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IN THE MATTER OF APPLICATION OF HEALTH NET INC. TO THE NEW JERSEY INDIVIDUAL HEALTH COVERAGE PROGRAM FOR AN EXEMPTION FROM ITS REIMBURSABLE LOSS ASSESSMENT FOR THE 1999/2000 TWO-YEAR CALCULATION PERIOD

ADMINISTRATIVE ORDER NO. 02-01

This matter comes before the Individual Health Coverage Program ("IHC") Board of Directors (the "IHC Board" or the "Board") on the filing of an appeal and request for hearing filed on October 31, 2001 (the "October 2001 filing"), as supplemented on December 13, 2001 (the "December 2001 filing") and on January 22, 2002 (the "January 2002 filing") (collectively, the "request for hearing") by Health Net Inc. ("Health Net"). Pursuant to N.J.A.C. 11:20-9.5(g) and -20.2, Health Net appeals from and requests a hearing with regard to the IHC Board's vote at its October 11, 2001 meeting, and from IHC Administrative Order No. 01-03 ("Order No. 01-03"), evidencing that vote.

Procedural History

The procedural history of this matter was set forth in detail in Order No. 01-03 and is incorporated herein by reference. Subsequent to the Board's vote on October 11, 2001 to deny Health Net's request for an exemption, Health Net appealed, by letter dated October 31, 2001, from the IHC Board's denial of Health Net's request and requested a hearing on its appeal.

At the same time, Health Net provided notice that it continued to maintain its prior appeal, filed on August 10, 2001, and supplemented on September 4, 2001, of the IHC Board's vote to issue assessments to members of the IHC Program, including Health Net, for the 1999/2000 two-year calculation period.[1] By letter dated January 22, 2002, Health Net further supplemented its appeal and request for hearing.

On November 28, 2001, the IHC Board issued Order No. 01-03 evidencing its October 11, 2001 decision to deny Health Net's application for a conditional exemption and to deny Health Net's request for a stay of the issuance of the assessment. By letter dated December 13, 2001, Health Net filed a Notice of Appeal and Request for a Hearing appealing from Administrative Order No. 01-IHC-03, noting that the appeal supplemented, but did not replace, Health Net's appeal filed on October 31, 2001 about the same subject matter, and requested a hearing pursuant to N.J.A.C. 11:20-20.2. Health Net also requested that the hearing sought in the October 31 appeal be consolidated with the supplemental appeal of December 13.

Findings of Fact and Conclusions of Law

The IHC Board's findings of fact and conclusions of law were set forth in detail in

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1. At its meeting of July 31, 2001, the Board voted to issue a notice of preliminary assessment for 1999/2000 losses pursuant to N.J.A.C. 11:20-2.17(b). That notice was issued on August 16, 2001. The notice of preliminary assessment is merely informational and does not subject IHC members to any assessment liability; only the assessment bill can do that. Therefore, Health Net's August 10, 2001, appeal of the Board's vote to issue the notice was premature. At its October 11, 2001, meeting, the IHC Board approved the final assessment and voted to issue assessment invoices. The enactment on January 6, 2002, of L. 2001, c. 349, required that the assessment, which had not yet been issued, be re-calculated. At its meeting of January 8, 2002, the Board voted to vacate its earlier vote approving the final assessment and the issuance of invoices. Even if Health Net's August 10 appeal could be construed as extending to the IHC Board's vote of October 11, the Board's subsequent action of vacating that vote renders Health

Order No. 01-03. The IHC Board incorporates those findings and conclusions herein by reference.

Discussion

Health Net requests that a hearing be held on its appeal. At issue here is whether this matter is a contested case requiring a hearing pursuant to the Administrative Procedure Act, L. 1968, c. 410 (N.J.S.A. 52:14B-1 et seq.) (the "APA"), N.J.S.A. 52:14B-9a. The APA defines a “contested case” as

a proceeding, including any licensing proceeding, in which the legal rights, duties, obligations, privileges, benefits or other legal relations of specific parties are required by constitutional right or by statute to be determined by an agency by decisions, determinations, or orders, addressed to them or disposing of their interests, after opportunity for an agency hearing. [N.J.S.A. 52:14B-2; accord N.J.A.C. 1:1-2.1.]

Health Net has no statutory right to a hearing; neither the IHC Act nor any other statute creates a right to a hearing based on the denial of an exemption from loss assessment. The existence of disputed adjudicative facts may also require a hearing. High Horizons v. State, Department of Transp., 120 N.J. 40, 53 (1990). Health Net's request for hearing sets forth nineteen allegations that it characterizes as disputed adjudicative facts warranting transmittal to the Office of Administrative Law ("OAL") as a contested case. Notwithstanding Health Net's contentions to the contrary, however, this is essentially a legal dispute not requiring transmittal to OAL for a contested-case hearing. The IHC Board finds that Health Net's allegations, set forth

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Net's appeal moot.

below, are not disputed adjudicative facts, either because they are undisputed or because they do not, as a matter of law, warrant the reversal of the IHC Board's decision to deny Health Net's request for an exemption. They therefore do not warrant transmittal of this matter to OAL as a contested case.

Set forth below in italics and quotations are each of Health Net's allegations, along with the IHC Board's reasoning with regard to why the allegation does not constitute a contested case warranting a hearing:

a. *"Health Net filed a request for exemption from assessments for the 1999/2000 cycle"*

This allegation does not warrant transmittal to OAL. It is undisputed that Health Net failed to apply for an exemption by the due date established in IHC Bulletin No. 00-IHC-01, issued on June 23, 2000, pursuant to the IHC Act, and that the request that it did file on June 6, 2001, was made long after that due date. Bulletin No. 00-IHC-01 stated clearly that all carriers wishing to request an exemption for 1999/2000 must do so no later than thirty (30) days after the Bulletin's date. Both Health Net and its counsel have acknowledged in correspondence to the IHC Board that Health Net failed to do so. Letter from Thomas Messer to Wardell Sanders (Jun. 12, 2001); Letter from Ivan J. Punchatz, Esq., to Ward Sanders (Jun. 26, 2001). Health Net's attempt to circumvent its responsibility to adhere to the statute by filing a request for an exemption nearly one year after the due date, and six months after the close of the calculation period at issue, does not suffice to qualify it for an exemption.

b. *"Officials of the Board made statements assuring Health Net that it had properly filed its 1999/2000 exemption request"*

The purported verbal statement by an official of the IHC Board with regard to

Health Net's exemption status, even assuming that such a statement was made, is not relevant in determining whether Health Net actually made a timely application for an exemption from its 1999/2000 loss assessment liability according to the requirements set forth in N.J.S.A. 17B:27A-12d(1) and N.J.A.C. 11:20-9.2(a). The alleged conversation took place on June 21, 2000 -- two days before the IHC Board issued Bulletin No. 00-IHC-01, advising carriers that they if they wished to ***apply for a conditional exemption*** for the 1999/2000 calculation period, they would be required to apply at that time, regardless of whether or not they had applied earlier for that exemption.

