NEW JERSEY
INDIVIDUAL HEALTH COVERAGE PROGRAM BOARD
20 West State Street, 10th floor
CN 325
Trenton, NJ 08625

May 7, 1996

Directors Present: J. Donnellan (Prudential); M.L.B. Kaplan (Blue Cross and Blue Shield of New Jersey); L. Moskowitz (Department of Insurance), R. Rondum; E. Shrem R. Smart (Mutual of Omaha); D. Williams (USHealthcare); L. Yourman

Others Present: K. O'Leary, Executive Director; DAG M. Smyth (DOL); E. DeRosa, IHC Program Assistant Director, S. Sanders (Deloitte & Touche)

I. Call to Order

J. Donnellan called the meeting to order at 9:50 a.m. K. O'Leary announced that notice of the meeting had been published in three New Jersey newspapers and posted at the Department of Insurance and the Office of the Secretary of State in accordance with the Open Public Meetings Act. K. O'Leary took roll call. A quorum was present.

II. Review of Minutes

R. Rondum offered a motion to adopt the minutes of the open session of the April 9, 1996 Board meeting, as amended. L. Yourman seconded the motion. The Board voted in favor of adopting the minutes, as amended. [8 in favor; 1 abstained - D. Williams]

III. Report of the Executive Director

Reimbursable Losses Audit
A final audit report was distributed to Board members. S. Sanders described the changes that were made to the draft that was previously distributed to the Board to arrive at this final report. He characterized most changes as cosmetic.

M.L.B. Kaplan asked why the second sentence had been added to the Expenses section of the Note to the Combined Statements of Net Paid Losses - Statutory Basis for Individual Business (Note). S. Sanders noted that the Board asked Deloitte & Touche (D&T) to include such sentence as a result of the Board's review of the draft audit report.

R. Rondum asked S. Sanders if the experience with auditing BCBSNJ allowed D&T to develop an agreed upon procedure for accounting. S. Sanders responded that the BCBSNJ audit was unique given the fact that BCBSNJ had provided Certifications for 1993 and 1994 to accompany the Exhibit Ks for those years in which certain expenses were specifically removed from the expenses reported on the Exhibit Ks.

M.L.B. Kaplan said that the audit regulations assumed a "perfect world." He noted that most carriers operate in more than one state and write multiple lines of business. He said he believed questions would be raised during subsequent audits. M.L.B. Kaplan said that the additional sentence in the Expenses section of the Note was language negotiated among the Board, BCBSNJ and the Attorney General's Office. Thus, the audit report was influenced by the actions of the Board. He stated that Program regulations called for an *independent* audit.

K. O'Leary commented that the Note to the expenses section of the report clarified that the audit report did not take the BCBSNJ Certifications into account and did not influence the substance of D&T's report. He further stated that he had advised M.L.B. Kaplan that no final audit report could have been issued until BCBSNJ issued a representation letter.

R. Rondum offered a motion to accept the final audit report prepared by D&T. L. Yourman seconded the motion.

Discussion:
R. Smart disagreed with M.L.B. Kaplan's questioning of whether an independent audit report was provided. She believed D&T performed and reported a valid independent audit. The inclusion of a sentence in the Expenses section of the Note, describing the report's scope, did not invalidate the independence of the report's conclusions.

M.L.B. Kaplan said BCBSNJ was advised that the statement that appeared in the Expenses section of the Note must be included in *both* the representation letter and in the Note.

L. Moskowitz asked if BCBSNJ took exception to the language. M.L.B. Kaplan said BCBSNJ provided a representation letter that did not include the language and that BCBSNJ had been directed to include the language. BCBSNJ did agree to the language, however, BCBSNJ would not have included it in the representation letter. The inclusion of the final language about the Certifications in the representation letter was eventually negotiated between M.L.B. Kaplan and the Executive Director.

J. Donnellan asked if D&T willingly agreed to add the language to the Note. S. Sanders said it was necessary in order to note that a difference existed between the D&T prepared BCBSNJ financial statements and the Exhibit Ks as prepared by BCBSNJ. J. Donnellan commented that the additional statement clarified the fact that a carrier was permitted to move away from statutory accounting.

By roll call vote, the Board voted to accept the final audit report prepared by D&T. [7 in favor; 1 abstained - M.L.B. Kaplan]

K. O'Leary said that the next issue related to the audit was the amount of losses reported. What amounts will the Board reimburse BCBSNJ for 1993 and 1994? For the years 1993 and 1994, BCBSNJ filed Certifications of the Allocation Methodologies for the IHC Carrier Market Share and Paid Loss Report in conjunction with Exhibit K. Such Certifications explained why the expense amounts shown on Exhibit K differed from the expenses reported on the Annual Statement filed with the Commissioner of Insurance. BCBSNJ did not seek reimbursement for employee incentive expenses and amortization of deferred system development costs for 1993 and 1994. Should BCBSNJ be reimbursed for those expenses, which are included in the D&T report as eligible expenses, or did BCBSNJ waive reimbursement of those expenses in the Certifications? M.L.B. Kaplan said that BCBSNJ intended to suppress the amount of reimbursement for 1993 and 1994. He contended that such action did not waive anything.

R. Smart offered a motion that the Board give effect to the BCBSNJ waivers of reimbursement, as specifically laid out and specifically waived, for employee incentive expenses and amortization of deferred system development costs for 1993 and 1994, when determining the amount of BCBSNJ losses for 1993 and 1994. That is, net paid losses for 1993: $54,153,372 - ($373,000 + $2,596,000), and net paid losses for 1994: $38,081,088 - ($885,000 + $2,238,000). E. Shrem seconded the motion. By roll call vote, the Board voted to approve the motion. [6 in favor; 2 abstained - M.L.B. Kaplan and L. Moskowitz]

Transfer of Funds to BCBSNJ

K. O'Leary asked the Board to consider the Funds Transfer Recommendation which was included in Board member materials. Thus far, the Program has paid reimbursement of $50,964,925.20 to BCBSNJ, which, when added to assessment credits which total $30,442,442 yields a total reimbursement of $81,407,367.20. Total reimbursement due to BCBSNJ for 1992, 1993 and 1994 is $88,255,380. The amount still due to BCBSNJ is $6,848,012.80. The Program had cash of $10,618,690.59. However, considering escrow, refunds due to carriers for 1993 and 1994 as well as the estimated administrative budget, only $5,754,390.01 of that amount was available to use to reimburse BCBSNJ. K. O'Leary noted that when the assessment is collected, the remainder could be paid to BCBSNJ. Thus, the Board could authorize the payment of all or part of $5,754,390.01.

L. Moskowitz noted that the amount to be paid to BCBSNJ would not consider interest on the money that was held.

L. Yourman offered a motion to authorize the Executive Director to release $5,754,390.01 to BCBSNJ within a reasonable time. E. Shrem seconded the

motion. The Board voted in favor of the release of $5,754,390.01 to BCBSNJ. [7 in favor; 1 abstained - M.L.B. Kaplan]

M.L.B. Kaplan commented that BCBSNJ would not be pleased with the Board's decision on the audit. He further stated that BCBSNJ expected to receive reimbursement with interest and that disbursements to other carriers should likewise include interest on the amounts due.

Assessment for 1995 / Reconciliation for 1994

K. O'Leary stated that part of the reconciliation for 1994 was a request for reimbursement by Greater Atlantic. He asked Greater Atlantic to provide a certification that the losses were attributable to standard IHC plans, and Greater Atlantic provided such a certification. He recommended that, given the minimal amount of reimbursement requested, the Board pay such amount. E. DeRosa noted that Greater Atlantic failed to submit a Certification of Compliance and that when questioned about the lack of a Certification, Greater Atlantic explained that the Company could not provide a Certification because the Company was not in a position to issue the standard plans. She noted that Greater Atlantic had not, to date, provided a Certification of Compliance, and according to IHC Regulations, no carrier is allowed to market individual health benefit plans in New Jersey unless and until it files a Certification of Compliance, Exhibit Q. The Board concluded that this is a compliance issue and asked Tom Smith and E. DeRosa to work together to determine exactly what Greater Atlantic had issued.

K. O'Leary explained that Oxford provided a Certification of non-group persons for 1995. Since Board records did not indicate the company had requested a conditional exemption for 1995, he called the company to ask why they sent the certification. The company faxed a copy of what it stated was sent. He suggested the Board might presume that the request for a conditional exemption was in fact sent, and that it was in order. K. O'Leary said the exemption would mean a difference of millions of dollars in terms of the assessment. He said he could bill for the 1995 assessment, assuming Oxford requested an exemption and it was in order, and in the meantime, gather evidence that the request either was or was not made, and ask TAC to review it.

M. Smyth suggested that if the Board accepted K. O'Leary's recommendation, it should notify Oxford, in writing, that the Board reserved the right to verify the request for an exemption, and adjust the assessment if verification could not be made.

M.L.B. Kaplan said that Oxford owed money to the Program until it could be verified that the request was made.

The Board decided to defer a decision on the amount to bill for the 1995 assessment until the next meeting.

Exemption Requests for 1996

Staff prepared a list of carriers that requested exemption from the 1996 reimbursable loss assessment. K. O'Leary noted that BCBSNJ filed for such an exemption, along with 14 other carriers. S. Kelly identified the major carriers that were not included on the list.

Miscellaneous

The Kennedy/ Kassebaum bill passed in the Senate. The bill contained a carve out for New Jersey.

K. O'Leary stated the press during the prior 2 weeks was critical of health insurance reforms in New Jersey, and specifically the IHC program. L. Moskowitz said he thought the Department of Insurance response had focused on the poor purchasing decision of an insured who elected Plan A. K. O'Leary said an Associated Press story, which was based on an article in the Asbury Park Press, focused on the soaring number of uninsured. He reported he wrote an editorial piece in response to the AP story.

The Senate Legislative Oversight Committee met on May 2, 1996. K. O'Leary prepared a report for that hearing. He asked the Board to review it and provide input before he uses it more widely.

R. Rondum said the Program needs to get the good news about the Program out to the press. The press needs to hear correct information. She said it was time for K. O'Leary to get out and do some "schmoozing" instead of him spending so much of his time on financial matters such as the assessments. The Board could hire someone else to handle financial business for the Program. J. Donnellan asked K. O'Leary to put together a concrete proposal to describe what the best type of help would be.

