IHC Administrative Order No. 06-IHC-01

STATE OF NEW JERSEY
INDIVIDUAL HEALTH COVERAGE PROGRAM BOARD OF DIRECTORS

IN THE MATTER OF THE CHALLENGES BY CHUBB COLONIAL LIFE INSURANCE COMPANY OF AMERICA, GUARDIAN LIFE INSURANCE COMPANY, JEFFERSON PILOT LIFE INSURANCE COMPANY, JOHN ALDEN INSURANCE COMPANY, MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY, TIME INSURANCE COMPANY, AND UNITED STATES LIFE INSURANCE COMPANY TO THE NEW JERSEY INDIVIDUAL HEALTH COVERAGE PROGRAM'S INTERIM RECONCILIATION OF THE 1996 LOSS ASSESSMENT	)	FINAL DECISION AND ORDER

This matter has been opened by the New Jersey Individual Health Coverage Program Board of Directors (the "IHC Board") pursuant to the authority of N.J.S.A. 17B:27A-2 et seq., and all powers expressed or implied therein. This matter involves challenges by seven members of the Individual Health Coverage Program (the "IHC Program") from the IHC Board's issuance of an interim reconciliation of the 1996 loss assessment (the "interim reconciliation"). For the reasons set forth below, the IHC Board denies the challenges.

Background

The IHC Board was created pursuant to N.J.S.A. 17B:27A-10 as part of the enactment of L. 1992, c. 161 (N.J.S.A. 17B:27A-2 et seq.) (the "IHC Act"), which was enacted to address a crisis in the availability of "individual" health coverage -- that is, health coverage sought by persons who were not eligible to be insured under a group health insurance policy or Medicare. N.J.S.A.

17B:27A-2 (definition of "eligible person").[1] In order to increase availability of individual health coverage, the IHC Act provided two incentives for carriers to write the coverage. The first incentive is that for carriers that write individual coverage, certain losses are reimbursable. N.J.S.A. 17B:27A-12a(1)(b). Those losses are funded by assessments on IHC Program members -- that is, carriers that have in force health benefits plans in New Jersey -- in the individual, small employer, and/or large employer markets. The loss assessments provide the avenue for the second incentive for carriers to write individual health coverage in New Jersey because any carrier can earn an exemption from its loss-assessment liability by enrolling an assigned number of lives in individual health coverage plans. N.J.S.A. 17B:27A-12d.

The IHC Act requires that carriers entitled to reimbursement be fully reimbursed for their eligible losses. N.J.S.A. 17B:27A-12a(2) (claims paid and reasonable administrative expenses in excess of net earned premium "shall be the net paid loss for the carrier that shall be reimbursable ..." (emphasis added).). See In re N.J. Individual Health Coverage Program's Readoption of N.J.A.C. 11:20-1 et seq. ("In re IHC Rule Adoption"), 353 N.J. Super. 494, 524 (App. Div. 2002), aff'd in part and rev'd in part on other grounds, 179 N.J. 570 (2004). However, granting exemptions to carriers that meet all or part of their enrollment targets means that not all the funds necessary to reimburse carriers for their losses will be collected. Therefore, the IHC Board crafted an assessment mechanism that was designed both to collect the amounts necessary to fully reimburse carriers and

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1. After the activities that form the basis for this litigation, both the IHC Act and the IHC's regulations were amended. See L. 1997, c. 146, §§ 1-6; 30 N.J.R. 3289(a) (Sept. 8, 1998). Unless otherwise noted, citations in this document to the IHC Act and the IHC's regulations refer to the pre-amendment versions of the statute and regulations, which govern both the original 1996 loss assessment and the interim reconciliation of the 1996 loss assessment.

to provide a meaningful incentive for carriers to market and sell individual health coverage for purchase in New Jersey.

Pursuant to this methodology, each member carrier's assessment share is based on the proportion that its net earned premium from all health benefits plans bears to the aggregate net earned premium of all IHC member carriers. N.J.S.A. 17B:27A-12(a)(2). IHC Program members are required either to offer individual health coverage on a guaranteed issue, community rated basis or to pay an assessment that is used to fund reimbursements to carriers that offer such coverage and have sustained certain losses. A carrier that chooses to offer individual health coverage can then elect either to seek an exemption to reduce its loss assessment liability (which precludes the carrier from seeking reimbursement for its own losses) or to pay its proportionate share of the loss assessment (which permits the carrier to retain the right to a reimbursement of its reimbursable losses). N.J.S.A. 17B:27A-4a.