Furthermore, even if such statements had been made, the fact remains that Health Net has never been able to provide documentation to support its allegation that it ever submitted an application for an exemption (other than the one it submitted in June 2001, too late to qualify for an exemption). The minutes of IHC Board meetings in which the Board discussed the applications for conditional exemptions set forth the names of the carriers that applied for an exemption, and they do not include Health Net. Finally, even if the statements in question had been made, the transcript of the e-mail message purporting to memorialize the alleged conversation notes that the conversation included notice by the Board official that the Board would be reissuing exemption targets and that carriers wanting to apply for a conditional exemption would be required to file at that time even if they had previously done so. Health Net acknowledges that it did not file a timely exemption request after the alleged conversation.

c. "Health Net justifiably relied on such statements"

Health Net's allegation of reliance is essentially an argument of estoppel, a doctrine generally disfavored against a governmental entity. See Kaiser Aetna v. United States,

444 U.S. 164, 179-80, 100 S. Ct. 383, 393, 62 L. Ed. 2d 332, 346 (1979); Utah Power & Light v. United States, 243 U.S. 389, 37 S. Ct. 387, 61 L. Ed. 791 (1917). Cf. Double J Land & Cattle Co. v. United Stated Dep't of Interior, 91 F.3d 1378, 1381 (10th Cir. 1996); Federal Deposit Ins. Corp. v. Hulsey, 22 F.3d 1472, 1489 (10th Cir. 1994). Estoppel should be applied sparingly to State entities, especially when the State and its agencies are enforcing laws.

Estoppel is rarely invoked against a public entity. Department of Envtl. Protection v. Dopp, 268 N.J. Super. 165, 175-76 (App. Div. 1993). This is particularly true "when estoppel would interfere with essential governmental functions." O'Malley v. Department of Energy, 109 N.J. 309, 316 (1987). Estoppel against a government entity, therefore, is appropriate "only in very compelling circumstances." Township of Fairfield v. Likanchuk's, Inc., 274 N.J. Super. 320, 331 (App. Div. 1994); Ranchlands, Inc. v. Township of Stafford, 305 N.J. Super. 528, 538 (App. Div. 1997), aff'd, 156 N.J. 443 (1998). Nothing indicates that departure from this well-established rule is warranted in this matter.

Even in the highly unlikely event that estoppel could be successfully invoked against the IHC Board here, the undisputed facts simply do not make out a case for estoppel. Equitable estoppel requires the following: (1) proof of misrepresentation of material facts or concealment thereof; (2) known to the party sought to be estopped and unknown to the party claiming estoppel; (3) done with the intention or expectation that it will be acted on by the other party; and (4) on which the other party reasonably and justifiably relies; (5) to its detriment. Eileen T. Quigley, Inc. v. Miller Family Farms, Inc., 266 N.J. Super. 283, 296 (App. Div. 1993). "[E]ssential to a finding of estoppel is a misrepresentation of material fact by one party and an unawareness of the true facts by the party seeking an estoppel." Horsemen's Benevolent and

Protective Ass'n v. Atlantic City Racing Ass'n, 98 N.J. 445, 456 (1985).

Even if one assumes that the telephone conversation in question took place, Health Net cannot demonstrate the elements for estoppel. Most notably, any reliance on this conversation by Health Net for the proposition that it was exempt for the 1999/2000 calculation period was unjustified, for two reasons. First, two days after the alleged phone call, the IHC Board issued Bulletin No. 00-IHC-01, clearly and unambiguously informing IHC carrier-members that enrollment targets had been recalculated and that carriers wishing to ***seek an exemption*** for 1999/2000 were required to apply at that time. Second, assuming that the telephone conversation took place in accordance with the e-mail transcription included in earlier submissions by Health Net, the conversation included notice by the IHC Board staff official to Health Net that the issuance of such a Bulletin, requiring that carriers apply at that time for conditional exemptions, was imminent. Formal fact-finding is not necessary to conclude that any reliance would have been unreasonable in light of both the issuance of Bulletin No. 00-IHC-01 and Health Net's alleged advance notice of that Bulletin; common sense dictates that conclusion.

This is not a case in which a government agency deceived or misdirected a party regarding compliance with the law. See State v. Kouvatas, 292 N.J. Super. 417 (App. Div. 1996). Nor is this an instance in which a grave injustice was visited on a party as the result of misdeeds by government officials. The IHC provided issued a Bulletin notifying carriers that they would have to make a written request for an exemption. In fact, if the alleged conversation on which Health Net places so much emphasis did take place, it actually gave Health Net additional information -- notice that it would shortly be receiving a Bulletin that would require it

to file its conditional exemption request at that time.

Therefore, this allegation fails as a matter of law, and does not constitute a disputed adjudicative fact warranting transmittal to OAL.

d. "The form and content of the notice dated June 23, 2000, requiring re-submission of exemption applications, was neither fair nor equitable under the circumstances in that it did not give adequate notice of the requirement to refile"

This allegation does not warrant transmittal to OAL because it raises an issue of law for a court to decide -- the interpretation of a document. E.g., Warthen v. Toms River Community Mem'l Hosp., 199 N.J. Super. 18, 24 (App. Div.) (identifying statutory interpretation as an issue of law to be decided by the court), certif. denied, 101 N.J. 255 (1985); Northeast Custom Homes, Inc., v. Howell, 230 N.J. Super. 296, 301 (Law Div. 1988) ("The construction of the terms of a written contract is a matter of law for the court."). As a matter of law, and notwithstanding Health Net's allegation, however, the Bulletin clearly provides adequate notice: the document was only two pages long; the word "VOID" in the text indicating that prior requests were voided is in capital letters; and the format and content of the Bulletin were largely similar to those of prior Bulletins. Furthermore, the Bulletin's title noted that its purpose was, in part, to provide notice of minimum enrollment share; the only purpose of the assignment of minimum enrollment share is to invite carriers to apply for exemptions. Notably, no other carriers have contacted the Board alleging that they did not understand the Bulletin.

