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 12, 2008

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

Others present: Ellen DeRosa, Executive Director; Chanell McDevitt, Deputy Executive Director; Rosaria Lenox, Program Accountant; Eleanor Heck, DAG.

I. Call to Order

E. DeRosa called the meeting to order at 10:05 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 – *July 18, 2008*

S. Kelly offered a motion to accept the Open Session minutes of the July 18, 2008 Board meeting, as amended. D. Farkus seconded the motion. The Board voted unanimously in favor of the motion.

III. Report of Staff

Expense Report

R. Lenox presented the August expense report, with expenses totaling $12,953.99.

G. Simon offered a motion to approve the payment of the expenses on the July 2008 expense report, totaling $12,953.99. M. Taylor seconded the motion. The Board voted unanimously in favor of the motion.

Exemption Requests for 2007-2008 Loss Assessments

E. DeRosa stated staff mailed a bulletin on July 7th to carriers explaining that the prior exemption requests for the 2007-2008 assessment period were no longer valid (because of a revised treatment of Medicare Advantage premium on Exhibit K filings), and that carriers seeking an exemption would need to resubmit their request. She noted not all carriers that previously submitted an exemption request had re-submitted a request. She stated the exemption requests are due within 30 days after receipt of the bulletin, so she expected the exemption requests would be coming soon.

Administrative Audit Contract

E. DeRosa reminded Board members the contract for the administrative audits for fiscal years 2000 through 2008 had been awarded to Withum Smith + Brown (WSB), and stated that the contract has been completed and was sent to WSB for signature.

Aetna Basic & Essential EPO filing

M. Taylor recused herself from any discussion of or action in this matter because of the direct interest her employer, Aetna Health Inc., has in the outcome.

E. DeRosa reported Aetna had submitted a Basic & Essential (B&E) filing using an EPO design, but that the filing failed to include the required certifications and contained provisions contrary to New Jersey law. She explained Aetna's intent is to begin offering the policy in October. The Board discussed approving the filing subject to Aetna making appropriate revisions.

G. Simon moved to approve the Aetna B&E filing subject to Aetna correcting all items outlined by staff as deficient. D. Farkus seconded the motion.

E. Heck stated she believed that, with M. Taylor recused, the Board no longer had a quorum necessary for it take official action.

S. Kelly made a motion to move the meeting into Executive Session for the purpose of obtaining legal advice from counsel and to review Executive Session minutes. G. Simon seconded the motion, and all members of the Board voted in favor of the motion.

[Executive session from 10:18 A.M. to 10:25 A.M.]

E. DeRosa reminded the Board members M. Taylor was still recused with respect to the Aetna B&E filing, and a motion regarding the filing remained on the table.

G. Simon amended her prior motion to approve the Aetna B&E filing subject to Aetna correcting all items outlined by staff as deficient within 10 days of notice from staff, and subject to further advice regarding a quorum. D. Farkus seconded the motion and the Board approved it.

IV. Report of the Operations and Audit Committee (OAC)

AEGON/UICI and Protective and Metropolitan

M. Taylor reported the OAC received information from Deloitte & Touche (D&T) regarding sampling options for the AEGON/UICI agreed-upon procedure (AUP). She stated D&T suggested an expanded AUP, with the Board deciding the sample size, which the OAC recommends be 73. It was noted this is a judgmental sample, not a statistically significant sample. E. DeRosa reported she contacted AEGON representatives regarding the OAC recommendation, and expected a response by September 3rd.

M. Taylor reported she spoke with D&T about the audit reports for Protective Life Insurance Company and Metropolitan Insurance Company, and the D&T representatives

stated the reports have been completed and await completion of D&T's senior management review.

Contract for Loss Audits
E. DeRosa reported the Evaluation Committee met to evaluate the two bidders for the loss audits, but one of the Evaluation Committee members had not yet completed the scoring process, so no recommendation was presented to the OAC to consider.

Loss Reimbursements for 1992 through 1995

S. Kelly recused herself from any discussion of or action to be taken by the Board on this issue because of the direct interest of her employer, Horizon Blue Cross Blue Shield, in the outcome.

R. Lenox reported she reviewed the loss reimbursements paid to Horizon for calendar years 1992 through 1995 following conclusion of the Horizon waiver case (*IMO the Individual Health Coverage Program Board's Adjustment of Blue Cross and Blue Shield of New Jersey's Requests for Reimbursement of Losses for Calendar Years 1993 and 1994)*, and determined the Board overpaid Horizon by $1,920,678. It was noted Horizon is now aware of the issue and the company's Controller is looking at the issue. E. DeRosa reported the OAC concurred with R. Lenox's calculations and recommended the Board send an invoice to Horizon with the documents supporting the invoice.