A member carrier may apply for a conditional exemption from the loss assessment by agreeing to enroll or insure a target number of lives assigned to it. Each member's target is based on its respective net earned premium. N.J.S.A. 17B:27A-12d(3). If a carrier seeking an exemption fails to enroll its assigned number of lives, it remains subject to assessment on a pro rata basis. N.J.S.A. 17B:27A-12d(5). As already noted, these exemptions from assessment, whether full or pro rata, create a shortfall in the amount needed to fund the reimbursements required by the IHC Act and the IHC Board's regulations. Therefore, the loss assessment mechanism that the IHC Board crafted provides for the collection of additional funds to make up the shortfall and ensure full payment to carriers with reimbursable losses, as required by the IHC Act. These funds are collected through what has come to be known informally as a "second-tier" calculation. Pursuant to the assessment

methodology that the IHC Board crafted, the "second tier" was apportioned among non-exempt carriers, based on market share. E.g., 30 N.J.R. 2581(a) (July 20, 1998) (N.J.A.C. 11:20-2.17(c)(3)). The inclusion of a second-tier calculation ensures full reimbursement of eligible losses, as required by the IHC Act. Apportioning the second tier among non-exempt carriers was intended to give carriers the strongest possible incentive to enter the individual health coverage marketplace. The IHC Board applied this methodology starting with the 1993 loss assessment, which was the initial loss assessment to be issued pursuant to N.J.S.A. 17B:27A-12. The IHC Board issued the 1996 loss assessment on December 15, 1997.

In 2002, however, the New Jersey Superior Court, Appellate Division, addressed a challenge to a 1998 readoption with amendments of the IHC Board's regulations.[2] In re IHC Rule Adoption, supra, 353 N.J. Super. 494. The challenged regulations provided, among other measures, for the methodology that apportioned the "second-tier" assessment among non-exempt carriers. The Appellate Division invalidated that provision, Id. at 525-26, although it upheld the second tier itself, Id. at 525 ("because a full reimbursement is mandatory, the Board must reallocate the equivalent of the shortfall through the use of a second-tier assessment or something similar"). The court expressly declined to apply its holding to loss assessments made before the 1997/1998 calculation period.[3] Id. at 526. The Supreme Court of New Jersey affirmed the Appellate Division's judgment in part and reversed it in part, invalidating an additional regulation that required that any carrier seeking an

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2. CIGNA HealthCare had brought the challenge in 1998, and in 2000 U.S. Life, one of the challengers in this matter, moved successfully to intervene in the appeal.

3. The IHC Act as originally enacted provided for one-year assessment periods. In 1997, however, the Legislature changed the calculation period to two years. L. 1997, c. 146, § 1 (amending N.J.S.A. 17B:27A-2).

exemption but that met less than half of its enrollment target must demonstrate that it had made a good-faith effort to market individual health coverage plans in New Jersey (the "good-faith marketing requirement").[4]

As explained in the memorandum of March 9, 2006, which accompanied the interim reconciliation, events occurred over time that required the collection of additional funds or the shifting of assessment liabilities -- in other words, a true-up, or reconciliation, of the 1996 loss assessment. For instance, pursuant to N.J.A.C. 11:20-8.8, the IHC Board had commissioned independent audits of the net -paid losses of carriers seeking reimbursements. Those audits resulted in the adjustments of the reimbursement amounts to which those carriers were entitled. In addition, after the issuance of the initial 1996 loss assessment some IHC Program members reported that they had inadvertently misreported their net earned premiums with the result that their proportional assessment liability was not correct. Finally, one carrier, which had met less than half its enrollment target and had been found not to have marketed in good faith, appealed from the IHC Board's denial of its request for an exemption from the loss assessment. In 2004, after the Supreme Court of New Jersey invalidated the good faith marketing requirement, the IHC Board voted to grant that carrier the exemption it had sought for 1996, based on the invalidation of the good faith marketing requirement, and then refunded to that carrier approximately $7 million, plus interest. Those monies represented disputed funds that the IHC Board had held in a segregated, interest-bearing account.

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4. The IHC Board has proposed a regulation that would calculate loss assessments according to a methodology based on "adjusted net earned premium" for all calculation periods starting with 1997/1998 and going forward. 38 N.J.R. 1159(a) (Feb. 21, 2006). Consistent with the IHC Board's determination that the Appellate Division's and Supreme Court of New Jersey's decisions regarding the IHC Board's loss assessment methodology do not apply to loss assessments prior to 1997/1998, those proposed regulations do not change the assessment methodology for the 1993, 1994, 1995, and 1996 loss assessments.