Furthermore, this Bulletin was not directed at a non-sophisticated entity. On the contrary, Health Net is a sophisticated participant in the health-insurance marketplace, and as such is regulated by the IHC Board (among other State agencies). For Health Net to claim that it was unable to familiarize itself with the entire contents of a two-page Bulletin, written in plain

language and sent by certified mail to an officer of the company, defies common sense. Therefore, Health Net's allegation that the Bulletin was unclear fails to state a disputed adjudicative fact, is without legal merit, and does not support Health Net's request for a trial-type hearing.

e. *"The Board treated Health Net in a disparate manner, since the Board formally and/or in practice, waived or failed to comply with various deadlines applicable to itself under the IHC Program regulations, including various deadlines relating to the computation and making of assessments and exemptions from assessments"*

f. *"The Board treated Health Net in a disparate manner, since the Board formally and/or in practice, waived or failed to enforce various deadlines applicable to IHC Program Members under the IHC Program regulations, including various deadlines for filings necessary for computation of assessments and exemptions from assessments"*

Neither of these allegations merits transmittal to the OAL. There is no factual dispute with regard to when the IHC Board issued certain documents to its membership, nor with regard to the fact that certain carriers made or revised certain filings after their due date. Any alleged decision by the IHC Board to allow carriers to file revisions to certain filings does not constitute a waiver; nor can any such decision be said to estop the IHC Board from enforcing the time limits established pursuant to statute and restated in mailings to IHC member carriers. E.g., DeBold v. Township of Monroe, 110 N.J. Super. 287, 296 (Ch. Div. 1970), aff'd o.b., 114 N.J. Super. 502 (App. Div.) (per curiam), certif. denied, 59 N.J. 296 (1971) ("Failure to enforce or apply the law by municipal authorities is not a waiver, nor does it give rise to an estoppel ....").

Although Health Net's request for hearing does not specify the filings at issue, it

appears to refer to the filing known as the "Exhibit K," in which carriers are required to file certain information with the Board regarding net earned premium, non-group enrollment, and IHC losses. N.J.A.C. 11:20-8. The information in the Exhibit K forms the basis for calculating loss reimbursements, loss assessments, and enrollment targets. N.J.A.C. 11:20-8.1(a). The Board therefore must ensure that each carrier's Exhibit K is accurate; it cannot accurately assess carriers otherwise. Not all carriers provided timely, accurate filings, and thus the Board was required to seek out the correct information from numerous carriers. Therefore, it was impossible for the Board to issue the enrollment targets and assessments within the time frames set forth in the Board's regulations.[2]

Health Net's failure to file its exemption request in a timely manner is quite different from the failures of many carriers, including Health Net itself, to make their informational filings in a correct and timely manner. Unlike a carrier's optional decision to apply for an exemption, the filing of an Exhibit K is mandatory for all IHC member carriers. It is not a question of "allowing" carriers to file Exhibit Ks after the due date, but of tracking down information that is necessary for the Board to perform its statutory and regulatory duties. The alternative for the Board would be to issue incorrect assessments and enrollment targets -- clearly an untenable choice.

Seeking an exemption, however, is not mandatory; rather, the decision whether to seek an exemption from assessment is a business decision that each carrier makes on its own. One of the features of the exemption mechanism is that all carriers make the decision during the

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2. Ironically, Health Net was one of the carriers that was required to re-file its

same 30-day period and during the calculation period for which the exemption is sought.

As a matter of law, the Board's alleged actions with regard to various filing dates applicable to other IHC Program members are not relevant in determining whether Health Net is entitled to an exemption. The only relevant inquiry is whether Health Net actually applied for an exemption in writing as required by N.J.S.A. 17B:27A-12d(1) and N.J.A.C. 11:20-9.2(a).

g. "Health Net issued non-group policies for the 1999-2000 cycle in sufficient numbers to entitle it to receive at least a partial, if not total, exemption from assessments, but for its allegedly late application"

This allegation does not support transmittal of Health Net's request for an exemption to the OAL. First, the IHC Board does not at this time have any reason to dispute the number of "non-group person life years" that Health Net wrote in 1999/2000.[3] The number is not relevant, however, because Health Net has failed to meet a prerequisite criterion to qualify for an exemption. A carrier must fulfill a number of requirements to qualify for an exemption from assessment. The first of those requirements is that it apply for an exemption in a timely fashion, according to a schedule established by the IHC Board, agreeing that it *will* cover a

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Exhibit K because of a failure to provide accurate information in the first instance.

3. In raising the number of *policies* that it wrote as an alleged issue in this matter, Health Net misstates the standard for satisfying an enrollment target for carriers to qualify for an exemption. A carrier is required not to sell a certain number of *policies*, but to enroll a certain number of *lives* -- referred to in the IHC Act as "non-group person life years," N.J.S.A. 17B:27A-12d(1). A "non-group person life year" is defined as "coverage of a person for 12 months by an individual health benefits plan or conversion policy or contract subject to [the IHC Act], Medicare cost or risk contract or Medicaid contract. N.J.S.A. 17B:27A-2. For the purpose of determining a carrier's satisfaction of its assigned target, "non-group persons" include individually enrolled persons, conversion policies issued pursuant to the IHC Act, Medicare cost and risk lives, and Medicaid recipients." N.J.S.A. 17B:27A-12d(1). For instance, if a carrier sells a policy to a family to cover five persons, that counts as 5 "lives," or "non-group person life years," even though it is only one "policy."

certain number of "non-group person life years" *during the calculation period for which it seeks the exemption*. N.J.S.A. 17B:27A-12d(1). A carrier that fails to seek an exemption for a given calculation period is not entitled to receive one, regardless of the number of non-group person life years it may have actually written during the period. If that were the case, then any carrier would be permitted to second-guess its exemption election based on hindsight. That would frustrate the Legislature's clear intent that that election be made on a prospective basis. Therefore, the number of non-group person life years that Health Net actually wrote during the 1999/2000 calculation period is, in addition to not being subject to any factual dispute at this time, not relevant to this matter.

