MINUTES OF THE MEETING OF
THE NEW JERSEY INDIVIDUAL HEALTH COVERAGE PROGRAM BOARD
AT THE OFFICES OF THE NEW JERSEY DEPARTMENT
OF BANKING AND INSURANCE
TRENTON, NEW JERSEY
May 11, 1999

Directors Participating: Sandi Kelly (Horizon Blue Cross Blue Shield of New Jersey); Jane Majcher (Department of Banking and Insurance); Mary McClure (The Prudential); Ritamarie Rondum; Eileen Shrem; Rebecca Smart, Chair (Mutual of Omaha); Lisa Yourman.

Others Participating: Ellen DeRosa, Deputy Executive Director; DAG Eleanor Heck (DOL); Pearl Lechner, Program Accountant; Wardell Sanders, Executive Director.

I. Call to Order

W. Sanders called the Board meeting to order at 9:50 a.m. He announced that notice of the meeting had been published in three New Jersey newspapers and posted at the Department of Banking and Insurance and the Office of the Secretary of State in accordance with the Open Public Meetings Act. A quorum was present.

II. Minutes

April 13, 1999
R. Smart offered a motion to approve the minutes of the Open Session of the April 13, 1999 Board meeting, as amended. J. Majcher seconded the motion. The Board voted in favor of accepting the motion, with two abstentions, E. Shrem and L. Yourman.

III. Report of Staff

May 11, 1999 Expense Report (See Attachment)
S. Kelly offered a motion to approve the payment of the expenses shown on the May 11, 1999 expense report. M. McClure seconded the motion. The Board voted unanimously in favor of accepting the motion.

Technology

W. Sanders reported that the new computers the Boards authorized staff to purchase were installed in late April. He noted that the new computers are on a network and have Internet access. He asked Board members to provide e-mail addresses.

W. Sanders said the entire Department is getting a new phone system and Board staff would be included in the new system. The system is scheduled to be operative as of Monday, June 14, 1999. Each area will have a main number, with the main number for the IHC/SEH Programs being 609-633-1882. Each staff member will have an extension.

1997/1998 Preliminary Notice of Losses and 1999/2000 Non-Group Person Targets
W. Sanders said that staff has continued to attempt to secure the missing Exhibit K data through phone calls and letters. He noted that carriers would have 30 days from the date of the notice of the non-group person target for 1999/2000 in which to make an election to seek a conditional exemption.

Outreach

W. Sanders reported that he spoke at a breakfast meeting of the Bayonne Economic Development Corporation on April 23, 1999. He noted that Assemblyman Doria was also a speaker.

W. Sanders said the Department requested information on the IHC/SEH Programs for the Department's Annual Report. He said he would distribute a draft article for Board member comments.

W. Sanders said he as invited to be a speaker at the annual conference of The National Academy for State Health Policy. He noted that unlike other organizations, this organization does not typically pay for transportation and lodging costs. He asked Board members if they thought he should attend and if he should attend, would the Board pay half the cost of travel expenses, assuming the SEH board would pay the other half. The Board agreed W. Sanders should participate in the conference and indicated that the Board would pay half the cost of the trip.

R. Rondum offered a motion to pay half the travel expenses associated with W. Sanders speaking at the conference in Cincinnati. E. Shrem seconded the motion. The Board vote unanimously in favor of the motion.

W. Sanders noted that web site activity continued to increase in March 1999, with 1287 "hits" for the IHC/SEH Programs information.

E. DeRosa reported that she spoke to a group of agents from Meeker Sharkey which is a large New Jersey insurance sales agency. She also reported that she taped a half-hour cable television show called *Financial Matters*.

Legislative Update

S. Kelly asked if there was any legislative action to report.

W. Sanders said there was a forum on NJ KidCare on April 20, 1999. J. Majcher said there would be another meeting to provide information on NJ KidCare and that they hoped to attract more attendees from the business community to this second meeting. J.

Majcher also reported that a number of NJ KidCare bills were expected to be considered by the Senate Appropriations Committee on May 13, 1999.

DAG E. Heck reported that two bills had been introduced that would amend the Open Public Meetings Act. She said one of the bills would require that the meeting schedule and the agenda for meetings be posted on the web site. She said the other bill would require that Executive Sessions be taped and the tapes kept on hand.

W. Sanders said Executive Order No. 92 created the Mandated Benefits Review Task Force. He said many people believed that the enactment of new mandated benefits might be delayed, pending review by the task force. He offered to provide a copy of Executive Order No. 92 to the Board.

IV. Report of the Technical Advisory Committee

Rate Filing
S. Kelly reviewed the recommendation of TAC that the Board find five rate filings as identified on the TAC Report (copy attached) as complete.

R. Smart offered a motion to accept the recommendation of TAC and find the rate filings identified on the TAC Report as complete. J. Majcher seconded the motion. The Board voted unanimously in favor of the motion.

Loss Ratio Guidelines

S. Kelly reviewed the guidelines formulated by TAC that were included in Board materials. She noted that the handout was missing the glossary and promised to get a copy of the glossary to staff so it could be distributed to the Board. S. Kelly noted that the items TAC recommends should be considered as claims costs for the loss ratio calculation are all designed to control the cost of care. Some Board members asked what costs would be considered administrative costs rather than claims costs. S. Kelly agreed to compile a list of administrative costs.

Board members were asked to fax any comments or questions on the loss ratio guidelines to staff.

Satisfaction of 1997/1998 Non-Group person Targets.
S. Kelly reminded the Board that 10 carriers sought a conditional exemption for 1997/1998. Of those carriers, two, Horizon and HIP, exceeded the target of non-group persons assigned by the Board. Five carriers, Aetna U.S. Healthcare, AmeriHealth, Foundation, Oxford and United, exceeded 50% of the target assigned, but enrolled less than 100% of the target of non-group persons assigned by the Board. Three carriers, CIGNA, Guardian and Prudential enrolled less than 50% of the non-group person target assigned by the Board. She noted that those three carriers, according to the Board's regulation, would be required to submit a Good Faith Marketing Report by July 1, 1999.

