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
SEPTEMBER 9, 2008

Directors participating: Darrel Farkus (United); Sandi Kelly (Horizon); Ulysses Lee (Guardian); Gale Simon (DOBI); Christine Stearns; Mary Taylor (Aetna Health Inc.).

Others present: Ellen DeRosa, Executive Director; Chanell McDevitt, Deputy Executive Director; Rosaria Lenox, Accountant; Vicki Mangiaracina, DAG.

I. Call to Order

E. DeRosa called the meeting to order at 10:03 A.M. She 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*

D. Farkus offered a motion to approve the August 12, 2008 open session minutes with amendments as discussed. G. Simon seconded the motion. The Board voted to approve the motion, with U. Lee abstaining.

G. Simon offered a motion to approve the August 28, 2008 open session minutes with amendments as discussed. M. Taylor seconded the motion. The Board voted to approve the motion, with U. Lee abstaining.

III. Report of Staff

Expense Report

R. Lenox presented the September expense report, showing expenses totaling $12,576.58.

S. Kelly offered a motion to approve the payment of the expenses on the September 2008 expense report, totaling $12,579.58. U. Lee seconded the motion. The Board voted unanimously in favor of the motion.

Exemption Requests

E. DeRosa reported that exemption requests for the 2007-2008 calculation period had been received timely from: Aetna, CIGNA, Health Net, Horizon and United. She stated an additional request for an exemption from the loss assessment had been submitted by AmeriHealth 30 days after the due date.

Upon discussion, it was determined the Board previously has received and conditionally approved late exemption requests, although none had been as much as 30-days late. The Board considered that AmeriHealth initially made a timely submission of a request for an exemption, and thus, had shown an intention to be exempt from the loss assessment.

M. Taylor, S. Kelly and D. Farkus each recused him- or herself from the vote on the exemption request filed by his or her employer (Aetna, Horizon and United, respectively), because of his or her employer's interest in the outcome of the vote.

G. Simon made a motion to approve the exemption requests of Aetna, CIGNA, Health Net, Horizon, United and AmeriHealth with respect to the 2007-2008 loss reimbursement calculation period. C. Stearns seconded the motion. The Board voted unanimously in favor of the motion, with M. Taylor recused from the vote as to Aetna, S. Kelly recused from the vote as to Horizon, and D. Farkus recused from the vote as to United.

IV. Operations & Audit Committee Report (OAC)

Loss Audits Request for Proposal (RFP)
E. DeRosa reported the Evaluation Committee reviewed the bids submitted by Withum Smith + Brown (WSB) and IS Partners LLC (partnering with Invotex) in response to the RFP for the loss audits, and recommended selection of Withum Smith + Brown (WSB) to the Operations & Audit Committee (OAC). The OAC considered the recommendation and accepted it, and thus, recommends to the Board to engage WSB for the loss audits for the 2001-2002, 2003-2004 and 2005-2006 calculation periods.

Upon discussion, C. Stearns recused herself from the vote on the matter because a principal of WSB chairs the Health Committee of the New Jersey Business & Industry Association (C. Stearn's employer), to avoid any appearance of impropriety.

M. Taylor offered a motion to award the audit contract for the 2001/2002, 2003/2004 and 2005/2006 reimbursable losses to Withum Smith + Brown. D. Farkus seconded the motion, and the Board voted unanimously to approve it.

Horizon's 1992-1995 Reimbursable Losses
E DeRosa reported the OAC reviewed Horizon's request not to issue an invoice to Horizon for overpayments made towards Horizon's 1992 through 1995 losses, but did not receive expected additional information on the issue from Horizon. She reported the OAC continued to recommend invoicing Horizon for the overpayment, noting that Horizon's liability for the total losses would be addressed when the reconciliation of liability of all member carriers is performed for the 1992 through 1995 time periods.

S. Kelly recused herself from any discussion of or action to be taken on the matter because of the interest of her employer, Horizon, in the outcome of the matter.