h. *"At all times throughout the 1999-2000 cycle, Health Net's made [sic] with non-group plans were either profitable or incurred no more than a fifteen (15) percent loss. Both public filings made with the Department of Banking and Insurance, as well as Health Net internal documents, confirm the truth of these facts and that such facts were known to Health Net at relevant times during the 1999-2000 cycle"*

This allegation is repeated in the allegation denominated "n." The Board's reasoning with regard to its conclusion that this allegation does not warrant transmittal to OAL is set forth with regard to that allegation; see supra at 16-18.

i. *"No prejudice to the Board, its members, or to the public interest, would result from allowing Health Net to file a late request for exemption"*

Allowing Health Net to file a late request for an exemption would cause prejudice by undermining the Legislature's intent in establishing the exemption mechanism. Other carrier-members of the Program would be prejudiced because the statutory and regulatory scheme for filing for exemptions places each carrier in the position of making an educated business decision

about how to best position itself in the market. Requiring carriers to file during the same period in time is essential to ensure that carriers are on an equal footing in terms of data available to them to make this business decision. Because it is a matter of common sense, testimony is not necessary to demonstrate that a carrier that applies for an exemption nearly one year after the due date, and long after the close of the calculation period, has an advantage over its competitors by virtue of having a greater period of time to review the profitability of its individual health benefits business (and thereby determine whether it anticipates being eligible for reimbursement of its losses), and to estimate its potential market share -- the basis for determining loss assessments, N.J.S.A. 17B:27A-12a(2) -- by examining its "net earned premium" in all markets of health coverage.

In addition, the public would be prejudiced because allowing a carrier to file its exemption request so far out of time would harm the individual coverage marketplace. The Legislative scheme was designed to encourage carriers that apply for an exemption to write non-group lives. The law accomplishes that goal by requiring carriers to affirmatively and ***prospectively*** state that they will enroll the number of non-group persons assigned to the carrier. A carrier that is locked into a promise to enroll a certain number of lives will have a greater incentive to aggressively market and sell individual coverage. A carrier's *retroactive* promise to agree to enroll a certain number of non-group persons undermines the importance of that promise and thus of the incentive. Therefore, this allegation does not support transmittal to the OAL.

j. *"Because of the nature of the IHC cost-sharing formula, denying an exemption to Health Net will, in addition to causing an unplanned loss by Health Net, result in an unplanned windfall to IHC members not fully exempt"*

This allegation does not state any disputed adjudicative fact requiring transmittal

to OAL. Whether Health Net's obligation to pay an assessment as a non-exempt carrier creates an obligation that Health Net had not planned on is not a fact requiring a contested-case proceeding. Rather, the issue is whether the unplanned nature of such an obligation is relevant to whether Health Net should be granted an exemption from assessment when it failed to follow the steps necessary to request one. That is an issue of law for a court, not a fact-finder, to decide. Furthermore, any obligation incurred by Health Net as a result of its failure to apply for an exemption is neither a penalty nor a punishment. Health Net's failure to file simply means that Health Net is to be assessed as a non-exempt carrier, like every other carrier that does not apply for an exemption.

Neither is the allegation that denying Health Net's request for an exemption would result in an "unplanned windfall" to the IHC's other carrier members a disputed adjudicative fact warranting a trial-type hearing. It is undisputed that the amount of any one carrier's assessment obligation affects other carriers' obligations; the total amount to be collected by assessments for any one calculation period is fixed, and any monies not collected from one carrier must be collected from others in the form of higher assessments. If a carrier fails to request an exemption, it pays a higher assessment and other carriers pay commensurately lower assessments.

To characterize the impact as a "penalty" on Health Net or a "windfall" to the other non-exempt carriers, however, is misleading and is not supported by law. If Health Net is not entitled to an exemption under the law and regulations, as the Board contends, then the Board's proper denial of Health Net's indisputably late request for an exemption is not a "windfall" to the other non-exempt member-carriers. In fact, if the Board were to ignore the

statute and regulations and award an exemption to Health Net, the non-exempt carriers would receive an assessment in excess of that which the mechanism developed by the Legislature contemplates.

The Legislature created the loss assessment mechanism as a device to encourage carrier participation in the individual market and to provide incentives to carriers in that market to write individual coverage. The exemption process, as an integral part of the mechanism, is more properly characterized as an incentive mechanism rather than as means of "penalizing" carriers.

k. "The Board's decision is not supported by adequate and competent evidence in the record"

This allegation does not support transmittal of the case to OAL. Because it refers to the standard to be followed in reviewing agency action, it sets forth a legal, rather than factual issue.

l. "The Legal Committee of the Board was illegally and improperly composed and its consideration of Health Net's application was improper"

This allegation does not warrant transmittal to OAL because it is incorrect as a matter of law. Pursuant to N.J.S.A. 17B:27A-11k, the IHC Board has the authority to appoint committees, including a legal committee, as necessary to provide technical and other assistance. Accordingly, the IHC Board has assembled various standing committees to provide it with technical or specialized advice as needed. See N.J.A.C. 11:20-2.6. The IHC Board consists of four public members (that is, persons appointed by the Governor subject to the advice and consent of the State Senate), four insurance carriers, and the Commissioner of Banking and Insurance (the "Commissioner") or her designee. N.J.S.A. 17B:27A-10b. (At all times relevant

to this matter, the carrier members of the IHC Board have been Aetna U.S. Healthcare, The Guardian Life Insurance Company, Horizon Blue Cross Blue Shield, and Oxford Health Insurance Company, Inc.) The IHC Legal Committee members are all IHC Board members.

The individual, public members of the IHC Board serve on committees in their individual capacities and may not name designees to represent them on the committees. An institutional member, however (including the Commissioner), may designate a person whose experience and technical expertise most closely match the needs of the relevant committee. It is the entity, whether a carrier or the Commissioner, that is a member of the Board or a committee, not the entity's designee.