L. Yourman offered a motion to accept the findings of TAC concerning satisfaction of non-group person targets for 1997/1998. J. Majcher seconded the motion. The Board voted in favor of the motion with S. Kelly abstaining with respect to Horizon and M. McClure abstaining with respect to Prudential.

[Break: 11:10 a.m. – 11:25 a.m.]

Report of the Operations Committee

Draft Audits for 7 carriers

W. Sanders said the Operations Committee considered the draft audits Deloitte & Touche (D&T) prepared for 7 of the 8 carriers that sought reimbursement for 1996 reimbursable losses. Of those draft audits, 5 of the 7 audits resulted in no adjustments (Manhattan National, National Casualty, Protective, Fortis, and Washington National). Two of the audits, for Metropolitan and Travelers, resulted in adjustments. W. Sanders said the carriers did not dispute the findings of D&T. W. Sanders said the Committee recommended that the Board accept the audits.

M. McClure offered a motion to accept the recommendation of the Operations Committee and accept the audit reports. E. Shrem seconded the motion. The Board voted unanimously in favor of the motion.

Status of Audit of The Mutual Group (TMG)

W. Sanders said TMG had failed to provide the pricing data D&T required in order to complete the claims portion of the audit. W. Sanders said the Committee discussed giving TMG 30 days to provide the information if D&T reported back within a week that the information was still unavailable. If TMG failed to provide the information, the Board should issue an order to demand that TMG return the $2.4 million the Board paid to TMG, which was an 80% payment of the requested loss amount. The Board agreed that the 30-day letter should be sent and would vote regarding an Order if TMG does not provide the required data.

Proposed Reimbursement

W. Sanders reported that as of March 31, 1999, the Board had $4,269,258.05 on hand that it could use to provide reimbursement to carriers for 1996 reimbursable losses. He noted that since Metropolitan had failed to provide the required Performance Report, it had not been paid the 80% partial reimbursement as had the other carriers that filed for reimbursement for 1996 losses. After paying Metropolitan 80% of the amount it requested on Exhibit K, there would be sufficient funds to reimburse carriers an additional 6% such that each carrier would be paid a total of 86% of the requested loss amount. However, he noted that no additional amounts would be paid to TMG pending successful completion of the audit.

M. McClure offered a motion to make payment to the following carriers such that each carrier would be paid a total of 86% of the loss amount requested: Fortis,

Manhattan National, Metropolitan Life, National Casualty, Protective, Travelers and Washington National. J. Majcher seconded the motion. The Board voted unanimously in favor of the motion.

1997/1998 Performance Reports
W. Sanders reported that some of the carriers seeking reimbursement for 1997/1998 losses had not filed the required Performance Reports. He said he had contacted the carriers that failed to provide the reports.

1995 Horizon Audit

W. Sanders reported that D&T provided the draft audit report to Horizon for review. He said that Horizon had some comments.

Product Design Discussion

W. Sanders reported that he and E. DeRosa met with Assistant Commissioner G. Simon concerning the EPO plan proposed by Horizon. He and E. DeRosa explained that G. Simon stated that New Jersey Law precludes an indemnity carrier from offering an EPO plan. W. Sanders and E. DeRosa reported that G. Simon indicated that the proposed plan could be offered using HMO paper. In addition, they reported that G. Simon noted that the Health Care Quality Act imposes the same type of reporting requirements on an indemnity-based managed care plan as would apply to an HMO. Thus, if the reason indemnity paper was preferred for the EPO plan was difficulty with HMO reporting requirements, writing the plan on indemnity paper would not alleviate the difficulty.

W. Sanders and E. DeRosa reported that they had contacted S. Kelly following the meeting with G. Simon, and S. Kelly had agreed to let the product people at Horizon know that the EPO design would be feasible on HMO paper. During the Board meeting discussion S. Kelly said she would bring an HMO paper EPO plan design to the Board for discussion.

W. Sanders explained that while the Board had asked that an industry representative be present for a meeting, staff did not organize the meeting and thus did not have control of attendance.

Report of the Legal Committee

W. Sanders reported that the Legal Committee considered two market withdrawal filings. He said the carriers seeking to withdraw, National Casualty and Washington National, had both stopped selling new business some time ago. He said the Committee recommended that both filings be approved.

S. Kelly offered a motion to approve the market withdrawal filings from National Casualty and Washington National. R. Rondum seconded the motion. The Board voted unanimously in favor of the motion.

The Board asked staff to prepare a list of all carriers that have withdrawn.

VIII. Executive Session

W. Sanders said the Board needed to discuss the Horizon appeal, Exhibit K issues and Executive Session minutes and asked for a motion to enter Executive Session. He said there would be no further discussion following the Executive Session.

E. Shrem offered a motion for the Board to begin Executive Session. M. McClure seconded the motion. The Board voted unanimously in favor of the motion.

[Executive Session: 12:10 p.m. – 1:15 p.m.]

IX. Close of Meeting

M. McClure offered a motion to adjourn the Board meeting. R. Rondum seconded the motion. The Board voted unanimously in favor of the motion. The meeting adjourned at 1:15 p.m.

Attachments: Expense Report
Report of TAC

MINUTES OF THE MEETING OF
THE NEW JERSEY INDIVIDUAL HEALTH COVERAGE PROGRAM BOARD
AT THE OFFICES OF THE NEW JERSEY DEPARTMENT
OF BANKING AND INSURANCE
TRENTON, NEW JERSEY
June 14, 1999

Directors Participating: Jeff Beck (Aetna USHealthcare);Sandi Kelly (Horizon Blue Cross Blue Shield of New Jersey); Jane Majcher, Robert Vehec (Department of Banking and Insurance); Mary McClure (The Prudential); Ritamarie Rondum; Eileen Shrem; Rebecca Smart, Chair (Mutual of Omaha); Lisa Yourman.