K. O'Leary said that based on available funds, the Access Program would only provide funding for current enrollees until the end of 1997. Thus, affordability would become a more important issue for the IHC Program. J. Donnellan commented that the New Jersey Reform began with a 3 part program: IHC, SEH and Access. The Access Program did not develop to the extent anticipated at the inception of the Reform.

Expense Report

M.L.B. Kaplan offered a motion to approve the payment of the expenses included on the May 7, 1996 expense report. L. Yourman seconded the motion. The Board voted unanimously in favor of approving the payment of the expenses included on the May 7, 1996 expense report.

[Break 11:35 a.m. - 11:52 a.m.]

III. Report of the Technical Advisory Committee

J. Donnellan said that Victor Paguia, an actuary from Celtic Life, was interested in participating in the TAC.

E. Shrem offered a motion to include Celtic Life Insurance Company to the Technical Advisory Committee. R. Smart seconded the motion. The Board voted unanimously in favor of adding Celtic Life to the Technical Advisory Committee.

Rate Filings

J. Donnellan said the TAC recommended that the Board deem rate filings from 5 carriers as **complete**.

L. Yourman suggested the board may want to put out a press release to explain the increases. For example, Trustmark filed for a 35% increase. L. Moskowitz commented that the increases shown on the TAC report were *average* increases. He questioned the usefulness of reporting an average increase. K. O'Leary suggested that TAC should explore developing a standard rate filing format and present recommendations during the June meeting.

M.L.B. Kaplan offered a motion that the Board deem the 5 rate filings shown on the May 7, 1996 TAC report as complete. R. Smart seconded the motion. The Board voted unanimously in favor of deeming the 5 rate filings complete, with D. Williams abstaining with respect to the USHealthcare filing, and M.L.B. Kaplan abstaining with respect to the BCBSNJ filing.

J. Donnellan said the TAC recommended that the Board deem rate filings from 2 carriers as **incomplete**.

Prudential filed rates for the HMO plan with a $15 copay for drugs which is a closed block of business and rates for the HMO plan with 50% reimbursement for drugs. TAC believed the filings were inconsistent with community rating.

M.L.B. Kaplan offered a motion to deem the 2 Prudential rate filings incomplete. R. Rondum seconded the motion. The Board voted in favor of deeming the rate filings incomplete. [7 in favor; 1 abstained - J. Donnellan]

J. Donnellan asked the Board to refer to material in the Board packets which described the MetraHealth issue. The Board deemed a rate filing complete subject to compliance with N.J.S.A. 17B:27A-4b. MetraHealth did not demonstrate compliance with N.J.S.A. 17B:27A-4b. The company has, however, sold individual standard HMO plans in New Jersey since January 1996.

M.L.B. Kaplan offered a motion to deem the November 28, 1995 rate filing for MetraHealth Care Plan incomplete and refer the matter of MetraHealth having marketed standard plans in violation of the requirements of N.J.S.A. 17B:27A-4b to the Department of Insurance for enforcement. R. Rondum seconded the motion. The Board voted in favor of the motion. [6 in favor; 2 abstained - R. Smart and L. Moskowitz]

Metropolitan Life requested guidance concerning the Board's direction, given during the April 9, 1996 Board meeting, that it must use rates in effect on December 31, 1995 to issue and renew business on January 1, 2 and 3 1996. The rates that were in effect for renewal business on December 31, 1995 were the January 1995 rates since the company guaranteed rates for 12 months. Since the rates that would have been used for new business on December 31, 1995 were December 1995 rates, TAC recommended that the renewal business should be renewed using the December 1995 rates.

R. Smart offered a motion that Metropolitan rate renewal business for January 1,2 and 3, 1996 using the December 1995 rates. M.L.B. Kaplan seconded the motion. The Board voted in favor of the motion. [7 in favor; 1 abstention - L. Moskowitz.

Pro-Rata Assessment

J. Donnellan called the Board's attention to an April 22, 1996 memo from K. O'Leary which captured TAC's recommended text changes to N.J.A.C. 11:20-2.17. The revisions to the assessment formula described in that memo would result in partially exempt carriers being included in the re-allocation of assessment amounts which must be re-distributed as a result of full or partial exemptions. L. Moskowitz suggested that maybe it would be appropriate to apply such re-distribution to carriers that failed to enroll at least 50% of their market target. K. O'Leary explained that there was no immediate need to act on the proposed language. J. Donnellan reminded the Board that this language was developed at the Board's request, following a discussion as to the treatment of partially exempt carriers. *If* the Board wished to include partially exempt carriers in the re-allocation of the assessment, the language TAC recommended would be appropriate. The Board was asked to review the result accomplished by this new language to determine if the result is the desired result.

1996 Exemption Requests

The requests for exemption were due May 1 and must be acted upon within 30 days. Thus, the Board must meet before the end of May. The Board agreed to meet on **May 30, 1996 at 10:00 a.m**. Members who wish to participate via teleconference may do so.

IV. Report of the Policy Forms Committee

Annual Review

R. Smart said the Plan of Operations required the Board to evaluate the policy forms at least once per year. There is no requirement, however, that the forms be changed once each year. The Committee met on May 6, 1996 to initially discuss issues that had been raised during the past year. By the June Board meeting the Committee would be prepared to present a list of issues to the Board, with recommendations. If changes are to be proposed, the language would be ready by the July meeting such that it could be proposed in August.

The Committee considered a Compliance and Variability rider and expected to be ready to bring it to the June Board meeting so it could be proposed.

The Committee is prepared to work with TAC recommendations on language to accomplish cost reduction methods, such as higher deductible options. L. Yourman suggested that a step deductible should be considered.

R. Smart said there had been consumer requests for an individual HMO POS plan and she asked D. Williams to seek input from her company as well as HMOs in the HMO Association, if possible.

[D. Williams left the meeting at 1:10 p.m.]

Grace Period

R. Smart said the Policy Forms Committee discussed the Grace Period and concluded that there should be no charge for coverage during the Grace Period. However, if a person incurred claims, the unpaid premium may be deducted from the claim payment before payment is made. The Committee suggested that the language in the pre-existing conditions provision which addresses the 30 day lapse in coverage should address 30 days as measured from the *date coverage was in force on a premium paying basis.*

The Board asked that a Bulletin be developed to address the Grace Period to ensure that all carriers are doing the same thing.

Passive Networks

Another issue the Committee discussed was "passive networks." L. Moskowitz said that the Department was looking into the matter and hoped to have a position by the June meeting. He said one concern was whether there would be balance billing.

Proposal (Children First Text and Medicaid Eligibility Text)

The Board needs to consider whether it want to allow a 5th rating tier given the fact that the Children First Program has no funding. L. Moskowitz expressed concern that the availability of a 5th tier might create adverse selection. High risk children covered under a group plan may be dropped from group coverage in favor of a child only plan.

K. O'Leary was asked to work with L. Moskowitz to discuss the status of Children First with the Commissioner of Health. Staff was asked to discuss the proposal with the Office of Administrative Law to determine if the hearing could still be held, given the fact that one of the main reasons for the proposal appeared to no longer exist.

[Break: 1:45 - 1:58]

V. Harvard Brandeis Study

Board members were asked to review the draft letter included in the Board materials and provide comments to R. Smart by the end of the week (May 10, 1996). L. Moskowitz said the first sentence should be revised to discuss helping people *obtain* instead of helping people *afford*.

The study team has been working on analyzing financial data.

VI. Report of the Marketing Committee

E. Shrem reviewed the report prepared by The Marcus Group with the Board. The Committee was scheduled to meet after the Board meeting to discuss changes to the draft of the Buyer's Guide.

VII. Report of the Complaint Committee

L. Yourman reported having received a copy of a report from Tom Smith's department which provided information on the complaints handled by Department of Insurance staff. T. Smith explained the report addressed only written complaints. T. Smith said he scheduled a meeting with his investigators due to the increasing number of complaints and inquiries concerning the IHC and SEH plans.

VIII. Report of the Legal Committee

Medicaid

The Committee reviewed information regarding the change to the IHC law which allows persons who are eligible for Medicaid to purchase an IHC plan, provided they are otherwise eligible. The change was effective retroactive to April 1, 1995. The Committee suggested that a Bulletin be released to advise carriers that the law had changed, and state that it is expected that carriers would comply with the law.

L. Moskowitz said he would be meeting with Human Services and asked to see the draft Bulletin before he had that meeting. He suggested that it may be wise to delay release of the Bulletin until after his meeting.

CIGNA Appeal

CIGNA requested a hearing to discuss the Board's denial of the Good Faith Marketing Report for 1994. The Legal Committee reviewed CIGNA's grounds for appeal and concluded the request did not raise any issues of material fact, and since there was no dispute of fact that would require a hearing, the request for a hearing should be denied.

E. Shrem offered a motion that the Board deny CIGNA's request for a hearing. M.L.B. Kaplan seconded the motion. The Board voted unanimously in favor of denying the request for a hearing.

E. Shrem offered a motion to move to Executive Session. L. Yourman seconded the motion. The Board voted unanimously in favor of moving to Executive Session.

[Executive Session: 2:37 p.m.- 3:05 p.m.]

M.L.B. Kaplan offered a motion to adjourn the Board Meeting. E. Shrem seconded the motion. The Board voted unanimously in favor of adjourning the Board Meeting. The Meeting adjourned at 3:06 p.m.

May 30, 1996

Directors Present: J. Donnellan (Prudential); S. Kelly (Blue Cross and Blue Shield of New Jersey); *C. McDevitt (Department of Insurance),* R. Rondum; E. Shrem R. Smart (Mutual of Omaha); L. Yourman

Others Present: *K. O'Leary, Executive Director*; DAG M. Smyth (DOL); *E. DeRosa, IHC Program Assistant Director*

[The names of persons who participated via teleconference from the 10th floor conference room of the Department of Insurance are shown in italics. All other persons participated via teleconference from other locations.]

I. Call to Order

J. Donnellan called the meeting to order at 10:03 a.m. K. O'Leary announced that notice of the meeting had been published in three New Jersey newspapers and posted at the Department of Insurance and the Office of the Secretary of State in accordance with the Open Public Meetings Act. A quorum was present.

II. 1996 Conditional Exemption Requests

The Board asked M. Smyth to identify the requirements that a carrier must satisfy in order to qualify for a conditional exemption. She directed the Board to N.J.A.C. 11:20-9.2(d) which outlines the conditions for the request.

J. Donnellan asked the Board to refer to the spreadsheet for 1996 Requests for Conditional Exemption which was distributed to Board members. He noted that the Technical Advisory Committee had referred several issues concerning the requests for conditional exemption to the Legal Committee.