Thus, it is not uncommon for different designees to represent an entity on the Board or on one or more standing committees. That is the case with the Commissioner, who has designated one person to represent her on the Board, and a different person to represent her on the IHC Legal Committee. That practice is appropriate in accordance with the IHC's enabling statute and the regulations promulgated thereunder. It is also desirable because it ensures that the IHC Board receives the best possible advice from its standing committees.

m. *"Denise Linton and/or Tom Messer, and not Robert Little, were the appropriate addressees of the Board's three notices concerning exemptions issued for the 1999-2000 cycle. The Board, however, addressed the three notices to Mr. Little*"

This allegation does not warrant transmittal to the OAL because it does not require fact-finding of the sort contemplated by the contested-case procedure. Consistent with the IHC Board's practice for all carriers, the IHC sent out these Bulletins by certified mail to Robert Little, Vice President of Underwriting and an officer of Health Net, because Mr. Little had prepared and submitted Health Net's most recent previous Exhibit K. Significantly, there is

no dispute that Health Net received all the Bulletins, including the June 23, 2000 Bulletin.[4]

n. *"At all times throughout the 1999-2000 cycle, Health Net's experience with non-group plans was either a profitable one or limited to no more than a fifteen (15) percent loss. Public filings made with the Department of Banking and Insurance, as well as Health Net internal documents, confirm this fact. Therefore, the IHC Board was aware of Health Net's enrollment experience before it issued any of the notices soliciting requests for exemption. In addition, Health Net was itself aware of this experience at all relevant times during the 1999-2000 cycle, i.e. at the times when Health Net had to determine whether or not to file for an exemption from assessment. Finally, Health Net's competitors had access to these public filings and could have gleaned the information from them*"

This allegation does not warrant transmittal to OAL because it is not material to the issue of whether Health Net (or any carrier) is entitled to an exemption when it made its request for exemption long after the time period established by the IHC Board. Although a carrier's profitability is certainly a factor that it can take into account when making the business decision about whether to seek an exemption, it does not provide an excuse to a carrier that fails to make that application in a timely fashion. Furthermore, filings with the Department of Banking and Insurance -- or with the IHC Board itself, for that matter -- are not relevant to Health Net's request for an exemption. Health Net seems to suggest that merely because certain filings were on file with a regulatory agency, the IHC Board should have been able to divine Health Net's intent -- unmanifested by the appropriate application -- to seek an exemption for 1999/2000.

Health Net has argued that the Board should have known about the profitability of

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4. Furthermore, there is no doubt that the Bulletin was routed to -- and read by -- a person of some responsibility; the additional assessment amount of $99,318.07 set forth in that Bulletin was paid, a fact acknowledged by Health Net in the certification of Thomas Messer, submitted to the Board on September 4, 2001.

its non-group plans. The profitability of Health Net's Medicaid contract or Medicare contracts (which are included in the definition of "non-group plans") is irrelevant. If by "non-group," Health Net meant to refer to the profitability of its individual plans, it is true that the Board does receive an annual loss ratio filing called Exhibit J from all carriers active in the individual market. However, the information in Exhibit J is used to determine whether a carrier has met the minimum 75 percent loss ratio required pursuant to N.J.S.A. 17B:27A-9e. The information contained therein is materially different from the information found in Exhibit K with regard to reimbursable losses. First, Exhibit J requires carriers to report information on "incurred" claims, N.J.A.C. 11:20-7.4(a)3, while for Exhibit K, carriers report "paid" claims data, N.J.A.C. 11:20-8.5(c). These are different calculations, leading to different results. See, e.g., N.J.A.C. 11:4-23.11(b)4.i (referring to incurred claims and paid claims as different calculations). Second, Exhibit K includes in the calculation of reimbursable losses a carrier's "net investment income," N.J.A.C. 11:20-8.5(d), while Exhibit J does not, N.J.A.C. 11:20-7.4(a)3. In short, even if it were legally relevant that Health Net had made other filings regarding the profitability of Health Net's individual book of business, it is also clear as a matter of law that Exhibit J simply does not provide information necessary for an entity (other than the carrier itself) to determine whether a carrier would have reimbursable losses.

In addition, Health Net implies that the IHC Board has the responsibility to review and analyze each carrier-member's Exhibit J filing in order to second-guess that member's business decision with regard to whether or not to seek an exemption from assessment. The IHC Board has no such duty, however. The Board has no obligation, legal or otherwise, to review and analyze filings submitted by carrier-members for purposes other than those for which the

filings were made. Moreover, it has no duty to second-guess those members' business decisions to apply (or not to apply) for an exemption from assessment, even if those filings did provide information that might be considered by a carrier deciding whether to seek an exemption. In any event, however, filings other than Exhibit K do not include information regarding reimbursable losses. For all these reasons, this allegation does not warrant transmittal to OAL.

Finally, Health Net alleges that the IHC Board was aware of Health Net's enrollment experience. The Board in fact received quarterly enrollment reports from Health Net as required by N.J.A.C. 11;20-17. Health Net reported enrollment that declined from 1707 as of first quarter 1999 to a low of 1168 as of second quarter 2000, rising to 1427 as of fourth quarter 2000. Contrary to Health Net's allegation, the enrollment experience Health Net reported provides no apparent correlation to profitability.

o. *"The active participation in individual health coverage was identical to that experienced by Health Net's predecessor, First Option Health Plan ("FOHP"), in the 1997-1998 calculation period, which had received exemptions for the 1997-1998 calculation period, facts well-known to the IHC Board"*

This allegation does not warrant transmittal to OAL as a contested case. There is no dispute that FOHP both applied and qualified for an exemption for the 1997/1998 calculation period. It is also beyond dispute that FOHP, as well as other predecessor entities to Health Net, neither received nor sought exemptions from assessment during various earlier calculation periods. Regardless of those undisputed facts, however, this allegation does not warrant transmittal as a contested case because it is based on the faulty premise that a carrier's exemption history is somehow relevant to its decision with regard to the current calculation period. To the contrary, each carrier's decision of whether to seek an exemption from assessment for a given

calculation period is completely independent of previous such decisions. Throughout the history of the IHC Program, carriers' decisions have varied from year to year, as noted in Order No. 01-03. Even if it were true that a carrier's past exemption decisions might, as a factual matter, be indicative of that carrier's current intention, that is not the case as a matter of law. The statute and regulations leave no doubt that a carrier makes its exemption election strictly for the current calculation period and that prior decisions are neither binding on nor predictive of that decision. Therefore, this allegation does not warrant transmittal to OAL.

p. *"Given the structure of the IHC Program, it would not be a rational business decision for a company fitting Health Net's business profile, i.e. one where its non-group health plans were either profitable or operating at no more than a fifteen (15) percent loss, to knowingly refrain from filing an application for exemption from assessments."*