Those disputed monies were part of the 1996 loss assessment. Had it not been for the legal challenge to the 1996 loss assessment, those funds would have been used to reimburse the carriers entitled to reimbursement. With the payment of those monies to the carrier that successfully challenged the assessments, that $7 million needed to be recovered through the reconciliation process.

Consequently, on March 9, 2006, the IHC Board issued the interim reconciliation in order to collect the monies needed to account for all of the "reconciling events" described above and "true up" the 1996 loss assessment. Thus, the interim reconciliation had several purposes and was not conducted for the sole purpose of recovering the $7 million that had been refunded to the party that had successfully appealed the 1996 loss assessment, as the challengers contend.

Seven IHC Program members challenged the interim reconciliation pursuant to N.J.A.C. 11:20-2.15(a). Those members are Chubb Colonial Life Ins. Co. of America, Guardian Life Ins. Co., Jefferson Pilot Life Ins. Co., John Alden Ins. Co., Massachusetts Mutual Life Ins. Co, Time Ins. Co., and United States Life Ins. Co. ("U.S. Life") (collectively, the "challengers").[5] Although each of the challengers filed a separate appeal (with each appeal being identical to the others), the seven appeals are being consolidated because they "involv[e] a common question of law or fact arising out of the same transaction or series of transactions ...," e.g., R. 4:38-1(a), N.J.A.C. 1:1-17.1.

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5. Since December 15, 1997, when the 1996 loss assessment was originally issued, Time has acquired John Alden, and the company is doing business as Fortis Insurance Company. In addition, Jefferson Pilot, which had earlier acquired Colonial Chubb, was acquired by the Lincoln Financial Group. However, because the interim reconciliation was calculated on the basis of each Program member's status at the time of the original loss assessment, each of the challengers is referenced in this Order by the name under which it did business in 1996.

The Challengers' Contentions

As an initial matter, the IHC Board notes that the challengers' request for transmittal of this matter for a trial-type hearing before the Office of Administrative Law ("O.A.L.") is conditional: "to the extent the Board makes any factual contention to justify the methodology it utilized other than the legal argument that the assessment is (allegedly) mandated by the statute." Moreover, the challengers have set forth no adjudicative facts to support transmittal to O.A.L., see High Horizons Dev. Co. v. State, 120 N.J. 40 (1990). Instead, they state that

> [w]e do not know the factual basis upon which the Board issued the most recent 1996 Interim Reconciliation -- 1996 Assessment. If the Board relies upon any facts other than the legal argument that the statute mandates the Board's assessment, we reserve the right to dispute those facts. Accordingly, it is impossible for us to determine if there are any disputed adjudicative facts until we know the Board's position.

Each of the challengers' identical submissions contends that the IHC Board should not have followed the same methodology that governed the original 1996 loss assessment and that only carriers with a pro rata exemption should have been assessed. The challengers contend that the interim reconciliation is "ultra vires, illegal, contrary to the statute, discriminatory, self-serving for certain Board members, violates due process, and is fundamentally unfair to its members." Finally, the challengers incorporate by reference three briefs that were filed in the Superior Court, Appellate Division, by U.S. Life in its an appeal that is currently pending in that court, of the 1993, 1994, 1995, and 1996 loss assessments. The three briefs were U.S. Life's appellate brief, its reply brief, and a brief in support of a subsequent motion to supplement the record on appeal (the "motion brief").[6]

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6. U.S. Life moved to supplement the record on appeal with spreadsheets that the IHC Board had developed to show the effect of re-calculating the 1993, 1994, 1995, and 1996 loss assessments according to an "adjusted net earned premium" methodology.

U.S. Life made the following arguments in the three briefs that the challengers have incorporated by reference into their arguments:

Appellate Brief:

THE COURT SHOULD ORDER THE BOARD TO REFUND THE SECOND-TIER LOSS ASSESSMENTS PAID BY U.S. LIFE FOR 1993-1996 BECAUSE THOSE ASSESSMENTS WERE INVALID AS A MATTER OF LAW.