Late Requests
J. Donnellan said the Legal Committee recommended that the late requests for conditional exemption (7 days late) be approved. Thus, the Legal Committee would recommend that the requests for First Option Health Plan (7 days late) and USHealthcare (copy of request faxed 7 days late; to date, unable to prove that the original request was sent on a timely basis) be granted.

New England
J. Donnellan said the Legal Committee suggested that the request be approved for New England. While the request indicated that the New England would be merging with Metropolitan later in 1996, the merger had not occurred. Therefore, at this time, the request could apply only to the companies that were affiliated at this time. S. Kelly added that New England filed for an exemption, but Metropolitan did not. If the merger occurs as planned, one affiliate would have requested an exemption and another would not have requested an exemption. She said the Legal Committee had a preliminary discussion as to the status of the conditional exemption if the companies should merge before the end of 1996. M. Smyth noted that under the law, all affiliated carriers are treated the same.

United Health Care Corporation (MetraHealth)
The company filed Exhibit Ks late, and was thus assigned an enrollment target which did not take all net earned health benefits premium into consideration. J. Donnellan said the Legal Committee recommended that the request could be approved, but with an adjusted market target. The MetraHealth market share would be increased. Carriers that had filed for a conditional exemption would be notified of the adjusted market target. The targets for Carriers other than MetraHealth would be appropriately reduced, but the reduction would be minimal.

Physicians Health Care
The carrier had minimal health benefits premium in 1995 and thus had a market target of 0. J. Donnellan said the Legal Committee advised that it was not inappropriate to assign a market target of 0, if that was what the net earned premium warranted. K. O'Leary said that carriers are only expected to issue their proportional share of non-group persons. S. Kelly said the company must actually enter the market in order to qualify for a final exemption, which would require the filing of rates and a Certification of Compliance. The same would apply to Guardian, which also requested an exemption, but is not yet in the individual market.

E. Shrem offered a motion to approve the 1996 conditional exemption requests of the carriers identified on the spreadsheet. S. Kelly seconded the motion. The Board voted unanimously in favor of approving the 1996 conditional exemption requests for the listed carriers. [Aetna, Amerihealth, BCBSNJ, Celtic, CIGNA, First Option, Guardian, HMO/NJ, HIP, New England, NYLCare, Oxford, PFL, Physician Health Care, Prudential, United Health Care Corp, United Insurance Co.]

III. Other Issues

K. O'Leary said he prepared a calculation of the refund due to HIP and faxed it to the Board the prior day. He would defer requesting action from the Board until after he shared his calculations with the auditors.

R. Smart said she received a final draft of the letter to be sent by the Harvard/Brandeis study. She asked that staff FAX it to the Board, and that members get back to her with comments before the close of business on Friday, May 31, 1996.

The Department of Insurance tentatively scheduled a summit for July 1, 1996, to discuss ways to help stabilize rates. The summit to discuss passive networks, scheduled for June 11, 1996, following the next IHC Board meeting, may be re-scheduled.

R. Smart offered a motion to close the Board meeting. L. Yourman seconded the motion. The Board voted unanimously in favor of closing the Board meeting. [The meeting adjourned at 10:25 a.m.]

NOTE: The Next Board meeting will be Tuesday, June 11, 1996.

June 11, 1996

Directors Present: J. Donnellan (Prudential); S. Kelly (Blue Cross and Blue Shield of New Jersey); L. Moskowitz (Department of Insurance), R. Rondum; E. Shrem R. Smart (Mutual of Omaha); L. Yourman

Others Present: K. O'Leary, Executive Director; DAG M. Smyth (DOL); E. DeRosa, IHC Program Assistant Director

I. Call to Order

J. Donnellan called the meeting to order at 9:34 a.m.

II. Public Hearing on Proposed Amendments to N.J.A.C. 11:20 - 1.2, 12.3

J. Donnellan invited any members of the audience who wanted to offer testimony on the proposed amendments to identify themselves and then present their testimony.

Eric Wilmer (Celtic Life Insurance Company) said that his company supported the concept of child only coverage.

Thomas Frank (Celtic Life Insurance Company) asked that the proposed text be clarified to state that the child would have to be a resident of New Jersey in order to be eligible for coverage. He further stated that he would like to see a residency requirement applied to all dependents. K. O'Leary asked if the company was interested in the child only tier due to the anticipated subsidy program, and noted that the subsidy program had not received the expected funding. Victor Paguia (Celtic Life Insurance Company) indicated that the subsidy program had not impacted Celtic's position.

K. O'Leary asked if a child only tier might result in higher single rates. T. Frank responded that Celtic markets child only coverage in other states and the child only rate is lower than the rate for single coverage for an 18 year old person. V. Paguia said that a child only rate is usually about 70% of the adult rate.

E. Shrem commented on the residency issue and noted that college students typically access health care through the health center at the college.

Thomas Crane (Broker) said he supported the proposed child only tier.

L. Moskowitz asked the presenters from Celtic if they had a preference as to the timing of any inclusion of child only coverage. T. Frank said that Celtic could adjust quickly. However, since New Jersey changes generally take effect on January 1, the introduction of the child only tier should probably occur as of January 1.

After asking if any other person wished to offer testimony, J. Donnellan said the Board would begin to conduct other Board business, but that the hearing would remain open until 10:30 in the event any other person arrived to offer testimony.

I. Call to Order (Continued)

J. Donnellan announced that notice of the meeting had been published in three New Jersey newspapers and posted at the Department of Insurance and the Office of the Secretary of State in accordance with the Open Public Meetings Act. K. O'Leary took roll call. A quorum was present. He noted that C. Wowkanech and G. Young were not present.

J. Donnellan welcomed S. Kelly as the representative from BCBSNJ.

III. Review of Minutes

May 7, 1996
S. Kelly asked that the Board defer adopting the minutes until she had an opportunity to speak with M.L.B. Kaplan who had been the BCBSNJ representative during that meeting. The Board agreed.

May 30, 1996
S. Kelly offered a motion to adopt the minutes of the open session of the May 30, 1996 Board meeting, as amended. R. Smart seconded the motion. The Board voted in favor of adopting the minutes, as amended. [6 in favor; 1 abstained - L. Moskowitz]

III. Report of the Executive Director

Expense Report

L. Moskowitz offered a motion to authorize the payment of the expenses noted on the June 11, 1996 Expense Report. R. Rondum seconded the motion. The Board voted unanimously in favor of approving the payment of the expenses included on the Expense Report, with L. Yourman abstaining with respect to the payment of her own expenses.

Operations Committee

K. O'Leary said the Operations Committee met on June 7, 1996 to discuss several issues pertaining to 1995 losses. BCBSNJ presented several issues regarding the assessment.

I. BCBSNJ demanded the payment of interest that had been earned on the amount of reimbursement due for 1992, 1993 and 1994. K. O'Leary said the Committee believed interest should be paid, to the extent funds designated for reimbursement were held in an interest bearing account. No interest should be paid if the Board had not yet collected the money. He noted that the Committee had not reviewed the Regulations to see if this recommendation may conflict with a Regulation, nor had the Committee determined how any interest should be calculated.
II. BCBSNJ wanted interest payments with respect to the funds held in escrow under the HMO/NJ v. Whitman assessment appeal. K. O'Leary said the court order stated that interest should be paid to the prevailing party. The manner of disbursement would be determined after the Order is received.
III. BCBSNJ disputed the Board's determination that it had waived reimbursement for expenses for the claims system and employee incentives for 1993 and 1994. BCBSNJ intended to appeal the Board's decision. BCBSNJ contended that the Board should therefore not release amounts for the 1993/1994 assessment reconciliation until the matter is resolved. Thus, the Program would bill for the 1995 assessment, but not consider the reconciliation for 1993 and 1994. In response to an inquiry from the Board, M. Smyth said BCBSNJ had 20 days after it received the Board's determination during which to appeal the decision. She noted that the time period had almost expired.
IV. HIP appealed the 1993 assessment, but paid the assessment bill, as was required. While the appeal was pending, the money was kept in an interest bearing account. The appeal was resolved in HIP's favor. K. O'Leary said the Board had held the funds since August 1994. HIP had repeatedly asked for the money (funds held in escrow plus interest). K. O'Leary said he calculated the amount to pay HIP using the interest earned in the Board's account and taking the conservative assumption that BCBSNJ would prevail in its appeal of the Board's decision to reduce its loss reimbursement for 1993 and 1994. (principal plus interest less 1995 assessment) He shared his calculations with Deloitte & Touche as well as the Operations Committee.

The Board addressed each of these issues, but not in the same order as they were presented.

IV. HIP Payment
R. Smart said it was clear from the Board's rules and regulations that interest was due and payable to HIP.

E. Shrem offered a motion that the Board authorize the payment of a refund to HIP, as detailed on the attached spreadsheet. R. Rondum seconded the motion. The Board voted unanimously in favor of authorizing the payment to HIP.

$867,308.00 (escrow principal)
+$83,524.15 (interest)
-$38,073.00 (1995 assessment)
$912,759.15 Amount to be Paid to HIP

III. Defer 1993 / 1994 Reconciliation Pending Any Timely Appeal by BCBSNJ
K. O'Leary said the disputed amount for 1993 and 1994 is almost $9 million. S. Kelly asked how this type of situation is addressed in the Regulations. M. Smyth said it is not specifically addressed, but could be considered, de facto, as a disputed assessment. S. Kelly noted that the Board had never acted on the final exemptions for 1994. 1995 final exemptions had likewise not yet been acted upon. [Note: Action on the 1995 exemptions cannot occur until after the Good Faith Marketing Reports have been received, reviewed, and the Board acts on such Reports.]

K. O'Leary reminded the Board that there is a reconciliation done in December that would take into account decisions on final exemptions. He further said that the Board should send out the assessment bill within the time frame set forth in regulation.

R. Rondum offered a motion that the Board defer the 1993/1994 reconciliation, and move forward with the 1995 assessment billing. If the BCBSNJ appeal were not filed, the Board should go forward with the reconciliation. L. Moskowitz seconded the motion. The Board voted in favor of deferring the reconciliation for 1993/1994, pending the filing of any appeal, and billing for the 1995 assessment. [6 in favor, 1 abstained (S. Kelly)]

II. Interest on Escrow Funds
R. Rondum said the Board should wait for the Court Order. The Board did not take action during this meeting, pending receipt of the Court Order.

