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 28, 2008

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

Others present: Ellen DeRosa, Executive Director; Chanell McDevitt, Deputy Executive Director; Vicki Mangiaracina, DAG; Neil Vance, DOBI.

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. She noted voting would be by roll call because one Board member was participating by phone.

II. Report of Staff

Expense Report

E. DeRosa presented the second August expense report, showing expenses totaling $3,149.09.

D. Farkus offered a motion to approve the payment of the expenses on the second August 2008 expense report, totaling $3,149.09. M. Taylor seconded the motion. By roll call, the Board voted unanimously in favor of the motion.

III. Old Business

E. DeRosa noted that DAG E. Heck had researched the quorum and voting issue raised at the August 12, 2008 meeting, and determined there had not been a quorum available at that meeting with respect to two of the Board's actions. E. DeRosa suggested the Board revisit both issues.

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 reminded Board members Aetna had submitted a Basic & Essential (B&E) filing using an EPO design that had not included the required certification and had contained provisions contrary to New Jersey law, which the Board voted to approve if

corrections were made within a specified period of time. She stated that, because there was no quorum for the vote, and thus, no official Board action, she had not sent a letter noting deficiencies to Aetna. She explained Aetna had not yet submitted a rate filing for the B&E Plan but she expected the filing within the next week. She said Aetna indicated it would submit the relevant certification and make other corrections to the form filing prior to the September 9th meeting. She said, however, in the interim, the form filing remained incomplete.

G. Simon moved to disapprove the Aetna B&E filing. D. Farkus seconded the motion, which carried by unanimous roll call vote.

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.

E. DeRosa reminded the Board that the Operations and Audit Committee had recommended issuing an invoice to Horizon for $1,920,678 for overpayments by the Board to Horizon for losses reported for calendar years 1992 through 1995, based on R. Lenox's analysis (following conclusion of the Horizon waiver challenge) of the audited losses and the monies paid or credited to Horizon for those years. E. DeRosa noted no invoice was sent because the Board lacked a quorum when taking action on the matter, but reminded the Board she previously made Horizon aware of the issue. She explained Horizon's Controller had spoken with staff and stated: (1) Horizon may not owe the full $1,920,678; Horizon would owe little (or might be owed a refund) when a reconciliation of the losses for calendar years 1992 through 1995 occurs, because of a likely reduction in Horizon's assessment liability; and, (3) Horizon should not have to pay unless and until such a reconciliation occurs. E. DeRosa explained no reconciliation can occur until the *CHUBB II* matter is resolved. E. DeRosa said Horizon has requested the Board take no action on the invoice until Horizon has the opportunity to provide more information to the Board regarding Horizon's position. After some discussion, the Board agreed to wait until the September 9th meeting before taking action, and requested Horizon submit its information first to the Operations and Audit Committee, which is scheduled to meet September 2, 2008.

VI. Discussion of Rulemaking (Implementation of S-1557(3R))

E. DeRosa requested comments on the draft rules and amendments implementing S-1557(3R) she had distributed to Board members prior to the meeting. She noted she also included language in the contract forms to implement the statutory changes regarding orthotics and prosthetics. The Board reviewed the draft page-by-page, while also discussing some topics not directly addressed in the specific draft.

The Board requested the following issues be presented to the Legal Committee for evaluation:

1. Whether the good faith marketing requirement applies only to the three standard plans a carrier is required to offer (at a minimum), or to all of the standard plans a carrier offers (if more than three).
2. Whether the good faith marketing requirement applies only to carriers offering coverage in both the SEH and IHC markets, or also to carriers operating only in the IHC market.
3. Whether an HMO that is not federally-qualified must offer Plan A/50, an HMO Plan and one OR two additional standard plans (i.e., Plans B through D).
4. Whether or not the law supports an option for carriers to close a block of business, but continue to renew the inforce policies indefinitely as an alternative to withdrawal of a plan (with requisite nonrenewal of inforce business), and forced conversions as a method of reducing a carrier's total number of standard plan offerings.

The Board requested the Technical Advisory Committee consider whether there are reasons for changing the rules restricting movements in the IHC market between plans, noting the original rules never assumed a change in rating systems.

The Board requested the following substantive changes to the draft:

1. Specifying a required annual deductible of $2,500/person or $5,000/family, and specifying the required HMO copayment is $30.
2. Language specifying that addition of a rider does not constitute a new "plan."
3. Simplification of language regarding the rider approval process.
4. Revisions to enrollment reports (annual only) to capture numbers on plans with and without riders.
5. Addition of policy form language permitting carriers to use the HMO Plan with a nonreferral option and optional primary care provider selection (i.e., as an EPO alternative).
6. Clarification of the forced conversion option, to specify that the 25% measurement is based on a carrier's market enrollment (for example, a carrier with 3,000 of its 50,000 lives enrolled in Plan C could elect to force convert all of its Plan C lives to another standard plan (of equal or greater actuarial value) because 3,000 is equal to or less than 25% of the carrier's total enrollment).

The following issues under DOBI's jurisdiction were also discussed:

1. Whether the 15% maximum rate increase caps on renewal and those 55 and older are a constraint on the required rating system, with N. Vance stating the caps are not constraints on the system; rather, the rating system is the same across plans, with renewals and 55+ lives being treated differently by virtue of the temporary cap on the rate increase.
2. Whether pure community rates satisfy the modified community rating requirement, with N. Vance stating they do, so carriers could elect not to change their current rating system immediately, or ever (but the 15% cap would still apply for four years).

3. Whether billings must break-out the premium for standards plans and riders separately, with N. Vance stating no decision had been made on the issue yet.
4. What the impact of a withdrawal from the IHC market would be, with E. DeRosa stating withdrawal from IHC also requires withdrawal from SEH, but the prohibition on re-entry to both markets runs from the last date of nonrenewal for either the IHC market or the SEH market, whichever is later, the presumption being the last nonrenewal would occur in a carrier's SEH business.
5. Whether B&E rider filings should be with DOBI or remain under the Board's oversight, with G. Simon stating the preference the Board retain jurisdiction for B&E rider filings.

V. Close of Meeting

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

The meeting adjourned at 1:30 P.M.