M. Taylor made a motion approving the issuance of an invoice with supporting documentation to Horizon, subject to further advice regarding a quorum. G. Simon seconded the motion, and the Board voted to approve it.

S. Kelly asked when final reconciliation of the 1992 through 1995 losses would occur, and E. DeRosa said staff suggested waiting for the outcome of the CHUBB II case (*IMO the Challenges by CHUBB Colonial Life Insurance Company, et al.*), which could have an impact on calendar years 1993 onward. E. Heck reported she had filed a motion to dismiss the CHUBB II appeal, and expected the decision was imminent.

V. Report of the Legal Committee

Supplemental Code of Ethics
E. DeRosa reminded Board members she had developed a Supplemental Code of Ethics (Supplemental Code), to supplement the Uniform Code of Ethics that all boards and commissions are required by the State Ethics Commission to use now. E. DeRosa reported the DOBI Ethics Officer, and subsequently, the Legal Committee reviewed the draft Supplemental Code and considered it fine. She reminded the Board its approval of the Supplemental Code means it will go to the Ethics Commission for review and approval, after which the Board may adopt the Supplemental Code. After discussion, the Board suggested the Supplemental Code be revised to include language prohibiting a Board member from using his or her position on the Board on letterhead, emails and similar materials.

M. Taylor made a motion to accept the draft Supplemental Code of Ethics as amended and forward it for review and approval to the State Ethics Commission. D. Farkus seconded the motion, and the Board voted unanimously to approve it.

Implementation of S-1557

E. DeRosa reported the Legal Committee reviewed a memo she prepared regarding implementation of those provisions of S-1557 that have a direct impact on the IHC Program. She reported the Legal Committee generally agreed the IHC Board needed to:

1. revise the definitions in the rules to include one for modified community rating;
2. remove references to NJ KidCare;
3. add rules to address the new statutory requirement that carriers offering coverage in the small employer market must also offer coverage in the individual market;
4. add rules to establish standards for good faith marketing of individual health benefits plans; the Legal Committee also agreed with the suggestion to use the same standards that apply to the B&E policies currently;
5. revise the rules to clearly designate Plan A/50 as the basic standard health benefits plan that all carriers must offer in the individual market;
6. add rules to address the permitted forced replacement of up to 25% of a carrier's plans by another plan of equal or greater actuarial value;
7. add rules to address filing requirements for optional benefits riders that carriers will be able to submit, and agreed in principle to standards similar to those in the SEH market;
8. discuss with DOBI whether DOBI or the Board want to maintain the B&E specimen (currently in the appendix to N.J.A.C. 11:20), when all form and rate filings for B&E transfer to DOBI;
9. discuss with DOBI what actions to take with respect to enhanced benefits for the B&E plans (with Legal Committee members agreeing this is probably a DOBI regulatory responsibility, not the IHC Board's);
10. transfer current rules regarding rates, rate filings, loss ratios, loss ratio filings, form filings, and plan withdrawals from the IHC Board to DOBI.

E. DeRosa reported the Legal Committee did not entirely agree on what constitutes an increasing (or decreasing) rider, debating whether a rider that both decreases and increases benefits with a resultant overall increase actuarially is an increasing rider.

Upon questioning from the Board regarding the removal of NJ KidCare and the consequences for Exhibit K filings, E. DeRosa explained that NJ KidCare was subsumed under NJ FamilyCare and removal of reference to NJ KidCare would have no impact on reporting premium.

Board members raised several questions regarding the revised rating and loss ratio requirements, including: (1) how a carrier could comply with the maximum 15% rate cap for renewal business and "uncapped" rates for everyone else under age 55; (2) how the four year period for capped rating is counted; (3) whether a new buyer includes people who are voluntarily or involuntarily switching plans; and (4) how a carrier could meet the

80% requirement when some of the policies in the calculation will have been guaranteed a rate based on a 75% loss ratio. G. Simon stated DOBI is developing standards for implementation of the rates, but nothing is complete.

The Board discussed what role it might have with respect to rates when 2009 starts. E. DeRosa noted TAC's role may be diminished before 2009, because rates for a post-1/5/09 effective date will be filed before 1/5/09. She noted, however, that TAC will continue to review B&E quarterly reports.

The Board discussed how to define "plan." Without coming to a conclusion, the Board questioned whether any action was required. The Board asked staff to draft the existing plans so all can be offered with multiple delivery systems, and requested the Legal Committee and Marketing Committee discuss whether the Board must (Legal) or should (Marketing) limit the number of standard plans.

The Board discussed whether to change its open enrollment rules, because the open enrollment period in November 2008 will not provide an accurate depiction of the 2009 market. The Board suggested it may offer two open enrollment periods in 2009.

The Board agreed to meet on August 28th at 10:00 A.M. for further discussion.

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 12:05 P.M.