I. Interest on Reimbursement Due to BCBSNJ
The Operations Committee recommended that interest be paid for the time the funds were actually held in an interest bearing account. This recommendation did not suggest that interest is due on funds that would have been collected had the assessment been billed earlier.

R. Smart offered a motion that interest be calculated on the amount of funds actually held, from the day the Board first held the money, and that amount should be presented to the Board for review and consideration at the next meeting. E. Shrem seconded the motion. The Board voted in favor of calculating the interest amount, as described. [6 in favor, 1 abstained (S. Kelly)]

1995 Losses

K. O'Leary said Manhattan National had requested reimbursement of $374,073 on Exhibit K. He asked if there should be an audit. J. Donnellan suggested that the matter be referred to the Operations Committee. Perhaps a scaled down audit could be done.

K. O'Leary said Deloitte & Touche had contacted the carriers it had been asked to audit and requested data tapes. Scott Sanders indicated that he could not give a time frame for the audits until the tapes were received and reviewed for the sample selection process.

Press Release on Summit

Commissioner Randall released a Press Release concerning the convening of a Summit to discuss methods to make health coverage more affordable and to stabilize rates. The Summit was scheduled for July 1, 1996. E. Shrem said the notice of the Summit should be given to the New Jersey Association of Life Underwriters and to the Association of Health Underwriters.

Medicaid Lives

The Assembly Insurance Committee heard a request to remove the limit for the number of Medicaid and Medicare risk enrollees a carrier may count toward the non-group person market target. The proposal would phase in the removal of the limit. The carrier that would be predominantly affected by the change would be USHealthcare.

First Quarter 1996 Enrollment

The preliminary compilation of the reported enrollment numbers suggested that there has been an increase in enrollment.

Outreach

5/16/96	Association of Health Underwriters meeting
6/3/96	American Bar Association
6/3/96	NJN Radio Business Plan show

Also, K. O'Leary said he had done a piece for Comcast newsmakers.

A press conference had been scheduled for 6/13/96 to release the report that K. O'Leary prepared.

L. Moskowitz, commenting on the enrollment statistics, asked if the Board could get an analysis of the pre-reform business still enrolled with BCBSNJ. S. Kelly observed

that the first quarter enrollment reports would not reflect the impact of the latest rate increase on the pre-reform plans.

II. Public Hearing (continued)

There being no additional persons present to offer testimony, the Public Hearing concluded at 10:45 a.m.

IV. Report of TAC

Rate Filings

J. Donnellan noted that the column which indicated average change in rates on prior TAC reports had been omitted from this current report. TAC would study the manner in which changes in rates could be reported and captured in a meaningful manner.

J. Donnellan explained that Prudential requested that the Board grant permission to terminate the HMO plan with the $15 copay option for prescription drugs. He noted that the $15 copay plan had higher medical costs than the HMO plan with 50% coinsurance for prescriptions. He said there were approximately 1200 persons enrolled under the $15 prescription copay for prescriptions and approximately 4700 enrolled in the HMO plans with 50% coinsurance for drugs.

L. Yourman asked what the rate changes had been. No TAC member present at the meeting had that information.

S. Kelly commented that, based on the rate filings, there were a few carriers that either offered or offer the HMO plan with prescriptions subject to a $15 copayment. [NYLCare, Qual Med (formerly known as Greater Atlantic), and MetLife HMO (no longer writing)].

L. Moskowitz said there was no clear path to allow a carrier to withdraw a plan. He said the matter should be discussed by the Department of Insurance, TAC and the Legal Committee.

L. Moskowitz suggested that the Board deem the Prudential rate filing for the HMO plan with the $15 copay for prescription drugs as complete, provided the rates are guaranteed for the same duration as the rates for the 50% coinsurance option for prescription drugs.

L. Moskowitz offered a motion to accept the recommendations of TAC and deem the rate filings noted on the June 11, 1996 complete, with the Prudential filing of the HMO plan with the $15 copay option for prescription drugs subject to the rate guarantee stipulation described above. L. Yourman seconded the motion. The Board voted in favor of deeming the rate filings complete, as stated. [7 in favor, with J. Donnellan abstaining with respect to the Prudential filings and S. Kelly abstaining with respect to the Medigroup filing]

K. O'Leary said that the researcher who analyzed statistics on one life rates had completed his work and K. O'Leary now had data on changes to rates.

J. Donnellan explained that National Group Life had submitted a rate filing in December, 1995 which the Board deemed incomplete on January 11, 1996. The company had not responded to that incomplete rate filing. The current rate filing was for PPO plans B-E. Thus the company had no rates for Plan A. Further, the filing suggested the company had inforce business.

L. Yourman offered a motion that the Board deem the National Group Life rate filing incomplete. R. Smart seconded the motion. The Board voted unanimously in favor of deeming the National Group Life rate filing, which was to be effective 6/1/96, incomplete.

1995 Exemption Request (Oxford)

J. Donnellan said that TAC considered the evidence Oxford provided, along with other data available to the TAC regarding Oxford having requested a conditional exemption on a timely basis in 1995, and recommended that the Board grant the Oxford request for a conditional exemption in 1995.

L. Moskowitz offered a motion that the Board grant a conditional exemption to Oxford for 1995. R. Rondum seconded the motion, The Board voted unanimously in favor of granting Oxford a conditional exemption for 1995.

Failure to Meet Deadlines

S. Kelly said that carriers have not been meeting the deadlines set forth in IHC regulations and wondered what the Board could do. R. Smart said that NJ reporting was burdensome. Many carriers operate in many states, each with specific reporting requirements. L. Moskowitz said the right people need to be reminded of what must be done and by when. E. DeRosa said she had released a bulletin outlining "critical dates" in 1995. T. Frank (audience member from Celtic Life) suggested that a policy and procedure guide may be useful. L. Moskowitz suggested that carriers writing in NJ may have ideas as to how to facilitate doing business in NJ. K. O'Leary was asked to identify the next steps.

V. Report of the Policy Forms Committee

Certification of Compliance

The spreadsheet included in Board packets outlined what carriers reported on Exhibit Q.

Qual Med had not provided a Certification in spite of follow-ups. The Board asked that the failure to provide the required Certification be referred to the Department of Insurance.

Aetna Health Plans had provided a plan as to how to be in a position to provide a Certification by late June. Board Staff was directed to discuss the Aetna circumstances with T. Smith.

S. Kelly offered to compare the Certification of Compliance summary to the rate filings carriers had submitted to the Board.

Compliance and Variability Rider

R. Smart explained that the compliance and variability rider would give carriers the ability, with the Board's permission, to implement policy forms changes without having to re-issue inforce plans.

L. Moskowitz offered a motion that the Board propose the compliance and variability rider. E. Shrem seconded the motion. The Board voted unanimously in favor of proposing the compliance and variability rider.

Policy Forms Review

R. Smart asked the Board to refer to the 1996 Policy Forms Review material that had been included in the Board packets.

No Change Issues

The Board concurred that there should be no change regarding:

1. acupuncture benefits
2. circumcision
3. abortion
4. dependent residency in HMO service area
5. Health Access program procedures
6. physical therapy / rehabilitation services

Change Recommendations

1. Inpatient Copay: The Board suggested that the proposed language be clarified to state that the copays are per covered person. The caption should be modified to refer to a hospital inpatient copayment rather than an inpatient cash deductible.

Partial Hospitalization: The Board suggested that the text be clarified to specifically state that the mental and nervous conditions and substance abuse partial hospitalization services covered under the HMO contract are counted toward the outpatient visits limitation.

2. Grace Period: The language attached to the recommendations contained in the Board packets addressed only the change to be made to the pre-existing conditions provision to clarify the date from which any 30 day lapse period should be measured. After some discussion as to whether coverage terminates at the end of the grace period or as of the paid to date, E. DeRosa offered to provide Board members with a copy of the law concerning grace period. The Board agreed that if coverage terminates at the end of the grace period, then a carrier may deduct the amount of unpaid premium from any benefits payment, but that a carrier could not require a person to otherwise pay a premium for the period the plan stays in force during the grace period.
3. Mental and Nervous Conditions Maintenance Benefit: The Board agreed that the forms should use the language the Department of Insurance had originally suggested, modified to add the last sentence of the text that the forms currently include.

<u>Board Discussion Needed</u>

1. Prescription Drug Benefits

   HMO Form: The Board agreed it needed more information from HMOs concerning what they may be able and willing to offer in terms of a copay feature, increased coinsurance, or an optional rider. Other suggestions would be welcomed. L. Yourman suggested that HMOs consider offering what they offer as prescription drug benefits in the SEH and other markets in New Jersey. J. Donnellan noted that if greater benefits would be provided it would be in exchange for an increased cost. L. Yourman suggested that maintenance drugs might be considered differently than non-maintenance drugs. She was particularly interested in the inclusion of a limit on the out of pocket drug expense a covered person may incur. For example, could carriers provide drug coverage subject to 75% or 50% coinsurance, up to a $1500 cap per covered person? Three specific questions were formulated to present to the HMO Association in a poll.

   Indemnity Forms: A carrier had suggested a rider that would require the satisfaction of a separate calendar year drug deductible, then a copayment per prescription. Carriers should be polled to find out what they could offer.

2. Fertility Benefits

   Carriers should be polled to find out if they would be interested in providing a benefit similar to what is contained in the SEH policy forms.

3. HMO/POS

   There seemed to be little or no interest among HMOs to offer a Point of Service plan.

4. Suicide / Intentionally Self Inflicted Injuries
While the Board recognized that the law in New Jersey allows carrier to limit the coverage for injury to *accidental* injury, M. Smyth was asked to review precedent on the issue.

5. Petition to Change Mental and Nervous Conditions Coinsurance in Plan D
L. Yourman offered a motion to again deny the request to increase the carrier mental and nervous conditions coinsurance in Plan D. R. Smart seconded the motion. The Board voted in favor of denying the petition [6 in favor, 1 opposed (R. Rondum)].

6. Termination of Coverage
L. Moskowitz said that under no circumstance should a person be covered under more than one plan. No person should be required to pay the premium for more than one plan. Coverage under a new policy should not take effect any earlier than the day coverage under a prior policy terminates. Thus, the forms need to allow a person to switch from one carrier to another, with neither an overlap in coverage nor a lapse in coverage. The replaced carrier can ask for proof of replacement. The Board should review the proposed language to see if it accomplished this objective.