Pursuant to discussion, the Board determined: (1) the primary issue is whether to require carriers to return identified overpayments prior to final reconciliations being performed; (2) reconciliations should not be performed until resolution of the CHUBB II case (for which oral arguments have not yet been scheduled), because the CHUBB II outcome has a direct bearing upon the formula to be used in allocating the losses, such that attempts at reconciliation before resolution of the case would be premature; and, (3) Horizon is unique, but similar issues (overpayment of losses via advances and credits) are likely when the agreed upon procedures for Metropolitan and Protective are complete.

U. Lee offered a motion to accept the OAC recommendation to issue an invoice to Horizon for return of monies identified to have been overpaid by the Board to Horizon with respect to Horizon's 1992 through 1995 losses. G. Simon seconded the motion. The motion carried, with U. Lee, G. Simon and C. Stearns voting in favor of it, M. Taylor voting no, and D. Farkus abstaining.

V. Technical Advisory Committee Report (TAC)

Aetna B&E rate filing
M. Taylor recused herself from any discussion of or action to be taken on the matter because of the interest of her employer, Aetna, in the outcome of the matter.

S. Kelly reported the TAC recommended finding the Aetna B&E rate filing to be complete.

G. Simon offered a motion to find the Aetna B&E rate filing complete, which was seconded by D. Farkus. The Board voted unanimously in favor of the motion.

Rule regarding voluntary movement by individuals among plans
E. DeRosa reported that TAC reviewed the regulations on replacement of plans by individuals, and made some suggestions, in particular recommending that comparison of plans be based on filed rates going forward (in light of modified community rating), so that there is a comparison between what the person would pay to continue in the current plan versus moving to another plan. She said TAC also recommended revising language at N.J.A.C. 11:20-12.4(c) to limit movement from an HMO plan outside of the annual open enrollment period.

Aetna B&E EPO form filing
M. Taylor recused herself from any discussion of or action to be taken on the matter because of the interest her employer, Aetna, has in the outcome of the matter.

E. DeRosa reported Aetna submitted the B&E EPO forms with all necessary corrections, and the Board has now approved rates for the submission. She explained that the difference between the B&E specimen form and Aetna's B&E EPO form is the requirement that covered persons use in-network health care providers except in the case of an emergency.

S. Kelly offered a motion to approve Aetna's B&E EPO form filing for use effective October 1, 2008. D. Farkus seconded the motion, and the Board voted unanimously in favor of it.

VI. Report of the Legal Committee

Good faith marketing
E DeRosa reported the Legal Committee considered several questions related to the good faith marketing requirement established by P.L. 2008, c. 38, and had recommended the following:

1. Requiring only those carriers marketing in both the Individual Health Coverage (IHC) and Small Employer Health Benefits (SEH) markets to file a report demonstrating good faith marketing; and
2. Requiring carriers to demonstrate good faith marketing for all plans the carrier offers in the IHC market, but not requiring such a demonstration for riders.

Plan counts
E. DeRosa reported the Legal Committee recommended allowing the HMO Plan to count as one of the three plans the carrier may offer to satisfy the three-plan requirement, if the carrier has an HMO affiliate.

Reducing to three plans and treatment of in-force business
E. DeRosa reported the Legal Committee was unable to make a recommendation about whether carriers could close books of in-force business as an alternative to withdrawing or converting the plan. At least one Legal Committee member argued that the language permitting forced conversion implied that closing the book was also permissible. At least one Legal Committee member argued that the good faith marketing and guaranteed issue requirements negate any implied option to close a book of business.

Upon further discussion, in which D. Farkus and S. Kelly requested input from technical experts from their companies (Scott Westphal of United and Joann Ryan of Horizon), the issue was distilled to be whether the 15% rate caps legislated by P.L. 2008, c. 38 would have any meaning if closed books of business were not permitted. It was agreed carriers could and would provide the 15% cap in the event of forced conversions (to the extent covered lives remain with the same carrier). It also was agreed, however, that carriers were unlikely to force convert plans when withdrawal is an option, and there is no practical means for the 15% cap to follow to a person's plan with another carrier. Board members agreed that, arguably, the 15% rate cap was only meaningful if carriers had the option to close a book of business. Upon further discussion, it was agreed that closing a book of business might be an exception to either the conversion rules (under the Board's jurisdiction), or the withdrawal rules (under DOBI's jurisdiction), and left staff to discuss the matter further with DOBI.