A. The Supreme Court Invalidated the Board's Second-Tier Assessment Methodology

B. U.S. Life Is Entitled to a Refund of All Invalid Loss Assessments

Reply Brief:

I. THE SUPREME COURT'S DECISION INVALIDATING THE SECOND-TIER ASSESSMENT IS EQUALLY APPLICABLE TO THE 1993-1996 LOSS ASSESSMENTS.

II. U.S. LIFE SUCCESSFULLY FOUGHT TO INVALIDATE THE BOARD'S SECOND-TIER LOSS ASSESSMENT METHODOLOGY AND IS ENTITLED TO A REFUND.

A. U.S. Life Promptly Challenged the Board's Methodology.

B. The Board Should Ensure That All Assessments Are Correct.

C. A Refund to U.S. Life Will Not Be Prejudicial or Disruptive.

Motion Brief:

THE BOARD'S SPREADSHEETS QUANTIFYING THE IMPACT OF A REFUND ARE MATERIAL AND SHOULD BE INCLUDED IN THE RECORD BECAUSE THEY DEMONSTRATE THAT THERE WILL BE NO DISRUPTION TO THE MARKET AS THE BOARD CLAIMS

A. The Spreadsheets Are Material and Should Be Part of the Record.

B. The Spreadsheets Demonstrate That a Refund Will Not Cause Chaos.

Discussion

A trial-type hearing is not warranted in this matter because it does not rest on any disputed adjudicative facts. The challengers request a hearing only "to the extent the Board makes any factual contention to justify the methodology it utilized other than the legal argument that the assessment is (allegedly) mandated by the statute." In fact, the issues before the IHC Board are strictly legal in nature: (1) whether the IHC Board followed the correct methodology in calculating the interim reconciliation; and (2) whether the seven challenges have been timely filed. Because the IHC Board does not rely on any disputed adjudicative facts in reaching its conclusion, a hearing is not warranted. High Horizons, supra, 120 N.J. 40.

With regard to the legal arguments the challengers raise, the IHC Board concludes as a matter of law that the challengers' challenge to the interim reconciliation is without merit. The IHC Board's actions were neither ultra vires, illegal, nor contrary to the IHC Act. The methodology used in calculating the 1996 loss assessment was within the Board's authority.

To clear up any possible misunderstanding, neither the Appellate Division nor the Supreme Court of New Jersey invalidated the second tier itself. The courts struck down only the methodology that the Board had been using for apportioning the second tier. Both courts expressly permitted the inclusion of a "second tier" calculation in the loss assessment. E.g., In re IHC Regulations, supra, 179 N.J. at 582 ("We do not suggest that a second-tier assessment that comports with the Reform Act would be invalid."). In fact, the Appellate Division required the second tier. In re IHC Regulations, supra, 353 N.J. Super. at 525 ("because a full reimbursement is mandatory, the Board must reallocate the equivalent of the shortfall through the use of a second-tier assessment or something similar" (emphasis added)).

The challengers' contention that the courts' rulings with regard to the apportionment of the second tier apply to the 1996 loss assessment and subsequent interim reconciliation is without merit for a variety of reasons. First, the Appellate Division's decision in In re IHC Regulations, which invalidated the IHC Board's 1998 regulation that apportioned the second tier calculation among non-exempt carriers, is inapposite because the court's decision was based on the version of the IHC Act that includes legislative amendments that were enacted in 1997. See L. 1997, c. 146 ("Chapter 146"), § 6. The distinction was one that the court drew expressly. 353 N.J. Super. at 526.

The 1996 loss assessment and any subsequent reconciliations are governed by the IHC Act in its pre-Chapter 146 form. Chapter 146, however, made a significant change to the IHC Act's assessment provision by repealing the following subsection from N.J.S.A. 17B:27A-12:

> e. Notwithstanding the provisions of this section to the contrary, no carrier shall be liable for an assessment to reimburse any carrier pursuant to this section in an amount which exceeds 35% of the aggregate net paid losses of all carriers filing pursuant to paragraph (1) of subsection a. of this section. To the extent that this limitation results in any unreimbursed paid losses to any carrier, the unreimbursed net paid losses shall be distributed among carriers: (1) which owe assessments pursuant to paragraph (2) of subsection a. of this section; (2) whose assessments do not exceed 35% of the aggregate net paid losses of all carriers; and (3) who have not received an exemption pursuant to subsection d. of this section. For the purposes of paragraph (3) of this subsection, a carrier shall be deemed to have received an exemption notwithstanding the fact that the carrier failed to enroll or insure the minimum number of non-group persons required for that calendar year. [L. 1992, c. 161, § 11e (N.J.S.A. 17B:27A-12e).]