VI. Harvard Study

R. Smart said that the letters the Board had an opportunity to review in late May had been released. The study team was making arrangements to speak with representatives of carriers.

VII. Ethics Manual

M. Smyth said she needed any comments on the Ethics Manual that was included in Board packets no later than Friday, June 14, 1996.

J. Donnellan offered a motion that the Board enter Executive Session. R. Smart seconded the motion. the Board voted unanimously in favor of entering Executive Session.

[Executive Session: 1:48 p.m. - 2:08 p.m.]

E. Shrem offered a motion to adjourn the Board meeting. L. Moskowitz seconded the motion. The Board voted unanimously in favor of adjourning the Board meeting. The meeting adjourned at 2:09 p.m.

July 9, 1996

Directors Present: J. Donnellan (Prudential); S. Kelly (Blue Cross and Blue Shield of New Jersey); R. Rondum; E. Shrem; G. Simon (Department of Insurance); R. Smart (Mutual of Omaha); G. Young (USHealthcare); L. Yourman (participated via teleconference)

Others Present: K. O'Leary, Executive Director; DAG M. Smyth (DOL); E. DeRosa, IHC Program Assistant Director

I. Call to Order

J. Donnellan called the meeting to order at 9:43 a.m. K. O'Leary announced that notice of the meeting had been published in three New Jersey newspapers and posted at the Department of Insurance and the Office of the Secretary of State in accordance with the Open Public Meetings Act. K. O'Leary took roll call. A quorum was present.

II. Review of Minutes

Minutes of May 7, 1996

R. Rondum offered a motion to adopt the minutes of the open session of the May 7, 1996 Board meeting, as amended. R. Smart seconded the motion. The Board voted in favor of adopting the minutes, as amended. [6 in favor; 1 opposed (S. Kelly) 1 abstained (G. Young)]

During the discussion of the minutes, L. Yourman asked for a clarification of the coverage provided under the standard HMO contract for respiration therapy. After reviewing the text of the standard HMO contract, E. DeRosa responded that while the form contains a definition of respiration therapy, the section which details covered services did not list respiration therapy among the covered therapy services. The Board agreed that coverage for respiration therapy was intended to be provided on an unlimited basis, and directed the Policy Forms Committee to draft appropriate language for the HMO contract. This revision would be included with the other policy form changes to be proposed in 1996. The Board was curious as to whether HMOs issuing the standard plans had been covering respiration therapy. Staff was asked to poll the HMOs issuing the standard plans to determine whether coverage for respiration services has been covered under the standard HMO plan.

L. Yourman offered a motion to adopt the minutes of the open session of the June 11, 1996 Board meeting, as amended. R. Smart seconded the motion. The Board voted in favor of adopting the minutes, as amended. [7 in favor; 1 abstained (G. Young)]

III. Report of the Policy Forms Committee

R. Smart advised the Board that Maureen Tagliafero had written another letter to the Board requesting that the Board again consider the coinsurance applicable to mental and nervous conditions under Plan D. R. Smart stated that since the Board had already acted to deny M. Tagliafero's petition for rulemaking the Board did not need to again vote to deny her request to modify the coinsurance to make it consistent with the coinsurance level applicable to charges for all other conditions. Correspondence to M. Tagliafero was sent, reiterating the Board's denial of the petition. R. Rondum expressed concern that the Board may be leaving itself vulnerable. M. Smyth noted that she had not seen the last correspondence from M. Tagliafero. R. Rondum asked that M. Smyth review that correspondence and the Board's response.

Regarding the proposal to create a child only tier and changes to accommodate the availability of coverage for persons who are eligible for Medicaid, R. Smart said the Board received not only the oral testimony heard during the June Board meeting, but also received some written comments.

Medicaid: R. Smart said that Time Insurance had commented that while they recognized the legislative requirement, they wanted the Board to be aware of the adverse selection that occurs as a result of the retroactivity of the law. Time asked the Board to consider the issue as a public policy decision.

E. DeRosa explained that she and C. McDevitt had met with several persons from Human Services several weeks ago. Medicaid does not actively seek persons for whom to pay the premiums for a private plan. However, if a person already has private coverage, Medicaid will pay the premiums, under certain circumstances, particularly those involving chronically ill persons or medically fragile children.

J. Donnellan said the Board should be careful to distinguish the managed Medicaid program as it exists in New York from what now exists in New Jersey.

R. Smart said there should be a Board response to Time.

Child Only Coverage: R. Smart said the oral testimony favored the inclusion of a child only rating tier. One of the written commenters opposed a child only tier. R. Smart asked if the Board wanted to go forward with a child only tier given the fact that the Child First Program was apparently not going forward. She noted that some held the opinion that there would be adverse selection and the IHC Program could become a "dumping ground" from group coverage. R. Rondum said she recalled the testimony from Celtic as having indicated that their experience in other states did not suggest adverse selection. Their experience, however, did not include experience in states that require coverage to be offered on a guaranteed issue basis.

R. Smart suggested that few carriers responded, perhaps because they believed the child only tier was required in order to accommodate the Child First Program. She also stated that the Board should recognize both the monetary and the time cost to carriers that may not already have a 5 tier rating capability.

S. Kelly suggested that the Board should poll carriers in the IHC market to find out if they support a child only tier. R. Rondum said it was a broad public policy issue and that the Board should solicit input from child advocates. She noted that there are other types of families besides the traditional 2 parents and children.

S. Kelly asked P. Thexton about the child only rate analysis the Department of Insurance had conducted for the Child First program. He said a child only rate was expected to be slightly less than a single rate.

G. Simon said the Department was still uncertain as to the potential of funding for the Child First Program and was thus not comfortable with "killing" the idea. R. Smart said there was no rush to act on the proposal and that the Board could vote to adopt the language up to 12 months after it had been proposed.

R. Rondum said the child only tier was attractive from a public policy perspective. She expressed concern with access to coverage if the proposal were not adopted.

J. Donnellan said the issue should be discussed by Committees, and that the TAC would discuss it during the next scheduled meeting. He noted that since coverage for a child or children could be purchased using the existing single rating tier or the parent/child rating tier, the issue was not whether child only coverage was available, but rather the rate at which the coverage could be purchased. Staff should poll IHC Carriers to find out if they are in favor of a child only rating tier.

The issue should be included on the agenda for discussion during the August Board meeting.

The Board then reviewed the meeting materials which outlined the issues and provided suggested language changes for the IHC policy forms.

The Board accepted the draft language addressing the *copayment* feature in plans A and B.

There was some discussion concerning the terms used in the provisions addressing *partial hospitalization* since the term "day" was used in some places and "visit" was used in others. The Board suggested that since the terms appear to mean the same thing, the text should state that "days" equal "visits."

[Break: 11:00 a.m. - 11:10 a.m.]

The Policy Forms committee recognized that the law states that coverage stays in force during the *Grace Period*. R. Smart said that the Committee was concerned that since coverage was in force during the Grace Period, a Covered Person could lapse coverage and not pick up replacement coverage until 30 days after the Grace Period ended, and still be afforded continuity. The draft text in the Pre-Existing Conditions provision was intended to limit the permissible 30 day lapse period to a period that would begin as of the paid to date.

G. Young said he understood the Grace Period as a time to pay a premium. He did not believe it to be a period for "free coverage."

J. Donnellan said carriers could handle the cost of coverage during the Grace Period in one of three ways: build it into the rate; offset by the amount of premium due; or initiate collection. He noted that there was a carrier that elected the third option, and he understood the Board wanted to eliminate that possibility in the future.

G. Young asked if there was a similar Grace Period requirement for HMOs. G. Simon said that one was not explicitly required.

R. Smart said one of the proposal comments from BCBSNJ asked to be able to terminate coverage after the carrier had used the offset provision to collect an unpaid premium. G. Simon said the premium is paid by using the offset and the Department would not allow a carrier to terminate coverage after the premium had been so paid.

The Board accepted the language modification in the *mental and nervous condition* section.

R. Smart said J. Donnellan had asked the HMO Association to poll members concerning *prescription drug coverage*. All the results were not in, but no member

who responded thus far favored any changes that would increase the cost of coverage and all of the suggested changes would have increased the cost of coverage. R. Smart said the poll of the indemnity carriers had not yet been done.

G. Simon said that before the Board does anything with a pharmacy benefit, it should consider the Any Willing Pharmacy Act. She suggested M. Smyth should look at the advice her office had given to the Department concerning the Any Willing Pharmacy Act. R. Smart asked M. Smyth to review the advice and also investigate if a plan could pay different levels of benefits for the use of a participating pharmacy vs. a non-participating pharmacy.

R. Smart said S. Kelly had compared the plans carriers reported on Exhibit Q to the plans for which those carrier had filed rates. The analysis indicated that while a couple of carriers included PPO plans on the Exhibit Q, those carriers had not filed rates for such plans. R. Smart reported there was some discussion during the Summit concerning the offering of PPO and POS plans, and reasons carriers were not offering such plans in the IHC market. J. Donnellan commented there may not be a value to providing a higher cost option. E. Shrem said the rate for a POS may fall between that for an indemnity plan and an HMO plan.

R. Rondum asked to offer her comments on the topic of *intentionally self-inflicted injury* before M. Smyth commented. She said the exclusion of coverage for intentionally self inflicted injury was covert. She believed it to be a serious policy issue that the plans would deny benefits for someone who failed at suicide. She noted that the language in the SEH policy forms would not similarly exclude coverage for a person who attempted suicide. She concluded that the Board was in a vulnerable position given the fact that the standard forms contain a covert exclusion. *[Note: There is no explicit exclusion, but rather the exclusion is accomplished by virtue of the manner in which accidental injury is defined.]* L. Yourman said it was a social issue since a person who attempts suicide must have some sort of emotional problem. M. Smyth said that suicide is not against the law in New Jersey. She added that there is a presumption that a sane person would not commit suicide.

Rondum offered a motion to amend the definition of accidental injury in the IHC plans to more closely track the definition of injury used in the standard SEH plans. E. Shrem seconded the motion. By roll call vote, the Board voted in favor of amending the definition of accidental injury. [6 in favor (E. Shrem, R. Rondum, S. Kelly, G. Simon, J. Donnellan, L. Yourman); 1 opposed (R. Smart); 1 abstained (G. Young)]

R. Smart said the draft policy forms changes were intended to clarify the *date coverage terminates* and the fact that premium after the date coverage terminates is unearned premium. There should be no duplicative coverage.