This allegation is clearly a matter of law and therefore does not warrant transmittal to OAL as a contested case. Whether or not a company's business decision is rational is not germane to this case. This argument essentially posits that a regulatory agency must examine each regulated entity's decisions, determine the decision-making process, evaluate the rationality of that process, and try to determine what the regulated entity's decision "should" have been. That is simply beyond the scope of any reasonable formulation of an agency's responsibility. The IHC Act and the IHC regulations lay out a clearly defined process for a carrier to follow in seeking an exemption. Health Net has never expressed a concern with those regulations in the past. The IHC Board issued Bulletins that provided notice to carriers of the steps to be followed in seeking to obtain an exemption -- Bulletins that Health Net acknowledges having received. Obligating the Board -- or any State agency -- to second-guess its regulated entities in such a manner would be both unreasonable and illogical. Such a requirement would

also impose a crushing administrative burden on the Board, requiring it to conduct a detailed analysis of each of the IHC Program's approximately 100 carrier-members. Such a requirement would overwhelm the resources of the Board, and in light of its suggested purpose -- bailing out a carrier that neglected to follow a simple set of administrative requirements -- is irrational.

q. *"The June 23, 2000 notice from the IHC Board meant that for the 1999-2000 cycle, any IHC member could make the decision to seek an exemption from assessments with 19 of the 24 months in the period completed. Thus, the Board's finding that an exemption filing serves as a 'carrier's prospective declaration of its position in the market,' is without basis for the 1999/2000 period since the IHC Board's actions permitting requests in July 2000 were contrary to that finding."*

Because it focuses on an interpretation of the IHC Act, this allegation fails to state a disputed adjudicative fact and therefore does not warrant transmittal to OAL as a contested case. As a threshold matter, Health Net's characterization of the Board's interpretation of the IHC Act as requiring carriers to apply for an exemption on a prospective basis as a "finding" is not correct. It was not a factual "finding," but rather a statement of the IHC Board's interpretation of the IHC Act -- a legal conclusion. There is no factual dispute with regard to when the June 23, 2000 Bulletin was issued. At issue is whether the timing of its issuance was consistent with legislative intent. That is a legal issue.

In analyzing that issue, the IHC Board notes that although the June 23, 2000 Bulletin may have been issued 19 months into the 24-month calculation period, it nevertheless did require carriers to make their exemption options before the end of that period. It also required them to make their elections on a level playing field -- that is, at the same time during the calculation period to which the exemption applied as all other carriers. That is consistent with legislative intent. Therefore, this allegation fails as a matter of law.

r. *"Because each carrier has a discretionary and nonreviewable right to choose to not enter the individual health coverage market, the availability of individual health coverage in New Jersey is not enhanced or broadened by the mere timing set forth in IHC's regulations (to which the IHC Board did not adhere in any event). Rather, the availability of individual health coverage in New Jersey is enhanced or broadened by the existence of incentives (i.e. an exemption) for enrolling a sufficient number of nongroup health insurance subscribers. Health Net's enrollment of a large number of nongroup subscribers - sufficient to qualify it for an exemption - was in furtherance of the statutory policy of the IHC Act"*

Like the preceding one, this allegation addresses the Legislature's intent in requiring that carriers seek an exemption on a prospective basis, according to a time schedule established by the IHC Board. That is a matter of statutory interpretation and therefore a matter of law. Therefore, this allegation does not state a disputed adjudicative fact warranting transmittal to the OAL. Furthermore, Health Net's argument that the timing of the exemption election is irrelevant misses the point. Requiring carriers to decide during the calculation period whether to seek an exemption furthers the legislative intent of enhancing the availability of individual health coverage in New Jersey. In seeking an exemption from assessment, a carrier must affirmatively agree, on a prospective basis, to enroll its assigned number of non-group person life years. N.J.S.A. 17B:27A-12d(1); N.J.A.C. 11:20-9.2.

Requiring the carrier to commit itself before it knows for certain how many non-group person life years it will write during the calculation period -- in essence, to "take a gamble" -- provides a carrier with a powerful incentive -- in addition to considerable financial incentives -- to aggressively market and sell coverage to the individual market, thereby earning the very real financial benefits that accompany even a *pro rata* exemption from assessment. Allowing a carrier to make its decision after the end of the calculation period, as Health Net seeks to do here, removes that additional incentive; allowing a carrier to base its decision on

existing enrollment numbers, rather than to make a decision and make affirmative efforts to live up to it, dulls the effectiveness of the exemption as a tool to enhance the availability of individual coverage in New Jersey, as the Legislature intended.

Health Net contends in its supplemental appeal of January 22, 2002, that the recent enactment of L. 2001, c. 349 ("Chapter 349"), indicates that the Legislature did not really intend that carriers make the exemption election on a prospective basis. Health Net's argument, however, is unsupported by either the plain language or legislative history of Chapter 349.

Chapter 349 made several changes to the IHC Act. The provision that Health Net cites in its January 22 supplemental appeal adds the following new section to the IHC Act:

> Notwithstanding the provisions of any statute to the contrary, a health maintenance organization established by the University of Medicine and Dentistry of New Jersey pursuant to the provisions of P.L.1992, c.84 shall be exempt from liability for the assessment provided for in section 11 of P.L.1992, c.161 (C.17B:27A-12) for the 1999-2000 two-year calculation period. [L. 2001, c. 349, § 2 (N.J.S.A. 17B:27A-12.1) (hereinafter "Section 12.1").]

Health Net's contention that the enactment of that new provision indicates a legislative intent that the timing of the exemption election is not important is simply not borne out by the enactment's plain language or structure; nor is there any legislative history supporting Health Net's contention. The plain language of Section 12.1 makes no reference, express or implied, to the existing enrollment-based exemption. The Legislature's action does not address, or even relate to, the considerations that underlie the requirement that the exemption election be made prospectively, and during the same time period -- namely, the need for all carriers to make the election on a level playing field and to agree in advance to enroll a certain number of non-group person life years so as to provide the strongest possible incentive for carriers to

aggressively market and sell individual health coverage in New Jersey.