The amendments made in Chapter 146 do not apply to loss assessments for 1996 or earlier years because the legislation took effect on July 1, 1997. Because N.J.S.A. 17B:27A-12e was applicable to the 1996 loss assessment, the Appellate Division's 2002 decision invalidating the IHC

Board's apportionment of the second-tier calculation among non-exempt carriers extends to neither the 1996 loss assessment nor the interim reconciliation.

In fact, with regard to the apportionment of the second tier, the Appellate Division focused specifically on the deleted language in N.J.S.A. 17B:27A-12e, which applied to assessment years 1993 through 1996. That deleted language included a cap on a carrier's assessment liability and provided that partially exempt carriers would not participate in an assessment to make up for funds not collected as a result of the application of that cap. The court held that the IHC Board's apportionment of the IHC Board's apportionment of the second-tier calculation among non-exempt IHC Program members was invalid "in the absence of the 35% cap that no longer exists," 353 N.J. Super. at 525 (emphasis added).

The Appellate Division recognized that the 1997 repeal of N.J.S.A. 17B:27A-12e created a distinction between assessments for calculation periods before and after that time:

> although N.J.S.A. 17B:27A-12e, repealed by L. 1997, c. 146, § 6, originally excluded all members that received any exemption, including pro rata exemptions, from paying any shortfall due to the 35% cap, the Legislature deleted that section in 1997. The Act is now clear that carriers that do not cover their minimum requirements must pay a pro-rata assessment. [353 N.J. Super. 526 (emphasis added).]

Thus, the court recognized a distinction between the pre- and post-Chapter 146 versions of the IHC Act and a sufficient ambiguity in the pre-Chapter 146 version (that is, N.J.S.A. 17B:27A-12e) to support the IHC Board's determination, made pursuant to its technical expertise, that before 1997, allocating the second tier among non-exempt carriers was an appropriate means of effectuating legislative intent. The IHC Board's second tier calculation methodology for collecting the shortfall resulting from exemption was consistent with the only methodology in the law --

N.J.S.A. 17B:27A-12e -- that described explicitly and clearly how the Legislature intended that the IHC Board make up for a shortfall in assessment collections.

The IHC Board had designed the second tier methodology at the inception of the IHC Program to further the legislative intent of building a workable and competitive market by providing carriers with a significant incentive to enter the individual market and offer coverage. Therefore, the IHC Board had the authority to allocate the second tier calculation among non-exempt carriers in 1996 and before, notwithstanding this court's later ruling.

In addition, the IHC Board rejects U.S. Life's contention that the Appellate Division's and Supreme Court of New Jersey's opinions apply to the 1996 loss assessment for a second reason: the Appellate Division expressly held that its holding in In re IHC Regulations, supra, did not apply to the 1996 loss assessment. 353 N.J. Super. at 526 ("Since the appeal challenges only the 1998 re-adoption of, or amendments to, the regulations, we decline to apply our decision to the assessments made prior to that year or its 'two year calculation period.'"). Although the Supreme Court of New Jersey did not speak directly to the issue, it did affirm the Appellate Division's ruling regarding the assessment methodology. 179 N.J. at 581 ("We agree with the appellate panel's thorough analysis of the infirmity of the second-tier regulation."). No language in the Supreme Court's opinion exists to compel any conclusion other than that the Court affirmed that portion of the lower court's decision in which the Appellate Division declined to apply its invalidation of the second-tier methodology to any calculation period earlier than 1997. Thus, the challengers' argument that the Supreme Court's ruling applies to the 1996 loss assessment is simply not correct as a matter of law.

The IHC Board further concludes that in addition to the substantive reasons set forth above, the challenge to the methodology used in calculating the 1996 loss assessment (and therefore

the interim reconciliation) is far out of time and is therefore procedurally defective. Because the interim reconciliation is simply a "true-up" of the original 1996 loss assessment, the methodology must be the same as for the original loss assessment. A dispute of the assessment methodology at this late date is tantamount to a challenge of the original loss assessment issued on December 15, 1997. The deadline for a challenge to the original loss assessment was on or about January 5, 1998. N.J.A.C. 11:20-2.15(a) (imposing 20-day deadline after receipt of the assessment to request a hearing). That must also be the deadline to challenge any issue that could have been raised at the time of the original loss assessment. The effect of the current challenge is exactly the same as if the challengers were contesting the original assessment now for the first time.[7] To change now the methodology that formed the basis for calculating an assessment originally issued nearly nine years ago would upset long-settled expectations, causing a significant and unanticipated shift in liability. (If this challenge raised an issue that appeared for the first time in the interim reconciliation, the analysis regarding timing might be different. However, it does not.)