G. Young said that with respect to a capitated HMO plan, there would not be a means for the HMO to recover the capitation in the event the member terminated coverage prior to the end of the premium period. G. Simon noted that only about 25% of provider compensation through HMOs in New Jersey is through capitation.

R. Smart said there is a particular concern when the Covered Person authorized pre-authorized checking to pay premiums. She commented that if a person were paying premiums by check, he or she could simply delay paying the premium for the first plan until receiving confirmation that the second plan had been issued. There is not a similar delay mechanism for persons who use pre-authorized checking for premium payment.

The term "unearned premium" needs to be clarified / defined. G. Young agreed to look at the proposed policy language as it would affect an HMO. The Board was comfortable with the proposed text for indemnity plans.

S. Kelly noted that the same or similar regulation would require modification.

R. Smart offered a motion to accept the proposed language concerning *immunizations and lead screening*. G. Simon seconded the motion. The Board voted unanimously in favor of accepting the draft language.

S. Kelly asked why the primary care services benefit uses the terms inoculations, immunizations, and vaccinations. Is there a difference? Staff should investigate with the Department of Health.

R. Smart said one of the proposal comments had asked that the primary care services benefit be expanded to say what is not covered. For example, the text should say that maintenance visits are not covered under the primary services benefit. The Board was not inclined to add language to the policy form but suggested that it might be useful to add as a Q&A in the new Buyer's Guide.

G. Simon explained what a *passive network* is. R. Smart said such an arrangement would not require changes to the standard forms. S. Kelly asked how a consumer would be able to distinguish between a passive arrangement and a true PPO. R. Smart explained that a true PPO would include policy language describing the network and non-network levels of benefits. Since passive networks would not require a policy form change, R. Smart said she would omit the topic from future Policy Forms Committee discussion items.

E. Shrem asked that a requested effective date space be added to the *application*. S. Kelly provided a form BCBSNJ uses to gather more information concerning the

level of benefits of the prior plans to enforce the same or similar regulation. S. Kelly also asked that the Board begin to consider the future possibility of electronic enrollments.

[Break: 12:45 p.m. - 1:03 p.m.]

Note: L. Yourman did not return to the meeting following the break.

IV. Report of the Executive Director

Expense Report

G. Young offered a motion to approve the payment of the expenses noted on the July 9, 1996 Expense Report. S. Kelly seconded the motion. The Board voted unanimously in favor of approving the payment of the expenses noted on the Expense Report.

Assessment

The 1995 assessment has been billed and payments have been coming in. They are being received by the Department of Insurance and the Department will provide reports to the Board.

1995 Reimbursable Losses Audit

D&T contacted the carriers to be audited for 1995 losses and requested data tapes. D&T cannot project a timetable for completing the audits until it has received the tapes and determines how usable the data may be. S. Kelly commented that the June 10, 1996 request from D&T was very general.

K. O'Leary said that Time had asked their auditors, Ernst and Young, to conduct a full audit of their losses, and that the Board had several options concerning what to do with the audit results.
1) Accept the audit performed by Ernst and Young;
2) Disregard the audit performed by Ernst and Young; or
3) Ask D&T to review the audit procedures and do a sample audit.

The cost associated with the third option would be about half the cost of a complete audit.

R. Smart said she would be concerned with the independence of the audit. J. Donnellan explained that Time wanted to verify the $27 million in losses since it was such a significant amount. The audit was a free-standing audit. He noted that the Board's regulations never contemplated that a carrier would contract with an auditor for an audit. The Board decided that D&T should conduct a full independent audit.

K. O'Leary said he had nothing to report on the interest earned on BCBSNJ funds but hoped to have it for the August Board meeting.

Summit

Approximately 25 panelists and about 100 audience members attended a July 1, 1996 Summit held by Commissioner Randall. The purpose of the Summit was to

discuss IHC rates and the volatility of the rates. Discussion topics included rating, and a movement away from community rating, plan design, the 75% minimum loss ratio, and some broader structural changes. The Commissioner hoped to be in a position to recommend legislative and / or regulatory changes in September or October.

Legislation

Assemblymen Bateman and Garrett introduced a bill that would essentially replace the IHC program with a high risk pool.

Corrected Enrollment Data

The first quarter enrollment data previously distributed to the Board inappropriately included enrollment in pre-reform BCBSNJ plans. The corrected data reflects a slight decrease in the enrollment. K. O'Leary commented that the enrollment has been rather flat for the past several quarters.

Code of Ethics

The Code of Ethics has been approved by the Attorney General's Office and the Executive Commission on Ethical Standards. M. Smyth said the Board still needs to review the standards for committee members from carriers other than carriers that hold a seat on the Board and promulgate the appropriate regulations.

G. Young offered a motion to adopt the Code of Ethics. R. Smart seconded the motion. The Board voted unanimously in favor of adopting the Code of Ethics.

M. Smyth advised Board members that they should complete the questionnaire that is part of the Code of Ethics, and return it to K. O'Leary.

Withdrawal Regulation

W. Sanders drafted a withdrawal regulation, using the SEH withdrawal regulation as the starting point. K. O'Leary said the draft had been sent to the IHC Legal Committee. R. Smart suggested that the Board needs to make policy decisions before the Legal Committee can consider the regulation. She believed some of the issues would require technical consideration by TAC, especially loss ratio and rating issues. M. Smyth said she would work with W. Sanders to formulate an issues list. J. Donnellan said there would need to be a substantive policy decision by the August Board meeting. E. DeRosa was asked to provide a list of carriers "leaving" for the August meeting.

Other

There was a press conference on June 13, 1996 on the Progress Report K. O'Leary had prepared.

K. O'Leary said he did a public service announcement for WWOR TV.

V. Report of TAC

Rate Filings

J. Donnellan said TAC had not yet discussed how to best specify rate changes.

J. Donnellan said TAC recommended deeming rate filings from Celtic, MetLife, Principal Mutual and Travelers as complete.

R. Smart offered a motion that the Board deem the rate filings from Celtic, MetLife, Principal Mutual and Travelers as complete. E. Shrem seconded the motion. The Board voted unanimously in favor of deeming the rate filings complete.

Cost Reduction Strategies

J. Donnellan said TAC was not yet in a position to make recommendations to the Board, but would offer a progress report.

Higher deductibles would reduce cost. TAC questioned the value of low deductible plans, particularly the $250 and $150 options which have minimal enrollment. TAC is considering whether it would be wise to eliminate these low options.

TAC believes Plan B is a better value than Plan A and is thus considering whether eliminating Plan A would benefit the market. J. Donnellan noted that there is little enrollment in Plan A. R. Rondum asked how the Board could eliminate Plan A. M. Smyth said the statute allows some restructuring after 3 years, so the Board does have some flexibility. She said another plan, possibly Plan B, would have to be designated as the Basic plan. J. Donnellan said the TAC is considering modifications to Plan B to allow a $2500 deductible, as a "pilot." The $1 million maximum benefit would be increased to an unlimited lifetime maximum. He said there was some risk that healthier risks would migrate to a high deductible plan so the rates for lower deductibles would escalate.

Modified community rating using the factors of age, gender and geography is currently used in the SEH market. J. Donnellan said geography is not very significant in New Jersey, and while gender has some significance, TAC is considering modified community rating using only age. TAC is studying the rate impact.

Another option being considered is increasing the coinsurance caps, although this would not have a tremendous rate impact.

The loss ratio, currently calculated over a one year period, is being evaluated to determine whether extending the period, perhaps to 2 years, would be helpful.

TAC considered MSAs, but believes that nothing should be done until there is action on either the state or Federal level.

J. Donnellan said TAC expected to be in a position to make final recommendations during the August meeting.

VI. Report of the Operations Committee

J. Donnellan said the Committee met with D&T. D&T submitted a bill for the 1993 and 1994 loss audit which exceeded the $115,000 cap. They billed for $170,000 plus $14,000 in expenses. G. Young said D&T submitted $115,000 as a firm fixed bid. J. Donnellan said the Board did not have a signed contract with D&T. During the meeting with D&T, D&T told the Operations Committee that they had advised the Committee about the extra resources that had to be used to conduct the audit. D&T thought they had acknowledgment from the Operations Committee.

S. Kelly offered to have people from BCBSNJ come in to describe the audit process. J. Donnellan said the Operations Committee would hold a meeting to discuss the audit process with BCBSNJ to determine whether additional payments should be made. J. Donnellan suggested the Board should pay $115,000 now, and decide what to do about the excess amounts later.

G. Young offered a motion to pay $115,000 to D&T for the 1993 and 1994 loss audit. E. Shrem seconded the motion. The Board voted unanimously in favor of paying $115,000 to D&T.

J. Donnellan said the bid had set a cap on out-of-pocket expenses at 10%. The billed amount was $14,000.

E. Shrem offered a motion to pay 10% of $115,000 to D&T for out-of-pocket expenses. G. Young seconded the motion. The Board voted unanimously in favor of paying 10% of $115,000 to D&T for out-of-pocket expenses.

J. Donnellan said the Committee discussed measures to more closely monitor the costs of the audit.

VII. Harvard Brandeis Ad Hoc Committee

R. Smart said the study was proceeding. She believed the statistical analysis would be completed within the next 60 -90 days. The consumer piece would require more time. The team is working with carriers to send mailings to covered persons to determine interest in participating in the study. They are working carrier by carrier.

As a result of the sale to PFS, Washington National would not participate. USHealthCare declined to participate.

VIII. Report of the Marketing Committee

E. Shrem said the Committee would have to evaluate proceeding with the new Buyer's Guide given the changes under consideration. The pamphlet had been reprinted. E. Shrem distributed a report of Marcus Group activity to Board members.

S. Kelly offered a motion that the Board enter Executive Session. G. Young seconded the motion. The Board voted unanimously in favor of beginning Executive Session.

[Executive Session: 2:50 p.m. - 3:25 p.m.]

IX. Close of Meeting

There was no action during Executive Session to report during the open session.

E. Shrem offered a motion to adjourn the Board Meeting. G. Young seconded the motion. The Board voted unanimously in favor of adjourning the meeting. The meeting adjourned at 3:25 p.m.