Others Participating: Ellen DeRosa, Deputy Executive Director; DAG Eleanor Heck (DOL); Pearl Lechner, Program Accountant; Joanne Petto, Assistant Director; Wardell Sanders, Executive Director.

I. Call to Order

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Department of Banking and Insurance and the Office of the Secretary of State in accordance with the Open Public Meetings Act. A quorum was present.

II. Minutes

May 11, 1999
S. Kelly offered a motion to approve the minutes of the Open Session of the May 11, 1999 Board meeting, as amended. J. Majcher seconded the motion. The Board voted unanimously in favor of accepting the motion.

III. Report of Staff

June 14, 1999 Expense Report (See Attachment)
R. Smart offered a motion to approve the payment of the expenses shown on the June 14, 1999 expense report. M. McClure seconded the motion. The Board voted in favor of accepting the motion, with L. Yourman abstaining with respect to payment to be made to her.

1997/1998 Preliminary Notice of Losses and 1999/2000 Non-Group Person Targets
W. Sanders said that staff has continued to attempt to secure the missing Exhibit K data through phone calls and letters. He said that staff was extremely concerned by information provided by some carriers that indicated they had provided data for only 1998, and not for the two-year period, 1997/1998. He said that the calls revealed that a number of carriers continue to be confused as to member and non-member status, as evidenced by filing both an Exhibit K and a Non-Member Certification, and the types of plan carriers have included on the Non-member Certification. He said his recommendation would be to delay releasing the 1997/1998 Preliminary Notice of Losses and 1999/2000 Non-Group Person Targets until after staff could call all the carriers that filed the Exhibit K and verify that the data shown was for the two-year period. He said the Operations Committee agreed with that recommendation. In addition, he said staff was still attempting to secure clarification of non-member status from a number of carriers. He noted that since the calculation period is on a two-year basis, the release of the notice could be delayed without jeopardizing the Program with respect to carriers that

need to make a decision concerning exemption status. The Board agreed that it would be preferable to delay the release of the 1997/1998 Preliminary Notice of Losses and 1999/2000 Non-Group Person Targets until staff could complete the follow-up process.

Outreach

W. Sanders reported that he spoke at the annual meeting of the New Jersey Association of Health Underwriters in Atlantic City on May 25, 1999. He noted there was a good turnout for his presentation.

W. Sanders said Commissioner LaVecchia recorded two Public Service Announcements (PSAs) concerning the IHC and SEH programs. He reported that these PSAs were intended to be broadcast on radio stations throughout the State, during peak hours. He said that copies of the scripts were included in Board materials.

Y2K Preparedness

W. Sanders said that the Department has been conducting Y2K preparedness meetings and he noted that the Department included the IHC and SEH programs among the areas to be considered. He said that it appears that the only area in which the IHC and SEH Programs may be affected would be the Quicken software the Programs have used. He reported that the version the Programs have been using appears to be Y2K compliant.

Exclusive Provider Organization (EPO) Plan Design

W. Sanders said that a plan design memorandum prepared by S. Kelly was included in meeting materials. S. Kelly said that Horizon outlined the plan as it could be offered on HMO paper, but that Horizon was most interested in offering the product on insurance paper rather than HMO paper. She reported that due to Horizon's market share in the individual market, a couple of Legislators had contacted Horizon to seek ideas regarding what steps could be taken to reduce the cost of individual coverage. She indicated that Horizon could suggest a statutory change that would permit indemnity carriers to offer the EPO plan. R. Rondum asked S. Kelly which Legislators had initiated contact with Horizon. S. Kelly said the contact was through the government affairs area of Horizon, and that she would make the appropriate inquiries to find out.

S. Kelly said that the EPO design, on HMO paper, would require the replacement of all copayments with deductible and coinsurance features. She said Horizon recommends that use of a gatekeeper be made optional at the carrier level.

M. McClure commented that administering an EPO product on HMO paper might be more expensive than on indemnity paper. S. Kelly noted that for Horizon, an advantage to indemnity paper would be the out-of-state discounts that would only be available if the plan were issued on indemnity paper. She said that customers have been requesting lower cost products. E. DeRosa commented that she frequently receives calls from

customers who are distressed by the cost of coverage. She noted that the callers have not asked for different products at a lower cost, but rather, for price relief for the current products.

W. Sanders asked if there was any interest in an EPO on HMO paper. The Board agreed that it would not make any sense for the Board to pursue an EPO plan on HMO paper if HMO carriers were not interested in such a product. Staff will survey HMO carriers to determine whether there is any interest in the EPO product.

E. Shrem said she was studying for a Registered Health Underwriter exam and that the course materials stated that managed care companies conduct exit surveys. She asked if the managed care companies in the IHC market were conducting such surveys. The sense among carrier Board members was that carriers are probably not conducting exit surveys. The Board discussed the possibility of conducting a survey of persons who called the toll free number for a Buyer's Guide, or a survey of those who visit the web site. S. Kelly asked if the Board would be required to fund such a study. The Board formed an ad hoc committee to investigate ways to determine why customers either decide not to purchase IHC coverage, or terminate it after it has been issued. The members of the Committee will be: a representative from Horizon; a representative from the Department; E. Shrem; and L. Yourman. M. McClure suggested that the ad hoc committee may want to contact the Department of Health and Senior Services since that agency has conducted a number of surveys.