Furthermore, the codification of Section 12.1 as a new, separate section leaves no doubt that Section 12.1 is unrelated to the exemption procedure set forth in N.J.S.A. 17B:27A-12d. The codification also demonstrates that notwithstanding Health Net's contention to the contrary, the enactment does not change (or even address) the Legislature's intent that exemption elections be made prospectively and is in fact not intended even to address the enrollment-based exemption process. The exemption procedure is set forth in N.J.S.A. 17B:27A-12d. The new provision is codified at N.J.S.A. 17B:27A-12.1, and although it refers to the *assessment* set forth in N.J.S.A. 17B:27A-12, it makes no reference to the *exemption* procedure set forth in that statute. In fact, the Legislature actually amended the bill to delete a provision that would have added the language at issue to N.J.S.A. 17B:27A-12. The fact that the Legislature considered that structure and instead chose to codify the provision as a new statutory section is further indication of its intent to separate the exemption provided for in Chapter 349 from the existing enrollment-based exemption.

The word "exemption" as used in Section 12.1 is similar to the same word in N.J.S.A. 17B:27A-12d only in its consequence: reduction or elimination of a loss assessment liability. The paths to obtaining an exemption under these two provisions, however, are dramatically different. The exemption in Section 12.1 is based on whether a carrier was established by the University of Medicine and Dentistry. It has nothing whatsoever to do with enhancing enrollment in individual health benefits plans, nor does it require application therefor. In addition, it is in no way linked with an incentive to write individual health benefits plans. In fact, the only carrier eligible for the exemption under Section 12.1 does not and has not issued

individual health benefits plans in New Jersey. In contrast, the exemption set forth in N.J.S.A. 17B:27A-12d is based on enrollment of persons in individual health benefits plans and is linked to the legislative intent of expanding access to individual coverage. As Health Net acknowledges in its December 13, 2001 filing, "the availability of health coverage in New Jersey is enhanced or broadened by the existence of incentives (i.e. an exemption) for enrolling a sufficient number of nongroup health insurance subscribers." Health Net's argument with regard to enactment of L. 2001, c. 349 only blurs the distinction between these two very different forms of exemptions.

s. *"Assuming arguendo that Health Net failed to file for an exemption in response to the June 23, 2000 notice or otherwise, Health Net will prove that its failure to file for an exemption was an administrative oversight on its part. There is no evidence that Health Net's failure to file an exemption was the product of a deliberate plan to seek advantage in the market"*

This allegation does not state a disputed adjudicative fact warranting transfer to the OAL as a contested case because it is irrelevant as a matter of law. Whether or not Health Net's failure to file for an exemption in a timely manner was nothing more than an administrative oversight or represented an effort by Health Net to "game the system" has no bearing on whether it is entitled to an exemption from assessment. Health Net's characterization of the time frames for seeking an exemption as some kind of meaningless procedural requirement misses the point of the Legislature's requirement that carriers apply for a conditional exemption on a prospective basis. That requirement serves the important legislative purpose of maximizing the availability of individual health coverage in New Jersey, and should not be taken lightly.

Even assuming that Health Net's failure to seek an exemption on a timely basis was due to an administrative oversight (a fact not conceded by the IHC Board), it is a matter of

law that that alleged innocence of motive does not entitle Health Net to the exemption it belatedly seeks. Health Net relies in part on the case Mayflower Securities Co., Inc. v. Bureau of Securities, 64 N.J. 85 (1973), in which the Supreme Court of New Jersey held that suspension had been an inappropriate penalty for a securities company that had failed to renew the license of one of its brokers. Health Net quotes the Court's determination that renewal was *pro forma*. October 2001 Filing, at 10. That is not the case here, however. A carrier's exemption request is not a renewal of an earlier exemption, to be re-filed and re-granted as a matter of course. As noted earlier, each carrier seeks an exemption for the current calculation period, without reference to its exemption elections in previous years. The fact, raised by Health Net in its October 31 appeal, that it had been exempt in the previous calculation period does not mean that the 1999/2000 request for an exemption was some kind of *pro forma* request for a renewal of its previous exemption.[5]

Health Net's reliance on In re Appeal of Progressive Casualty Insurance Co., 307

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5. Other aspects of the Mayflower Securities case, relied on by Health Net in earlier submissions during the course of its appeal, actually undermine its arguments. In Mayflower Securities, the court based its holding in part on the fact the order being appealed from had made no finding that the broker's failure to renew its broker's license had been wilful. 64 N.J. at 99. In Mayflower Securities, however, the statute at issue specifically provided that the sanction in question could be imposed only in the face of a wilful violation. Id. at 90. That is not the case here. The statute and regulations establishing the exemption from assessment do not condition compliance on a certain level of conduct or intent. Failure to comply with the filing requirements -- for *any* reason -- simply results in failure to earn an exemption. Moreover, in Mayflower Securities the Court addressed the appropriateness of certain penalties for failure to file the appropriate renewal form. The matter under consideration by the IHC Board, however, is not about penalties; Health Net is not being penalized for its failure to comply with the statutory and regulatory requirements for obtaining an exemption from assessment. Rather, it is simply being assessed as a non-exempt carrier -- just like any other carrier that has failed to apply for or has not been granted an exemption.

N.J. Super. 93 (App. Div. 1997), is not convincing. In Progressive, the court addressed a situation in which an insurance carrier sought to correct information that it had submitted to the Governing Committee of the Commercial Automobile Insurance Plan ("CAIP") in connection with an assessment mechanism similar to that of the IHC Program.[6] The Appellate Division reversed the Department of Banking and Insurance's order affirming the Governing Committee's determination that due to a recently enacted change to CAIP's plan of operations imposing a time limit on reporting changes in enrollment data, Progressive would not be allowed to make the desired corrections. The court remanded the matter to the Department of Banking and Insurance for a contested-case hearing because of concerns regarding the Governing Committee's composition. Id. at 105-06. In so doing, the court noted several circumstances calling into question the fairness of the CAIP's decision (although the court's decision to reverse and remand was not based on those factors). Id. at 103. The court looked at "the totality of the specific circumstances surrounding Progressive's application ...." Id. at 102. Not all of the factors that court found to be relevant in the Progressive case exist here, however. For instance, the court in Progressive noted that the request to submit additional data was the result of an error by Progressive's statistical agent -- an entirely separate corporate entity -- and that Progressive had been unaware of the error. Id. at 103. Here, however, Health Net states that its failure to apply for an exemption in a timely manner was due to a lapse on its own part. The court in Progressive also noted that the limitation rule had not been in effect during the year for which Progressive sought to adjust its data. Ibid. Here, however, Health Net, like every other IHC carrier-member,