August 12, 1996

Directors Present: J. Donnellan (Prudential); S. Kelly (Blue Cross and Blue Shield of New Jersey); L. Moskowitz (Department of Banking and Insurance); R. Rondum; E. Shrem, R. Smart (Mutual of Omaha); G. Young (USHealthcare); L. Yourman

Others Present: K. O'Leary, Executive Director; DAG M. Smyth (DOL); E. DeRosa, IHC Program Assistant Director, W. Sanders, SEH Program Assistant Director

I. Call to Order

J. Donnellan called the meeting to order at 9:45 a.m. K. O'Leary announced that notice of the meeting had been published in three New Jersey newspapers and posted at the Department of Insurance and the Office of the Secretary of State in accordance with the Open Public Meetings Act. K. O'Leary took roll call. A quorum was present.

J. Donnellan welcomed L. Moskowitz back.

II. Review of Minutes

Minutes of July 9, 1996
R. Smart offered a motion to adopt the minutes of the open session of the July 9, 1996 Board meeting, as amended. G. Young seconded the motion. The Board voted in favor of adopting the minutes, as amended. [2 abstained (L. Moskowitz, L. Yourman with respect to the segment of the meeting in which she did not participate)]

III. Report of the Policy Forms Committee

Grace Period / Unearned Premium / Termination of Coverage
R. Smart briefly reviewed the open issue for HMO carriers concerning the grace period provision, unearned premium and the effective date of termination, as raised during the July 9, 1996 Board meeting. She reminded the Board that there was not a corresponding concern for non-HMO carriers.

G. Simon said she spoke with E. Unger who advised her that he requires HMO carriers to include a grace period provision in HMO contracts, based on the Department's position that lack of a grace period provision would be unfair, unjust and inequitable.

G. Young said that while it was suggested during the last Board meeting that carriers could build something into the rates in anticipation of grace period liability, his company did not include anything in the rates for grace period claims. In response to an inquiry from L. Yourman, G. Young said the timing of payment to providers by an HMO varies.

L. Moskowitz asked how the grace period provision operates in other coverages. G. Simon and T. Smith explained that in life insurance if the insured dies during the grace period, the unpaid premium may be deducted from the death benefit, but that if the insured lives during the grace period, the carrier may not collect the grace period premium. For a carrier issuing indemnity plans, an unpaid premium may be collected via an offset mechanism whereby the carrier reduces any payment for a claim incurred during the grace period by the amount of the unpaid premium. However, if no claims were incurred, the offset could not take place. The proposal before the Board would eliminate the possibility of a carrier initiating collection against a person in order to collect the grace period premium.

G. Young agreed that for an HMO carrier, if there are no claims during the grace period, no premium should be due. However, if claims are incurred, he believes the carrier should be able to either collect the premium, or retroactively terminate the coverage, back to the paid to date. He believes the grace period should be a window of opportunity to pay a premium. If the premium is not paid and coverage is retroactively terminated, the consumer would be liable to the providers for the payment of the charges for the services provided.

The Board agreed that the following text should be included in the HMO contract grace period provision as optional alternate text:

> *....coverage will end as of the end of the period for which premium has been paid. You may be responsible for the payment of charges incurred for services or supplies received during the grace period.*

R. Smart asked that the proposal comments clearly state that a carrier may not require the payment of grace period premium, other than as may be collected via the offset provision in the event claims are incurred.

L. Moskowitz expressed concern with the fact that the continuity text of the pre-existing conditions provision of the IHC forms only allows for a maximum lapse period of 30 days in order to qualify for prior coverage credit. He asked what happens in situations of a 28 day or a 31 day month. The Board agreed the issue should be reviewed in Committee.

Child Only Rating Tier
R. Smart explained that coverage is currently available for a child or children. Coverage for a single child could be secured by purchasing single coverage. Coverage for multiple children could be purchased by either securing single coverage for each child, or, if all of the children share a common legal guardian, by securing parent-children coverage. Under the parent-children rating tier, the "parent" need not be covered. The issue is the rate at which such coverage would be available. L. Moskowitz asked that the discussion of a child only rating tier be deferred until the TAC report.

Prescription Drug Benefit Structures
Based on the results of the survey to members of the HMO Association, R. Smart said there was no interest in modifying the prescription drug benefit in the HMO contract. Members had been asked to consider including out of pocket maximums for prescription drugs, alternate coinsurance levels and/or other copays.

Staff conducted a survey of all IHC carriers in which carriers were asked if they were interested in various prescription drug rider options. Three of the eleven carriers that responded to the survey, with the three being HMO carriers, indicated an interest in a card option. J. Donnellan noted that the HMO plan currently allows a carrier to provide prescription drug coverage subject to either a $15 copay or 50% coinsurance. Therefore, those carriers already have the availability of a card type option.

Application
R. Smart explained that BCBSNJ provided a copy of an administrative form they use to investigate whether the coverage to be replaced is the same or similar to the coverage applied for. G. Simon commented that the form had not been filed with the Department. S. Kelly said BCBSNJ viewed the form as an administrative clarification.

E. Shrem asked that the standard form include a space for a requested effective date.

Therapy Services
Staff requested clarification of the therapy services benefit available under Plans B - E. The forms are not clear whether the 30 visit per benefit period maximum applies cumulatively or separately to physical therapy, occupational therapy, speech therapy and cognitive rehabilitation therapy. R. Smart said she reviewed all her records and could not locate anything to indicate what was intended. She noted that the SEH forms specifically describe a limitation on these services. S. Kelly commented that pre-reform plans did not generally provide an internal limit for therapy services. She was concerned that if carriers had been administering the 30 visit limit as a limit for each of the four therapies, a movement to otherwise apply the 30 visit limit would represent a benefit decrease. L. Yourman suggested that a 30 visit limit was not adequate for persons who have birth defects. E. Shrem said that all persons who have disabilities, not just those due to birth defects, may require more therapy services than the forms specifically allow. R. Rondum expressed concern that the benefits may be arbitrarily cut off. She recalled testimony that was provided when the plans were first developed and suggested that the Board should review that testimony before making any decision to modify the therapy services benefit. Thus, two issues must be addressed: clarification of the 30 visits limit; and whether to expand the therapy services benefit. J. Donnellan asked E. Shrem to forward her

concerns with the therapy benefit limits to the Policy Forms Committee. The Policy Forms Committee should consult with TAC regarding the cost impact. Staff should informally check with some of the IHC carriers to find out how the existing 30 visit limit is being applied. In addition, the IHC Policy Forms Committee should review the language used in the standard SEH policy forms.

Intentionally Self Inflicted Injury
R. Smart said the draft text included a modification to the definition of Injury to accomplish the revision discussed during the July Board meeting. Thus, benefits would not be denied solely due to the fact that the injury was an intentionally self inflicted injury.

Immunization terminology
The Board accepted staff's recommendation that it is appropriate to use all three terms: immunization; inoculation; and vaccination in the Primary Care Services provision of the forms.

[Break: 11:15 a.m.- 11:30 a.m.]

IV. Report of the Executive Director

Expense Report
L. Moskowitz offered a motion to approve the payment of the expenses noted on the Expense Report. G. Young seconded the motion. The Board voted unanimously in favor of approving the payment of the expenses noted on the August 12, 1996 Expense Report, with R. Rondum abstaining with respect to payment to herself.

IHC 1995 Assessment Collection
K. O'Leary reported having called and sent duplicate notices to carriers that had not yet paid the 1995 assessment.

G. Young asked if there had been an attempt to go back to carriers that may have had conversion lives or FEHBA premium in prior years. K. O'Leary said the reconciliation would reflect necessary adjustments.

E. Shrem noted that for some of the carriers, the amount due was not consistent with the sum of the loss assessment and the administrative assessment. K. O'Leary explained that the discrepancy was the result of rounding.

K. O'Leary said that Tom Gallagher (the replacement for Ed Troy) asked for a specific resolution to transfer funds from the treasury account to the Board account. He drafted a resolution and read it to the Board. The resolution would authorize the transfer on an ongoing basis.

L. Moskowitz offered a motion to approve a draft resolution that allows K. O'Leary to request that the Department transfer funds in the Treasury Account to the Board's account, on an ongoing basis. E. Shrem seconded the motion. The Board voted unanimously in favor of allowing the transfer of funds.

Reimbursement for 1995 Losses
Four carriers sought reimbursement for 1995 losses. K. O'Leary recommended that the Board release 90% of the requested amount, with the balance due payable upon completion of the audits. [See the attached Loss Payments spreadsheet which was distributed to Board members.] Responding to R. Rondum's inquiry as to the basis for the 90%, K. O'Leary said it was based on available funds and the need to withhold some portion until the completion of the audits. He noted that the carriers would have to agree to reimburse the Board for any amounts that audit may determine are not payable.

G. Young said he was concerned with two issues: conversion lives and FEHBA premium; and whether the Board had adequate funds on hand. K. O'Leary said the 1995 Exhibit Ks would not have included FEHBA premium, and carriers should have reported any eligible conversion lives. Further, he said he set aside funds for all appeals.

S. Kelly asked about the audit of Manhattan National. J. Donnellan said the nature of the audit would be discussed by the Operations Committee.

L. Moskowitz offered a motion that the Board release 90% of the amount requested to each of the four carriers that sought reimbursement. E. Shrem seconded the motion. The Board voted unanimously in favor of authorizing the payment. [See attached spreadsheet.]

Appeals
K. O'Leary summarized the issues and the Legal Committee's recommendations on each of the appeals. The Board voted to accept or deny each recommendation, as follows.

First Option Health Plan: While the appeal was filed late, allow the appeal. However, deny the appeal since there was no material issue of fact that would require a hearing.

L. Moskowitz offered a motion to deny the appeal. S. Kelly seconded the motion. the Board voted unanimously in favor of denying the appeal.

Trustmark Insurance Company: The company reported it overstated the NEP on Exhibit K for 1994 and 1995 since it included stop loss coverage which would be exempt from the definition of a health benefit plan. L. Moskowitz asked that K. O'Leary verify that the stop loss premium Trustmark wants to exclude form NEP is truly excludable.

L. Moskowitz offered a motion to grant the appeal with respect to 1995, but deny the appeal with respect to 1994. G. Young seconded the motion. The Board voted unanimously in favor of granting the appeal for 1995 but denying the appeal for 1994.

Guarantee Trust Life: The company filed two Exhibit Ks and requested that the lower figure included on the second Exhibit be used. L Moskowitz asked why the company filed another Exhibit K. K. O'Leary said he did not inquire.

L. Moskowitz offered a motion to grant the appeal. G. Young seconded the motion. The board voted unanimously in favor of granting the appeal.

Pacific Mutual Life Insurance Company: The company reported it included non-health benefit premium on the Exhibit Ks for 1993 - 1995.