1Q99 Enrollment

J. Petto reported that HIP in liquidation had not been able to provide enrollment data for 1Q99. Since all HIP coverage terminated as of March 31, 1999, and the new coverage may not have taken effect until April 1 or later, she said it would not be until 2Q99 that HIP membership would be reflected under replacement coverage. Assuming most HIP members did secure replacement coverage, she said the IHC enrollment decreased by about 5% as compared to 4Q98. Without HIP membership, enrollment was 118,054 as of 1Q99, as compared to 131,136 as of 4Q98, representing a decrease of 9.98%.

July 13, 1999 Meeting Status

The Board agreed to delay discussion of whether to hold the July meeting until later in the meeting.

Operations Committee Report

Audit Status:

- *1996 Audit of TMG*: W. Sanders said he advised the Operations Committee that TMG indicated it could produce the data Deloitte & Touche (D&T) requested and that D&T would be on-site to review the data beginning June 21, 1999.
- *1995 Audit of Horizon*: W. Sanders said he advised the Operations Committee that the only outstanding elements to the audit were the signed engagement letter from Horizon and the Board's review of the Draft audit. He noted that as a result of the audit, the loss amount to be paid would be reduced by approximately $2.8 million.

W. Sanders said he hoped the Board could be in a position to approve the draft audit during the next Board meeting.

- W. Sanders reported that the 90-day notice of audit information had been sent to the carriers that requested reimbursement for losses for 1997/1998. He noted that of the carriers seeking reimbursement, performance reports have not been provided by MetLife, Principal and TMG.

Issues:

- *Agreed upon Procedure for Manhattan National 1995 Audit*: W. Sanders said the Board needed to sign the agreed upon procedures engagement letter.
  S. Kelly offered a motion that the Board sign the agreed upon procedures engagement letter with Manhattan National for the 1995 reimbursable loss audit. R. Smart seconded the motion. The Board voted unanimously in favor of the motion.
- *RPF for Audit Firm*: W. Sanders said he forwarded a draft of the RFP for an audit firm to the Operations Committee for comments.

Legal Committee Report

Application of P.L. 1999, c. 49 to the IHC Plans:

W. Sanders said that as a condition of obtaining and retaining a certificate of authority, HMO carriers were required to comply with this law that stipulated coverage for certain dental procedures. He said the Legal Committee recalled the past practice of the Board to apply mandated benefit requirements to all carriers whether or not the mandated benefit applies to all carriers and recommended a similar practice with respect to this law. The Board agreed.

Draft Policy Forms Changes

E. DeRosa discussed the policy forms proposal that was included in Board materials. She said the proposal, which she prepared as a result of the Board discussion during the May Board meeting, included provisions to comply with the recently enacted law for mental health coverage, the dental procedures law, and the inflation adjusted amounts for preventive services. She said she circulated the draft to the Policy Forms Committee for comments, and received comments from the carrier members of the Committee that stated the proposal was fine.

S. Kelly said the drafts were circulated to various operating areas at Horizon and that while there were no comments from the policy forms perspective, some other areas had comments. She said Horizon believed more research needed to be done concerning the mental health law to see if there could be a means to include some limits on the coverage. E. DeRosa said the law was very clear in stating that coverage needed to be to the same extent as for any other illness which would mean no limits could be applied. S. Kelly said Horizon thought the Legal Committee should review the law to be sure. She also said that Horizon believed that if coverage did have to be provided without internal limits, that the unlimited coverage should perhaps not be limited to biologically based mental illnesses. She suggested that it might be more costly for a carrier to differentiate between a biologically-based mental illness and a non-biologically-based mental illness than to just pay for all mental illnesses without limit. She wanted TAC to review the

coverage to determine if it makes sense to extend the unlimited coverage beyond biologically-based mental illness, as defined in the law.

Concerning the preventive care adjusted amounts required under the Health Wellness Promotion Act, S. Kelly said Horizon questioned whether the law applies to the standard plans. Again, she asked that the Legal Committee review the law. W. Sanders and E. DeRosa noted that the Attorney General's office provided an opinion concerning the applicability of the law to the SEH Program when the plans were first being developed, and that the opinion stated that the reform plans were subject to the law.

[Break: 11:10 a.m.- - 11:25 a.m.]

IV. Report of the Technical Advisory Committee

Rate Filings
S. Kelly reviewed the recommendation of TAC that the Board find three rate filings as identified on the TAC Report (copy attached) as complete.

S. Kelly offered a motion to accept the recommendation of TAC and find the rate filings identified on the TAC Report as complete. M. McClure seconded the motion. The Board voted unanimously in favor of the motion.

1997 Loss Ratio Report

S. Kelly reported that the only outstanding 1997 loss ratio report had been received from

TMG and reviewed by TAC. No Board action was required.

Loss Ratio Guidelines

S. Kelly said the TAC recommendation for loss ratio guidelines indicated that expenses associated with arranging, coordinating and overseeing patient care should be considered as claims for the purpose of determining the loss ratio. She reviewed the list TAC compiled concerning what would not be considered a claim. (See the attached Report of TAC.) Claims adjudication is a part of claims administration, and thus should be considered as a claim cost.

R. Rondum said her understanding of the health reforms was that there were to be 5 standard plans, guaranteed issue, and a cap on administrative costs at 25%. She said she viewed this expansion of the definition of a "claim" as part of a pattern of insurers to eat away at the fundamental protections of the reform. She recalled the Summit that Commissioner Randall convened in 1996. She commented that the suggestions made at the Summit appeared to be attempts to chip away at consumer protections. R. Rondum noted that the definition of a claim in an insurance sourcebook states that a claim is a demand for benefits. She noted that the standard policy forms do not include a definition of claim. R. Rondum said her understanding of the functions TAC recommends to be

considered as claims was that these were management functions, not claims functions. She said she feared that if these items were to be considered as claims it would chip away at the 75% loss ratio protection of the reform.