M. Taylor offered a motion, seconded by C. Stearns, to take a brief break. The Board voted unanimously in favor of the motion.

[Break from 11:35 to 11:45 A.M.]

VII. Review of the Draft Proposal implementing P.L. 2008, c. 38 and P.L. 2007, c. 345

E. DeRosa reviewed the revised draft rule proposal. The following issues were discussed:

- The *de minimis* amount for purposes of collecting an assessment will be changed from $20 to $10 for loss assessments or combined loss and administrative assessments, and would be set at $5 for administrative assessments alone.
- A carrier must offer the deductible or copayment specified in the rule for the carrier's plans designated to meet the three-plan requirement, but does not have to do so with respect to other IHC plans offered.
- The update rider – as it regards deductible changes being proposed – also applies to the HMO Plan (using deductible and coinsurance options).
- Enrollment reporting language may need to be modified to make it clear that reporting is only with respect to the IHC standard plans, whether community rated or modified community rated, but not community rated or modified community rated pre-reform plans.
- The definition or explanation of modified community rating should be clarified to specify that modified community rating includes community rating.
- It is permissible for individuals to move from the HMO Plan to a lower-cost B&E Plan outside of the open enrollment period.
- It is impermissible for individuals to add a rider to any plan except during the open enrollment period.
- There will be a proposal to have an additional open enrollment period in 2009, running from 1/5/08 through 3/31/08, with an effective date of no later than 4/1/08.
- Forced plan conversions do not have to occur upon anniversary dates.
- Carriers will be required to submit new Exhibit H (the Identification of Standard Plans form) to the Board so that the Board can determine which plans a carrier is designating to comply with the three-plan requirement. The form is not redundant with the filing of certification of compliance information (with DOBI) because the certification of compliance demonstrates that a carrier is offering each plan in accordance with plan-specific requirements, but does not identify which plans will meet the three-plan requirement (and thus, must comply with certain deductible and copayment options), and which plans are "extra."
- Exhibit K is being amended primarily to address the Medicare premium issue and to remove reference to NJ KidCare.
- The proposal will use the Board's expedited rulemaking process to reduce some of the time necessary to get through the proposal (and adoption) process, but will allow for a 45-day comment period. Because changes to the forms

will be proposed, there will be a public hearing on the proposal. Details on that remain to be determined.

M. Taylor made a motion, seconded by D. Farkus, to move into executive session to discuss prior executive session minutes, and obtain legal advice from counsel. The Board voted unanimously in favor of the motion.

[Executive Session from 12:20 to 12:45 P.M.]

Return to discussion of the rulemaking process
The question of the closed book of business arose again, because the draft is currently silent on the closed book of business issue. The Board again agreed there should be further discussions between staff, DOBI and V. Mangariacina on how to handle the issue.

E. DeRosa reminded the Board the proposal must go to Governor's Counsel prior to sending it to OAL, and stated that, if necessary, the 45-day comment period could be reduced (to no less than 20 days).

M. Taylor made a motion to authorize staff to forward the rule proposal to Governor's Counsel and subsequently to the Office of Administrative Law pursuant to the Board's expedited rulemaking process, subject to the proposal being amended as discussed in the meeting, and as may be agreed upon between staff, Board counsel and DOBI regarding the issue of permitting carriers to close books of business. C. Stearns seconded the motion. The Board voted unanimously in favor of the motion.

V. Close of Meeting

G. Simon offered a motion to close the meeting, seconded by S. Kelly. The Board voted unanimously in favor of the motion.

The meeting adjourned at 1:00 P.M.