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6. Unlike the IHC Act, however, the CAIP's assessment scheme did not provide for

is being asked to adhere to rules that not have been materially changed since the IHC Program's inception in 1993.[7]

Health Net's claim that its error was an innocent one has no bearing on its appeal. Neither lack of bad intent nor innocence of motive will necessarily excuse a failure to meet duly enacted filing requirements. For instance, New Jersey's courts require a finding of "extraordinary circumstances" to relax the 30-day time limit, set forth in New Jersey Court Rule 4:21A-6(b), for demanding a trial *de novo* after the filing of an arbitration award. Hartsfield v. Fantini, 149 N.J. 611 (1997). Innocent mistakes do not constitute extraordinary circumstances, and the standard does not include "excusable neglect," Sylvia B. Pressler, Rules Governing the Courts of the State of New Jersey, 2002 Edition R. 4:21A cmt 6, at 1408 (2001). Courts have refused to excuse such administrative errors as the failure of counsel's computer diary system to pick up the date to appeal, Martinelli v. Farm-Rite, Inc., 345 N.J. Super. 306 (App. Div. 2001), counsel's failure to mark the filing date on his calendar, Wallace v. JFK Hartwyk at Oak Tree, Inc, 149 N.J. 605, 610 (1997), counsel's heavy workload and failure to properly supervise staff, Hartsfield, supra, 149 N.J. at 619, or the party's delay in mailing in the notice, Flagg v. Township of Hazlet, 321 N.J. Super. 256, 259-60 (App. Div. 1999).

In affirming the "extraordinary circumstances" rule, the Supreme Court examined the Legislature's purpose and intent in enacting the statute that had given rise to Rule 4:21A, noting that the "integrity of the arbitration process and enforceability of arbitration awards"

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exemptions from assessment.

7. Additionally, the timing issue in Progressive was not the same as in this matter, where the carrier's timing in seeking an exemption ties in with legislative intent.

required a strict interpretation of the term "extraordinary circumstances." Hartsfield, supra, 149 N.J. at 617 (quoting Behm v. Ferreira, 286 N.J. Super. 566, 574 (App. Div. 1996)). The integrity of a statutory and regulatory scheme is also at stake here. The statutory and regulatory mechanism of loss reimbursements, assessments, and exemptions is central to the IHC Program. The exemption process relies in part on carriers deciding whether to seek an exemption during the calculation period, and during the same time period, in order to ensure that all carriers are on an equal footing when making their decisions. To allow a carrier to disregard statutory and regulatory procedures and specific, plain-language Bulletins from the IHC Board and receive an exemption despite having applied for it nearly a year late and several months after the end of the calculation period, all because it missed a filing date of which it had been affirmatively informed by the IHC Board, would undermine the integrity of the IHC Board's regulations. As with the arbitration cases cited earlier, such disruption is not warranted when caused by an "administrative oversight."

Health Net attempts to find further support in Bernstein v. Board of Trustees of the Teachers' Pension and Annuity Fund , 151 N.J. Super. 71 (App. Div. 1977), in which the Appellate Division held that a teacher's late application for disability retirement, filed twenty-six days late, must be accepted. The factual circumstances of the Bernstein case, however, were extraordinary -- involving a teacher whose inability to make the required filing was in large part due to serious physical and mental disabilities -- and very different from Health Net's situation.

Health Net simply does not benefit from the court's analysis in Bernstein, which relied on the doctrine of substantial compliance, noting the following five factors:

(1) the lack of prejudice to the defending party; (2) a series of steps

> taken to comply with the statute involved; (3) a general compliance with the purpose of the statute; (4) a reasonable notice of the petitioner's claim, and (5) a reasonable explanation why there was not a strict compliance with the statute. [Id. at 76-77 (citations omitted).]

Health Net would not prevail under the substantial compliance analysis set forth in the Bernstein case. Health Net cannot meet the first factor because, as already noted, granting Health Net an exemption would cause prejudice to the IHC Program. Allowing a carrier that files its exemption request nearly a full year late, several months after the close of the calculation period, would undermine the legislative intent of encouraging carriers to market and sell individual coverage. (The application in Bernstein had been filed twenty-six *days*, not a full year, late.) The second factor is also not met because Health Net took no steps to comply until long after the due date, notwithstanding that by sending the June 23 Bulletin, the IHC Board had provided Health Net, along with all other IHC member carriers, with clear notice of the need to file for an exemption by a specific date. The third factor -- a general compliance with the purpose of the statute -- is also missing here. To the contrary, a decision to grant Health Net an exception based on a request filed one year late and six months after the close of the calculation period, would undermine the legislative intent in expressly requiring such requests to be filed prospectively. Health Net's situation is also inconsistent with the fourth factor because the only notice it provided of its intent to seek an exemption came far too late -- a year late. In the Bernstein case, on the other hand, the court cited instances in which Ms. Bernstein had provided the pension fund with notice, before the deadline, of her pending claim. 151 N.J. Super. at 77.

Finally, Health Net can provide no reasonable explanation for its failure to comply with the filing dates set forth in the IHC Act and the IHC's regulations. In Bernstein, the

court took note of the petitioner's illness and fear that filing earlier would prejudice her with a possible future employer. Id. at 78. No such explanation exists to excuse Health Net. It had notice of the applicable due date and still failed to comply. It has offered no reasonable explanation for its failure -- merely that it resulted from an "administrative oversight." Therefore, the Bernstein case is simply not apposite.

Thus, notwithstanding Health Net's allegations to the contrary, its claim that its lapse was due merely to an "administrative oversight" does not entitle it to an exemption.

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, and the decision of the IHC Board as expressed by this Administrative Order,

IT IS on this 14th day of February, 2002,

ORDERED that Health Net's appeal of the IHC Board's denial of Health Net's request for an exemption for the 1999/2000 calculation period is hereby denied; and

IT IS FURTHER ORDERED that Health Net's request for hearing pursuant to N.J.A.C. 11:20-9.5(g) and -20.2 is hereby denied; and

IT IS FURTHER ORDERED that Health Net's appeal, dated August 10, 2001, and supplemented September 4, 2001, of the IHC Board's vote to issue a notice of preliminary assessment to all members of the IHC Program, including Health Net, for the 1999/2000 two-year calculation period is dismissed as moot.

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

the Order.

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Wardell Sanders, Executive Director
Individual Health Coverage Program Board