R. Smart noted that TAC attempted to put HMO and indemnity carriers on equal footing with respect to what is treated as a claim.

S. Kelly again explained that the costs TAC recommends to be considered as claims are related to arranging, coordinating and overseeing care, and that if a carrier were to not perform such functions, the cost of coverage would likely be even higher. But, she noted that there is a cost associated with these functions which TAC believes should be classified as a claim cost.

R. Vehec said that the Department took a position nearly 2 years ago that the items TAC recommended to include as claims should not be included as claims. He also said that the Department had invited industry comment concerning the Department's position. He said the new Commissioner would develop a position after reviewing the Department's current position and comments from the industry, including any comments from the Boards.

R. Rondum offered a motion that the Board table the discussion until after the Commissioner formulates a position. L. Yourman seconded the motion. The motion did not carry, with 2 votes in favor (R. Rondum, L. Yourman), 3 opposed (R. Smart, M. McClure, S. Kelly) and 2 abstentions (J. Majcher, E. Shrem).

After further discussion, the Board agreed to create a recommendation to present to the Commissioner that expresses the conflicting opinions of Board members. The recommendation should include the TAC recommendation as well as the concerns raised by consumer members on the Board. E. DeRosa agreed to prepare the draft, including input from the TAC recommendation and consumer members. The Board would review the recommendation during the next Board meeting.

S. Kelly offered a motion that the recommendation be revised to include consumer concerns. R. Smart seconded the motion. The Board voted in favor of the motion, with one abstention, J. Majcher.

V. Executive Session

W. Sanders said the Board needed to discuss advice from counsel, a contract issue, application of laws, and Executive Session minutes and asked for a motion to enter Executive Session. He said there would be no further discussion following the Executive Session.

E. Shrem offered a motion for the Board to begin Executive Session. M. McClure seconded the motion. The Board voted unanimously in favor of the motion.

[Executive Session: 12:15 p.m. – 2:15 p.m.]

VI. Close of Meeting

R. Rondum offered a motion to adjourn the Board meeting. E. Shrem seconded the motion. The Board voted unanimously in favor of the motion. The meeting adjourned at 2:16 p.m.

Attachments: Expense Report
Report of TAC

MINUTES OF THE MEETING OF
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Directors Participating: Jeff Beck (Aetna USHealthcare); Sandi Kelly (Horizon Blue Cross Blue Shield of New Jersey); Jane Majcher, (Department of Banking and Insurance); Mary McClure (The Prudential); Ritamarie Rondum; Eileen Shrem; Lisa Yourman.

Others Participating: DAG Eleanor Heck (DOL); Joanne Petto, Assistant Director; Wardell Sanders, Executive Director.

I. Call to Order

W. Sanders called the Board meeting to order at 9:45 a.m. He announced that notice of the meeting had been published in three New Jersey newspapers and posted at the Department of Banking and Insurance and the Office of the Secretary of State in accordance with the Open Public Meetings Act. A quorum was present.

Comments from Assemblyman Nicholas Felice

W. Sanders introduced Assemblyman Nicholas Felice and asked if the Assemblyman had any comments or concerns. Assemblyman Felice thanked the Board for the opportunity to share some of his thoughts with the Board. He indicated that he was aware of the problems being faced in the individual market with respect to affordability of coverage. He indicated that he was also aware of decreased carrier participation in the market. He spoke about the HIP insolvency and the need for a guarantee fund.

Assemblyman Felice noted that the 75 percent minimum loss ratio provision in the law was designed as a mechanism to control cost in the market. He noted that over $5 million had been provided in refunds since the inception of the IHC Program. He indicated that he was aware that the Board was considering what is a "claim" versus what is not a claim. He suggested a willingness to consider the loss ratio issue as a legislative matter, but cautioned the Board against developing a regulatory interpretation that would modify the intent of the loss ratio protections. He also mentioned that he did not think we would see changes to the community rating requirement or pre-existing conditions protection of the IHC Act.

III. Minutes

June 14, 1999
M. McClure offered a motion to approve the minutes of the Open Session of the June 14, 1999 Board meeting, as amended. L. Yourman seconded the motion. The Board voted in favor of accepting the motion, with J. Beck abstaining.

IV. Report of Staff

July 13, 1999 Expense Report (See Attachment)
J. Beck offered a motion to approve the payment of the expenses shown on the July 13, 1999 expense report. J. Majcher seconded the motion. The Board voted in favor of accepting the motion.

E. Shrem noted that she had called the 800 number and found that the operators spoke too quickly. W. Sanders indicated that he would speak with those responsible for operation of the 800 number to instruct the operators to speak clearly and slowly.

Outreach

W. Sanders reported that the two Public Service Announcements (PSAs) Commissioner LaVecchia recorded concerning the IHC and SEH programs have been aired. He said he had heard positive comments on the announcements from a number of people.

Loss Ratio Guidelines

W. Sanders said the draft report summarizing the distinct positions of TAC position and the public members concerning loss ratio guidelines was included in Board materials. R. Rondum expressed a desire to receive a list of all items that could be included as claims. The Board discussed the link between annual statement reporting and loss ratio reporting. W. Sanders offered to obtain copies of the annual statement blanks for the public members. Board members then offered editorial comments to the draft, and it was agreed that W. Sanders would send out the cover letter to the Commissioner for review and approval by the Board. R. Rondum requested that the cover letter to the Commissioner make clear that the public members, in voting to provide the Commissioner with the report, did not necessarily agree with the section written by TAC.

R. Rondum offered a motion to approve the draft report, with amendments, and to provide the report to the Commissioner. L. Yourman seconded the motion. The Board voted in favor of the motion, with J. Majcher abstaining.