L. Yourman offered a motion to grant the appeal with respect to 1995, but deny the appeals with respect to 1993 and 1994. G. Young seconded the motion. The Board voted unanimously in favor of granting the appeal for 1995, but denying the appeals for 1993 and 1994.

Qual Med Plans for Health: No action necessary since appeal not yet filed.

American National Insurance Company: The company overstated NEP due to double counting of association business.

L. Yourman offered a motion to grant the appeal. G. Young seconded the motion. The Board voted unanimously in favor of granting the appeal.

CNA Insurance Companies: The company reported non-health benefit premium on the 1995 Exhibit K.

G. Young offered a motion to grant the appeal. L. Yourman seconded the motion. The Board voted unanimously in favor of granting the appeal.

Reliable Life Insurance Company: The company reported non-health benefit premium on the 1995 Exhibit K.

G. Young offered a motion to grant the appeal. S. Kelly seconded the motion. the Board voted unanimously in favor of granting the appeal.

Canada Life Assurance Company: The company reported non-health benefit premium on the 1995 Exhibit K.

G. Young offered a motion to grant the appeal. S. Kelly seconded the motion. the Board voted unanimously in favor of granting the appeal.

[G. Young left the meeting at 12:05 p.m.]

Audit Status
K. O'Leary noted the auditors are billing on an hourly basis for the 1995 loss audits. There is no cap on the fee. D&T provided a written status report regarding the reimbursable loss audits.

Interest Earned on Funds Held by Board
K. O'Leary reported that he had raised the issue of interest earned on funds held by the Board with Deloitte & Touche and that he would also raise the issue with the Department of Banking and Insurance.

Summit Follow-Up Meeting
K. O'Leary said he believed the goal of the follow-up meeting was to produce statutory and regulatory recommendations. L. Moskowitz said the meeting *might* result in some recommendations. The Board should be brought into the process before any recommendations would be made.

Code of Ethics
W. Sanders briefly discussed the Code of Ethics which the Board had voted to adopt during the July Board meeting. A copy, signed by the Executive Director, was distributed to Board members. The Conflict of Interest Questionnaire should be completed and returned to K. O'Leary. W. Sanders explained the changes that would be required to the Plan of Operations in order to require non-Board member committee members to be bound by the Code of Ethics. K. O'Leary said there were many changes that need to be made to the Plan of Operations and he would recommend that the changes not be handled piecemeal. W. Sanders said the Board could nevertheless ask non-Board members to complete the Conflict of Interest questionnaire.

E. Shrem offered a motion that the Board require non-Board members who serve on Board Committees to agree to be bound by the Code of Ethics, and complete the Conflict of Interest questionnaire as a condition of serving on the Committees. R. Smart seconded the motion. The Board voted unanimously in favor of the motion.

One Life Group Study
K. O'Leary reported having completed a first draft of the study on the effects of one life group business being written as individual as opposed to group plans. That draft was being reviewed by a committee the SEH Board formed to consider the report.

Federal News
The Kennedy / Kassebaum bill passed and awaits the President's signature. K. O'Leary commented it is more than a portability law, as the news reports indicate. He said the Department would have a briefing

V. Report of the Technical Advisory Committee

Rate Filings (as identified on the attached Report of TAC)
L. Moskowitz offered a motion to deem the rate filings of the carriers identified on the TAC Report as complete. R. Smart seconded the motion. The Board voted unanimously in favor of deeming the rate filings complete.

Loss Ratio Reports
J. Donnellan reported that TAC recommended that the Board not audit the calculated reserve for loss year 1994. The Board agreed.

Performance Reports
J. Donnellan advised the Board that the performance reports for Time and BCBSNJ had been forwarded to D&T for informational purposes. The reports for the remaining carriers did not contain adequate information, and staff had written to those carriers to secure such information.

Cost Reduction Recommendations
J. Donnellan categorized the recommendations as related to benefit design, rating and loss ratio calculations.

Benefit Design

Eliminate Plan A, and re-designate Plan B as the Basic plan.
L. Moskowitz asked if the Board could eliminate Plan A. M. Smyth said that the Board has the discretion to do so and designate another plan as the "basic plan." L. Moskowitz asked what would happen to the customers who purchased Plan A. S. Kelly explained that TAC has discussed inforce business and proposed that subject to 60 days notice, the coverage should be terminated and that a special open enrollment period be allowed to give the customers the opportunity to purchase any other plan. K. O'Leary said there were approximately 4500 persons enrolled under plan A. S. Kelly said TAC discussed the consequences of allowing the inforce Plan A plans to continue, and believed that termination would be preferable to the rate spiral that would likely occur.

Modify Plan B to:
- increase the lifetime maximum benefit from $1 million to unlimited
- eliminate the $250 and $500 deductible options
- add a $2500 deductible option

Modify Plans C and D to eliminate the $250 deductible options and modify Plan E to eliminate the $150 deductible option.

L. Yourman asked the Board to consider the consequences to the Health Access Program that makes a Plan D, $250 deductible, available.

Rating
J. Donnellan said TAC recommended using a modified community rating structure, based on age, subject to a 2:1 ratio. L. Moskowitz commented that would be "strange" given the fact that SEH uses a modified community rating structure that considers the factors of age, gender and geography. J. Donnellan explained that gender and geography are less significant factors than age. S. Kelly further

explained that TAC wanted to keep rating as simple as possible such that an understandable rate comparison sheet could continue to be produced.

R. Rondum said she was deeply troubled by the recommendation to use age as a rating factor. She said it appeared the Board was only considering carrier experience and had not tapped into the wealth of information that exists, or would soon exist. For example, the Harvard Brandeis study promises to provide some credible data on the program as now structured. Information is available from the Division on Aging. There has been no complete audit of the program. She fears the Board would be moving too fast if it were to modify rating without truly analyzing all available data. She urged the Board to look at everything, not merely listen to some carriers.

L. Moskowitz said the Board has an obligation to evaluate the performance of the program on an ongoing basis. He noted that there is considerable pressure on the Board due to changes in the marketplace. New Jersey chose a unique route. Rather than using a high risk pool, New Jersey structured a "pay or play" mechanism. He suggested that now is an appropriate time to look at the program.

L. Yourman asked why the Board doesn't audit carriers other than those that seek reimbursement. K. O'Leary said there is a provision that allows the Board to audit the Loss Ratio Reports. L. Yourman commented on the number of carriers that had incorrectly reported data on Exhibit K. S. Kelly explained the difference between the Exhibit K (Carrier Market Share) and the Exhibit J (Loss Ratio Report). L. Yourman asked if the 75% loss ratio was being effectively policed. L. Moskowitz asked that the Department's actuaries evaluate whether a spot check is necessary or appropriate.

L. Moskowitz said experience is looked at each year. Some carriers were hurt by their early marketing experience. If a carrier sold a small share of the market and attracted some bad risks, the carrier would have to increase the rates to support those risks over a small block of business.

R. Rondum again said she wanted to look beyond carrier experience. Her main concern would be deviating from pure community rating.

L. Moskowitz asked the Board to consider the impact to the baby group marketplace.

Loss Ratio Calculation

J. Donnellan said TAC believed that the loss ratio calculation should be spread over a two year period and that the refund calculation should be modified in a manner similar to the SEH calculation.

Child Only Rating Tier

J. Donnellan said TAC was not in favor of moving forward with a child only tier. L. Moskowitz said a meeting of the Health Care Administration Board was scheduled and he believed there would be a proposal to move forward with the Child First program, even though the funding issue had not been resolved. He believed there was a possibility that the Child First program could be implemented by January 1997.

L. Moskowitz suggested that carriers be given the option to expand the current 4 tiers to 5 tiers. Further, carriers that want to use a fifth, child only tier, could decide to make that rate a composite rate for one or more children, or a per child rate.

R. Rondum asked if the Board would have to start with a new proposal. K. O'Leary said the Board had already published a proposal, but depending on the nature of any changes to that proposal, it may be possible to adopt what was proposed, with no more than non-substantive changes.

[Break: 1:45 p.m.- 1:55 p.m.]

VI. Report of the Marketing Committee

E. Shrem reported that the pamphlets had been re-printed. Some quotes on the cost to print the new Buyer's guide had been received, but E. Shrem said she wanted to secure some other quotes.

E. Shrem said she asked C. Nicholas to attend the follow-up summit meeting and prepare a synopsis to release to the news media.

S. Kelly asked if the Committee had considered the 1995 Good Faith Marketing Reports. E. Shrem said she hoped to be in a position to discuss the Committee's findings during the September meeting.

R. Smart noted that The Marcus Group material suggested that the 18-29 age group was the largest segment of the uninsured. She asked the source of the data. C. Nicholas said it came from an article in the Philadelphia Inquirer.

VII. Harvard Brandeis Ad Hoc Committee Report

R. Smart said she had heard nothing new from the study team and assumed they were proceeding to work with the carriers.

VIII. Report of the Legal Committee

K. O'Leary said that while the Committee discussed what may occur to pre-reform plans in terms of removing or adding dependents, he was going to refer the issue back to the Committee since some new information became available.

The committee had been asked to consider rates that may be charged by affiliated carriers. M. Smyth said the fundamental issue was whether, based on the definitions

of carrier and community rates, affiliated carriers could charge different rates for the same plan. The Legal Committee was not in a position to make a recommendation, and the Department of Banking and Insurance had asked the Attorney General's Office to consider the issue.

Regarding rate guarantee periods, the Committee believed that a carrier should not be permitted to have a rate guarantee of one duration for new business and another duration for inforce business. S. Kelly commented that this conclusion differed from the conclusion TAC reached. L. Moskowitz said that eventually, everyone needs to get to the same rate. J. Donnellan said TAC would need to discuss the Legal Committee recommendation.

The committee was still considering a withdrawal regulation. L. Moskowitz said carriers need a viable mechanism to exit the market.

E. Shrem offered a motion to close Open Session and begin Executive Session. L. Yourman seconded the motion. The Board voted in favor of closing the Open Session and beginning Executive Session.

[Executive session: 2:25 p.m. - 3:15 p.m.]

E. Shrem offered a motion to authorize the expenditure of funds to print an interim Buyer's guide, following securing additional quotes. L. Yourman seconded the motion. The Board voted unanimously in favor of authorizing the expenditure of funds to print an interim Buyer's guide.

E. Shrem offered a motion to close the meeting. L. Yourman seconded the motion. The Board voted unanimously in favor of closing the Board meeting. The meeting adjourned at 3:15 p.m.