Because the challengers never filed a timely appeal to the 1996 loss assessment and in fact paid the assessment without protest, their contention that their appeal is based on a subsequent court decision does not render their challenge any more timely. The "voluntary payment" doctrine precludes any refund of past loss assessment payments when, as here, there has been no timely appeal. "[W]here a party, without mistake of fact, fraud, duress, or extortion, voluntarily pays money on a demand that is not enforceable against him, he may not recover it." New Jersey Hosp. Ass'n v.

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7. This is actually not the first time that U.S. Life has challenged the 1996 loss assessment. In February 2001, it lodged a tardy challenge to the 1993, 1994, 1995, and 1996 loss assessments. That matter is currently pending in the Appellate Division, and it is the briefs that U.S. Life submitted in support of its appeal that the challengers have incorporated by reference into the current challenge.

Fishman, 283 N.J. Super. 253, 264 (App. Div. 1995). This rule is grounded in sound and longstanding public policy: "the party paying had an opportunity to dispute the claim," and its failure to do so constituted a waiver of the claim. Mayor and Aldermen of Jersey City v. Riker, 38 N.J.L. 225, 225-26 (Sup. Ct. 1876). It also furthers the State's interest in having an end to lawsuits. Ibid.

The voluntary-payment rule is also based on the fundamental rule that "[e]very man is supposed to know the law," and that therefore, "[i]gnorance or mistake of law by one who voluntarily pays a tax illegally assessed furnishes no ground of recovery." In re Increase in Fees by the N.J. State Bd. of Dentistry, 84 N.J. 582, 588 (1980).[8] Especially in this case, where the challengers are sophisticated and knowledgeable members of a highly regulated industry, there is no equitable reason to fashion any relief months or years after they have voluntarily made such payment.

The challengers' action is also barred by the equitable doctrine of laches. A party that has knowledge of a claim but fails to seek a remedy promptly is barred by the doctrine of laches from pursuing that claim. Enfield v. FWL, Inc., 256 N.J. Super. 502, 522 (Law Div. 1991), aff'd o.b., 256 N.J. Super. 466 (App. Div.), certif. denied, 130 N.J. 9 (1992). The challengers are presumed to have knowledge of a possible claim because as noted earlier, they are sophisticated participants in the marketplace who are presumed to know the law. In addition, they are hard-pressed to claim ignorance of the assessment methodology that was used in 1996 because the assessment itself included a clear

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8. Furthermore, the Board of Dentistry case, 84 N.J. 582, in which the appellant received the refund that it sought, is distinguishable because the appellant there sought a refund of a fee that it had already challenged and that the Appellate Division had already struck down. Id. at 585. The Court found that a refund was appropriate because although the dentists had paid "what they believed to be an excessive tax," they had also "protested the higher levy from the outset." Id. at 588. The overpayments at issue related to time period for which the court had already struck down the assessment, unlike the facts in this appeal. In Board of Dentistry, there was no attempt to seek reimbursement of monies already paid, without protest, for a different time period, as the challengers seek here.

explanatory memorandum. Therefore, they had knowledge of their claim as far back as 1997 but they failed to act on it, and the claim that they bring now is barred by laches.

Finally, the IHC Board finds the challengers' contention that the interim reconciliation is "self-serving for certain Board members, violates due process, and is fundamentally unfair to its members" to be without merit, especially in light of the complete absence of any analysis, substantiation, or support for those contentions.

Conclusion

NOW THEREFORE, pursuant to the authority granted to the IHC Board by N.J.S.A. 17B:27A-2 et seq., N.J.A.C. 11:20-1 et seq., and all powers expressed or implied therein,

IT IS on this 20th day of June, 2006,

ORDERED that the challengers' challenge to the March 9, 2006, interim reconciliation of the 1996 loss assessment is hereby denied; and

IT IS FURTHER ORDERED that the challengers' request for hearing is hereby denied.

This Order constitutes a final agency decision and is effective immediately. Any appeals from this Order must be filed with the New Jersey Superior Court, Appellate Division, within 45 days from the date of service of the Order.

/s/ Mary Taylor

Mary Taylor, Chair
Individual Health Coverage Program Board