Rate Filings

W. Sanders reported that TAC was provided with copies of rate filings but did not meet due to scheduling problems. TAC members were asked to provide comments and

concerns to Ellen DeRosa. W. Sanders reported that no TAC member contacted her with concerns about the filings. Since there was no indication as to whether the materials had been reviewed by all TAC members, the Board decided not to consider the filings and asked that TAC meet and make recommendations for consideration at the August meeting. W. Sanders did note that one carrier, Manhattan National, provided a filing that did not include rates for the current standard plans. The Board agreed to vote on that filing.

J. Majcher offered a motion to find the rate filing from Manhattan National incomplete. L. Yourman seconded the motion. The Board voted unanimously in favor of the motion

Report of the Operations Committee

Board Bookkeeping

W. Sanders reported that Hughes & McLauglin had agreed to return IHC Board payments to the IHC Board in return for a release from its obligation to provide the bookkeeping services. W. Sanders reported that he would draft a termination contract and would provide it to the Attorney General's Office for review. He indicated that staff would proceed to seek bids on a replacement accounting firm.

Horizon Blue Cross Blue Shield 1995 Audit

W. Sanders reported that the Committee reviewed Deloitte & Touche's draft audit of Horizon's 1995 losses and recommended that the Board approve the draft audit.

M. McClure offered a motion to accept the recommendation of the Operations Committee to approve the draft loss audit report for Horizon. J. Majcher seconded the motion. The motion was approved, with S. Kelly abstaining.

Manhattan National 1995 Audit

W. Sanders reported that the Committee reviewed Deloitte & Touche's draft letter of agreed upon procedures of Manhattan National's 1995 losses and recommended that the Board approve the draft agreed upon procedures.

S. Kelly offered a motion to accept the recommendation of the Operations Committee to approve the draft agreed upon procedures report for Manhattan National. M. McClure seconded the motion. The motion was approved unanimously.

Payment of 1995 Loss Reimbursement to Horizon and Manhattan National

W. Sanders reported that the Operations Committee reviewed a spreadsheet prepared by P. Lechner showing the reimbursement amounts due to Horizon and Manhattan National. He noted that, consistent with prior practice, the distribution includes a payment of interest to a carrier not seeking reimbursement in future years, and that this applied to Horizon. The recommendations were for a payment of $1,920,453.09 to Horizon and $112,618.35 to Manhattan National.

E. Shrem offered a motion to accept the recommendation of the Operations Committee to provide a payment for 1995 losses to Horizon and Manhattan National as described above. J. Majcher seconded the motion. The motion was approved with S. Kelly abstaining with respect to the payment to Horizon.

Net Investment Income Reporting

W. Sanders reported that the Committee reviewed a draft bulletin clarifying net investment income reporting for the 1997/1998 Exhibit K which had already been approved in concept by the Board. The Committee provided input on the draft. W. Sanders reported that the bulletin was sent to all carriers seeking reimbursement.

W. Sanders reported that the Committee discussed a draft letter to carriers whose net investment income reported did not appear to be reasonable, along with P. Lechner's analysis of the reasonableness of the reported net investment income. W. Sanders said that, after some discussion, the Committee agreed that the letter should be modified and sent to all carriers requesting reimbursement. W. Sanders reported that the letters were sent with the above-referenced bulletin.

Report of the Legal Committee

RFP for Auditing Services

W. Sanders reported that the Legal Committee reviewed the draft RFP for auditing services that had been approved by the Operations Committee. W. Sanders reported that the Committee did not have further comments to the revised RFP. DAG E. Heck said that her office had not completed review of the draft RFP. W. Sanders recommended that the Board vote to approve the draft RFP pending review and approval by the Attorney General's Office.

J. Majcher offered a motion to approve the draft RFP, pending review and approval by the Attorney General's Office. L. Yourman seconded the motion. The motion was approved unanimously.

Policy Forms Changes

W. Sanders reported that he recommended that the Board delay consideration of policy form changes until the August meeting. He noted that the SEH Board was faced with some of the same issues with respect to compliance with the Mental Health Parity Act and the Health Wellness Promotion Act but had not yet considered the matters. He noted that it would be helpful to have input from the SEH Board and its Legal Committee. He also noted that the IHC Legal Committee did not have a quorum when it discussed the application of these two laws to the standard plans. The Board agreed to delay proposal of the modifications to the forms until the August meeting.

VII. Executive Session

W. Sanders said the Board needed to discuss advice from counsel, a Contract issue, and Executive Session minutes and asked for a motion to enter Executive Session. He said there would be no further discussion following the Executive Session.

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

[Executive Session: 11:30 a.m. – 12:30 p.m.]

VIII. Close of Meeting

J. Beck offered a motion to adjourn the Board meeting. L. Yourman seconded the motion. The Board voted unanimously in favor of the motion. The meeting adjourned at 12:35 p.m.

Attachments: Expense Report

MINUTES OF THE MEETING OF
THE NEW JERSEY INDIVIDUAL HEALTH COVERAGE PROGRAM BOARD
AT THE OFFICES OF THE NEW JERSEY DEPARTMENT
OF BANKING AND INSURANCE
TRENTON, NEW JERSEY
August 10, 1999

Directors Participating: Sandi Kelly (Horizon Blue Cross Blue Shield of New Jersey); Jane Majcher (Department of Banking and Insurance); Ritamarie Rondum; Eileen Shrem; Rebecca Smart (Mutual of Omaha); Lisa Yourman.

Others Participating: Ellen DeRosa, Deputy Executive Director; DAG Eleanor Heck (DOL); Pearl Lechner, Program Accountant; Joanne Petto, Assistant Director; Wardell Sanders, Executive Director.

I. Call to Order

W. Sanders called the Board meeting to order at 9:48 a.m. He announced that notice of the meeting had been published in three New Jersey newspapers and posted at the Department of Banking and Insurance and the Office of the Secretary of State in accordance with the Open Public Meetings Act. A quorum was present.

