. Guhl of the Association of Health Plans asked for the opportunity to address the Board. She said the Association membership supports the Cohen bill method for assessments. M. McClure noted that Aetna Health, which is a member of the Association, did not affirmatively support the language. Rather, she said Aetna Health had stated it would not oppose it. M. Guhl said HealthNet and Horizon and the two Medicaid-only HMOs had not yet responded to whether they supported the language. She said three carrier members, CIGNA, Oxford and AmeriHealth, voiced support for the language. M. Guhl said those carriers represented a significant mass of the players that endorsed the method in the Cohen bill.

D. Mannis and M. Guhl left the meeting.

The Board briefly discussed presentations made by D. Mannis and M. Guhl and concluded that it would not take any specific action in response to the presentations.

III. Minutes

May 10, 2005

V. Mangiaracina offered a motion to approve the Open Session minutes of the May 10, 2005 Board meeting, as amended. S. Kelly seconded the motion. By roll call vote, the Board voted in favor of the motion, with U. Lee abstaining.

May 24, 2005

M. McClure offered a motion to approve the Open Session minutes of the May 24, 2005 Board meeting, as amended. V. Mangiaracina seconded the motion. By roll call vote, the Board voted in favor of the motion, with L. Yourman abstaining.

June 6, 2005

The Board discussed the minutes and agreed to postpone voting on the minutes until the August 2005 Board meeting.

IV. Report of Staff

Expense Report

V. Mangiaracina offered a motion to approve the payment of the expenses on the June expense report. L. Yourman seconded the motion. By roll call vote the Board voted unanimously in favor of the motion.

Blackberry Request

W. Sanders requested that the Board authorize the purchase of a Blackberry for his use. He noted he is often out of the office for business and the Blackberry would enable him to access e-mail, his calendar and address book. He said it also functions as a cell phone. W. Sanders said the equipment cost and the monthly fees would be shared with the SEH Board if that Board approves the request.

U. Lee offered a motion to authorize the purchase of a Blackberry, with the IHC Board paying half the cost. D. Farkus seconded the motion. By roll call vote, the Board voted unanimously in favor of the motion.

Board Appointments

W. Sanders reported that the Acting Governor nominated two appointees to the IHC Board, Christine Sterns as a representative of an employer and Steve Lennox as a representative of

organized labor. Both would need to be confirmed by the Senate before being seated on the Board.

Legislative Report
W. Sanders briefly summarized the following bills: A. 2006, A. 3359, A. 3340, A. 3759, S. 1912 and A. 4264.

[D. Farkus left the meeting at 10:40 p.m. A. Wallace replaced him as the Oxford representative.]

Executive Order 41
W. Sanders said this recent Executive Order deals with State Boards and, among other things, will require Board members to receive training in government ethics and perhaps other areas by January 1, 2006.

Good Faith Effort to Market the Basic and Essential Healthcare Plan (B&E Plan)
E. DeRosa referred to her memos and attachments of June 24, 2005 and June 27, 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 included in the June 24, 2005 memo and updated in the June 27, 2005 memo that identifies what each carrier submitted. She explained that copies of the marketing efforts carriers provided were attached to her memo to enable Board members to review the marketing efforts.

The reports were due May 1, 2005. E. DeRosa said two carriers, Aetna Life Insurance Company and Celtic Life Insurance Company, did not submit B&E marketing reports and that she sent letters to both carriers, requesting that reports be sent.

V. Mangiaracina offered a motion to accept the B&E marketing reports as submitted by AmeriHealth and CIGNA. L. Yourman seconded the motion. By roll call vote, the Board voted unanimously in favor of the motion.

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

V. Mangiaracina offered a motion to accept the B&E marketing report as submitted by Horizon Blue Cross Blue Shield of New Jersey. L. Yourman seconded the motion. By roll call vote, the Board voted unanimously in favor of the motion.

U. Lee recused himself with respect to the B&E marketing report 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.

V. Mangiaracina offered a motion to accept the B&E marketing report as submitted by Health Net. L. Yourman seconded the motion. By roll call vote, the Board voted unanimously in favor of the motion.

A. Wallace recused herself with respect to the B&E marketing report filings from Oxford Health Insurance and United Healthcare of New Jersey, citing a conflict of interest since the

matter related to filings submitted by her employer, Oxford Health Insurance and its owner, United Healthcare of New Jersey.

M. McClure offered a motion to accept the B&E marketing reports as submitted by Oxford Health Insurance and United Healthcare of New Jersey. L. Yourman seconded the motion. By roll call vote, the Board voted unanimously in favor of the motion.

The Board agreed to take action with respect to the two carriers that failed to submit B&E marketing reports during the August 2005 meeting.

V. Report of the Operations and Audit Committee

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

Protective Life
W. Sanders provided a narrative of the recent events concerning the Protective Life audit. Premium and claims information is still unavailable for an 11-month period of time which is part of the two-year calculation period for which Protective Life has sought loss reimbursement. He said the Committee recommended that the Board give Protective Life until July 15, 2005 to provide outstanding information. The Board agreed.

Fortis
W. Sanders said Deloitte & Touche had indicated that it would be providing information regarding an additional claims sample of Fortis claims which will be necessary because of the exception level in the original sample selection. He said Fortis has not yet agreed to an additional sample and noted that if Fortis objects to the adjustments D&T has made and the additional sampling, D&T may not be able to complete the audit due to a scope limitation. He explained that no Board action is required at this time.

VI. 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.

L. Yourman offered a motion to begin Executive Session for the purpose of reviewing minutes and receiving advice from counsel. V. Mangiaracina seconded the motion. By roll call vote, the Board voted unanimously in favor of the motion.

[Executive Session: 11:25 a.m. – 11:40 a.m.]

VII. Close of Meeting

L. Yourman 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 11:40 a.m.