II. Minutes

July 13, 1999
E. Shrem offered a motion to approve the minutes of the Open Session of the July 13, 1999 Board meeting, as amended. J. Majcher seconded the motion. The Board voted in favor of accepting the motion, with R. Smart abstaining.

III. Report of Staff

August 10, 1999 Expense Report (See Attachment)
S. Kelly offered a motion to approve the payment of the expenses shown on the August 10, 1999 expense report. J. Majcher seconded the motion. The Board voted in favor of accepting the motion with R. Rondum abstaining with respect to personal reimbursement and E. Shrem abstaining with respect to personal reimbursement.

Outreach

W. Sanders reported that he contacted DeptCor concerning E. Shrem's comment during the July Board meeting regarding the quickness of the speech of the operators who answer the 800 lines for the Board. He said the operators were asked to speak more slowly and that he called the number twice to hear the operators for himself and was satisfied that they were speaking at an appropriate pace.

W. Sanders reported that he participated on a panel on State health reforms at the National Conference of State Health Regulators in Cincinnati on August 2, 1999. He also reported that he was invited to speak at a HCFA conference in San Francisco later in August. He noted that HCFA would pay for the trip and that information on the conference was included in Board materials.

1997/1998 Preliminary Notice of Assessment and 1999/2000 Non-Group Enrollment Targets
W. Sanders reported that the follow-up efforts of staff with respect to confirming that carriers reported net earned premium for both 1997 and 1998 on the 1997/1998 Exhibit K proved worthwhile. He said that nearly half the carriers submitted revised Exhibit Ks. He suggested that Exhibit K be revised to show separate lines for the net earned premium for each of the two years in the calculation period.

R. Rondum expressed concern that staff had spent so much time with follow-up calls to the carriers. She suggested that perhaps the Board should hire an additional person to be a "chaser" to handle follow-up calls on the various filings, thus allowing staff the time to perform other necessary duties. W. Sanders expressed appreciation for the suggestion, but said that he did not think an additional person was needed at this time.

IV. Report of the Technical Advisory Committee (TAC)

Rate Filings

S. Kelly reviewed the TAC Report (copy attached) that was included in Board materials. She said that the Committee members who were available to participate on the teleconference or sent in comments, recommended that all of the filings be found complete.

R. Smart offered a motion to find the rate filings identified on the August 10, 1999 TAC Report as complete. L. Yourman seconded the motion. The Board voted in favor of the motion with S. Kelly abstaining with respect to the Horizon filings.

V. Report of the Legal Committee

Mental Health Parity

W. Sanders explained that the Committee considered whether the standard plans could include a provision that would require pre-approval or pre-certification in connection with outpatient care and treatment of a biologically-based mental illness. He reported that the Committee was split on a recommendation with some members believing that the law would allow the imposition of pre-approval or pre-certification, and others believing that the law would not permit such provisions. He noted that the law required that coverage be provided on the same basis as any other illness. E. DeRosa explained that while the standard plans do include a pre-approval or a pre-certification requirement for certain services, most outpatient services do not require pre-approval or pre-certification. She also noted that Gale Simon, the Department representative on the Legal Committee, was among the Committee members who opposed the inclusion of pre-approval or pre-certification in connection with outpatient services for the treatment of a biologically-based mental illness. E. DeRosa added that G. Simon indicated that the Department

opposed the use of pre-approval or pre-certification for outpatient care of biologically-based mental illness for all indemnity-based plans and any indemnity-based forms submitted to the Department that contained such a provision would not be approved.

R. Rondum discussed the needs of a bipolar patient who is just recovering from depression. She explained such a patient requires immediate care and any delay that would be encountered as a result of pre-approval or pre-certification process could be dangerous to the wellbeing of the patient.

S. Kelly explained that there are cost savings associated with applying pre-approval or pre-certification to a benefit. E. DeRosa said that based on the Legal Committee discussion, it appeared that some carriers wanted to impose a pre-approval or pre-certification requirement in order to determine medical necessity before the care is rendered. Committee members argued that pre-certification would avoid the problem of a person receiving the care expecting benefits to be payable only to learn after the fact that the carrier did not agree the care was medically necessary. E. DeRosa noted that the TAC recommendation on loss ratio calculations stated that there was a cost associated with performing pre-approval or pre-certification. She said that if pre-approval or pre-certification considered only whether the care is medically necessary and appropriate, then it would be expected that a determination of medical necessity made after care has been received should result in the same determination as would be made before care is received. She said if there is a cost associated with performing pre-approval or pre-certification, then it appears to consumers that it costs more for a carrier to use pre-

approval or pre-certification, and that there are no cost savings. S. Kelly disagreed with that reasoning and noted that the experience of carriers shows that pre-approval or pre-certification operates to provide cost savings.

R. Rondum offered a motion that the Board propose a standard plan provision for coverage of biologically-based mental illness that does NOT include a requirement that outpatient care be subject to pre-approval or pre-certification. L. Yourman seconded the motion. The Board voted in favor of the motion with S. Kelly and R. Smart in opposition.

Health Wellness Promotion Act

W. Sanders said the Legal Committee agreed that the Health Wellness Promotion Act applies to the standard IHC plans. He reported that the Committee did not agree on *how* the Act applies. He said various members of the Committee believed a number of approaches staff compiled to address requirements of the Act would result in compliance with the Act. After some discussion, the Board agreed that TAC should consider the potential cost implications associated with the various approaches so that the Board is aware of any expected rate changes that could occur as a result of the approaches. The Board agreed that the forms proposal to be filed to comply with the law for biologically-based mental illness would not include revised text with respect to the Health Wellness Promotion Act.

Disposable Medical Supplies

W. Sanders said that six carriers responded to a survey on whether they believed disposable medical supplies that are prescribed by a physician are covered under the standard plans. He said four indicated they cover such supplies, but that the criteria applied by each carrier differs. He said two carriers said the supplies are not covered. Of those two, one further said it would be opposed to adding the coverage.

W. Sanders suggested that the Board needs to take time to better understand the coverage for disposable medical supplies before it acts to make changes, if any are needed, to the standard plans to address coverage for disposable medical supplies. The Board agreed that the forms proposal to be filed to comply with the law for biologically-based mental illness would not include new text with respect to coverage for disposable medical supplies. Such coverage for medical supplies, along with other forms issues, would be considered in the upcoming review of the standard plans.

Proposal

E. DeRosa reminded the Board that the forms proposal addresses coverage for a biologically-based mental illness, certain dental procedures as required by law, a correction made to the HMO plan to remove the exclusion for injectable drugs, and a correction to the prosthetic devices exclusion to except certain dental prosthetics from the exclusion.

R. Smart offered a motion that the Board file a proposal, using the expedited rule proposal process, to address coverage for a biologically-based mental illness, certain dental procedures, and to make the corrections that had been identified. L. Yourman seconded the motion. The Board voted in favor of the motion, with S. Kelly in opposition.

VI. Composition of the Policy Forms Committee

The Board considered the issue, first raised during the July 13, 1999 meeting, of the need to re-constitute the Policy Forms Committee. E. DeRosa explained that the purpose of the Policy Forms Committee is to actually write and review policy forms language. She said the Committee needs members who are technicians who have experience with policy drafting. She reminded the Board that the Committee is not charged with making policy decisions. Policy decisions are the responsibility of the Board. She asked that the Board consider the function the Committee is expected to perform when voting for Committee members.

R. Rondum said that although she had no technical background, she had made numerous contributions to the development of the forms.

The Board voted for Committee members but the result was a tie. The composition of

the Committee will be considered again at the September Board meeting.

R. Rondum said that the three consumer representatives on the Board believe the Policy Forms Committee should have two members who are consumer representatives and that all future votes would reflect that belief.

VII. Executive Session

W. Sanders said the Board needed to discuss advice from counsel and Executive Session minutes and asked for a motion to enter Executive Session. He said the Board would continue with Open Session following the Executive Session.

R. Smart offered a motion for the Board to begin Executive Session. R. Rondum seconded the motion. The Board voted unanimously in favor of the motion.

[Break: 11:15 – 11:30]
[Executive Session: 11:30 a.m. – 1:20 p.m.]

VIII. Final Business and Close of Meeting

1997/1998 Good Faith Marketing Reports

CIGNA

The Board discussed CIGNA's Good Faith Marketing Report. The Board noted that the regulation does not require a carrier to market during every month of the two-year calculation period. Thus, even though CIGNA's efforts were confined to 1998, the Board believed those 1998 efforts may be sufficient to demonstrate a good faith marketing effort for the entire 1997-1998 calculation period.

E. DeRosa read the section of the good faith marketing regulation that specifies the basis upon which the Board will accept or reject a Good Faith Marketing report. One test determines if a carrier has undertaken significant media advertising or other marketing campaign in proportion to its minimum enrollment share in direct support of sales of standard individual plans in New Jersey. The alternative test is whether the carrier has undertaken significant efforts in proportion to its minimum enrollment share to educate licensed insurance producers about its standard individual health benefit plans in New Jersey and offered to pay competitive commission schedules for sales of such plans and competitive rates. E. DeRosa noted that the regulation does not require the carriers to satisfy BOTH tests.

E. Shrem offered a motion that the Board approve the CIGNA 1997/1998 Good Faith Marketing Report based on the first test, which focuses on media advertising or other marketing campaign. R. Rondum seconded the motion. The Board voted unanimously in favor of the motion.

The Board noted that if the only standard by which to measure a good faith marketing report were the second test, using agents, CIGNA would not have demonstrated a good faith effort since CIGNA did not use agents to market individual plans. The Board asked that the letter sent to CIGNA note that the report was approved based on the first test and that CIGNA did not satisfy the second test.

Guardian

The Board discussed Guardian's Good Faith Marketing Report. Although Guardian used agents to market the individual plans, the Board noted the primary means Guardian used to market individual plans was media and other marketing campaigns. Therefore, based on the first test that uses media advertising or other marketing campaign, the Board voted on the Guardian report.

E. Shrem offered a motion that the Board approve the Guardian 1997/1998 Good Faith Marketing Report based on the first test, which focuses on media advertising or other marketing campaign. J. Majcher seconded the motion. The Board voted unanimously in favor of the motion.

The Board noted that while Guardian did use agents to market individual plans, the Guardian report did not demonstrate a sufficiently significant effort using agents that would have supported approving the good faith marketing report based on the second test. The Board asked that the letter sent to Guardian note that the report was approved based on the first test and that Guardian did not satisfy the second test.

Prudential

The Board discussed Prudential's Good Faith Marketing Report. Although Prudential undertook a media campaign in late 1996 in support of sales of individual plans, the Board noted the primary means Prudential used to market individual plans was licensed insurance producers. Therefore, based on the second test, that uses education of and commissions to licensed insurance producer, the Board voted on the Prudential report.

R. Rondum offered a motion that the Board approve the Prudential 1997/1998 Good Faith Marketing Report based on the second test, that use of licensed insurance producers. R. Smart seconded the motion. The Board voted unanimously in favor of the motion.

The Board noted that if the media advertising test were the only available test, Prudential would not have demonstrated a good faith marketing effort. The Board asked that the letter sent to Prudential note that the report was approved based on the second test and that Prudential did not satisfy the first test.

Close of Meeting

R. Rondum offered a motion to adjourn the Board meeting. E. Shrem seconded the motion. The Board voted unanimously in favor of the motion. The meeting adjourned at 1:35 p.m.

Attachments: Expense Report
TAC Report