NOT FOR PUBLICATION WITHOUT THE
APPROVAL OF THE APPELLATE DIVISION

SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
DOCKET NO. A-6116-05T2

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.

Argued May 2, 2007 - Decided August 28, 2007

Before Judges Stern, A. A. Rodríguez and Sabatino.

On appeal from the New Jersey Individual Health Coverage Program Board of Directors, 06-IHC-01.

Thomas P. Weidner argued the cause for appellants Guardian Life Insurance Company; Massachusetts Mutual Life Insurance Company; Assurant Health (f/k/a Fortis Insurance Company), on behalf of its affiliates Time Insurance Company and John Alden Life Insurance Company; Jefferson Pilot Life America Insurance, on its own behalf and as successor in interest to Chubb Colonial Life Insurance Company of America; and United States Life Insurance Company (Windels Marx Lane & Mittendorf, attorneys; Mr. Weidner, of counsel and on the brief; Antonio J. Casas, Sandy L. Galacio, and Julie R. Tattoni, on the brief).

Eleanor Heck, Deputy Attorney General, argued the cause for respondent New Jersey Individual Health Coverage Program Board of Directors (Stuart Rabner, Attorney

General, attorney; Patrick DeAlmeida, Assistant Attorney General, of counsel; Ms. Heck, on the brief).

John M. Pellecchia argued the cause for intervenors CIGNA Healthcare of Northern New Jersey, Inc.; CIGNA Healthcare of New Jersey, Inc.; and Connecticut General Life Insurance Co. (Riker Danzig Scherer Hyland & Perretti, attorneys; Mr. Pellecchia, of counsel and on the brief; Kimmo Z. Hussain, on the brief).

Michael X. McBride argued the cause for intervenor Aetna Health, Inc. (Connell Foley, attorneys; Mr. McBride and John W. Bissell, of counsel; Marc C. Haefner and Patricia A. Lee, on the brief).

PER CURIAM

Appellants, health insurance carriers, appeal from a June 20, 2006 administrative decision of the Board of Directors of the Individual Health Coverage Program ("IHCP") denying their challenge to the Board's decision to recalculate their loss assessment for 1996. Appellants argue that the additional assessments were wrongfully based on "the second-tier methodology invalidated by the Supreme Court two years earlier" in In re N.J. Individual Health Coverage Program's Readoption of N.J.A.C. 11:20-1 et seq. (In re N.J. IHCP's Readoption), 179 N.J. 570 (2004). Appellants specifically assert that we should vacate the new assessments, because the "Board's actions were patently unlawful," its "equitable arguments are disingenuous," appellants' "challenge was timely," and "a refund will not require the expenditure of public funds."

We treat appellants' challenge as timely but uphold the challenged assessments.

I.

Appellants are seven members of the IHCP. They argue that the Board's second-tier assessment methodology[1] was invalidated by the Supreme Court in In re N.J. IHCP's Readoption, supra, 179 N.J. 570, because it allowed both full and pro-rata exempt members "to pay nothing for second tier assessments." They assert that the Board nevertheless used that methodology to calculate the interim reconciliations for the 1996 IHCP loss assessments. We are asked to vacate the assessment and remand the matter to the Board with instructions to recalculate the entire 1996 assessment using a methodology that accords with the Supreme Court's decision. Intervenors, CIGNA Healthcare of Northern New Jersey, CIGNA Healthcare of New Jersey, Connecticut General Life Insurance, and Aetna Health, support the methodology used by the Board.

On December 15, 1997, the Board issued its 1996 calendar-year IHCP annual loss assessments to all members of the IHCP,

[1] The regulation at issue here is N.J.A.C. 11:20-2.17 (1994), which was amended and readopted by the Board in 1998, see 30 N.J.R. 3289-3308 (Sept. 8, 1998). The amendment took place after the Board had calculated appellants' original 1996 IHCP loss assessments but before the Board calculated the interim reconciliations of the 1996 assessments. See In re N.J. IHCP's Readoption, 353 N.J. Super. 494, 506-09 (App. Div. 2002), aff'd in part and rev'd in part, 179 N.J. 570 (2004).

including appellants and intervenors.[2] All members paid without protest. Subsequently, the intervenors challenged their 1996 loss assessments in separate appeals, but did not prevail. In both appeals, we declined to address the validity of the second-tier assessment methodology and good faith marketing policy. In re Appeal by U.S. Life Ins. Co. of the City of N.Y. of Its Loss Assessments by the Individual Health Coverage Program Bd. for the 1993, 1994, 1995 & 1996 Calculation Periods, No. A-1453-04 (App. Div. Nov. 21, 2006); In re Request by CIGNA Healthcare of N.J., Inc., Along with Affiliated Carriers CIGNA Healthcare of N.J., Inc., Ins. Co. of N. Am., & Life Ins. Co. of N. Am., for Exemption from Assessment for 1996 Reimbursable Losses, No. A-1847-02 (App. Div. Aug. 23, 2005). On March 9, 2006, the Board issued an "Interim Reconciliation-1996 Assessment[,]" an adjustment to the 1996 loss assessments. However, this time, appellants challenged the Board's methodology for calculating

[2] The assessments were accompanied by a memorandum detailing how the assessments were calculated. The memorandum also stated that the assessments

> [did] not include a final reconciliation of the reimbursable losses for calendar years 1993, 1994, 1995 and 1996. The IHC Board commissioned an independent audit of the reported losses for 1993 and 1994, which was conducted by Deloitte & Touche, LLP. . . . The 1995 and 1996 loss audits are not yet complete.

the assessments and requested a hearing. The Board consolidated the seven appeals, and subsequently denied appellants' requests for hearings and their challenges to the interim reconciliation of the 1996 loss assessment. Appellants thereafter appealed to us. We granted intervenors' motions to intervene.

II.

In 1992, the Legislature created the IHCP through the Individual Health Insurance Reform Act ("the Act"), effective November 30, 1992. N.J.S.A. 17B:27A-2 to -16.5; L. 1991, c. 161, §§ 1-17, § 21.

In In re N.J. IHCP's Readoption, Justice Albin described the Act's purposes as follows:

> In 1992, the Legislature enacted the Individual Health Insurance Reform Act (the Reform Act or the Act), N.J.S.A. 17B:27A-2 to -16.5, to address a looming health care crisis that was making health care coverage both unavailable and unaffordable to many of this State's residents. Before passage of the Reform Act, health insurance carriers were reluctant to enter the high-risk market of individual health care coverage because of the losses associated with offering such coverage. Those carriers followed the profits, which were to be found in issuing group coverage to employers and sizeable organizations. That grim market reality inevitably created a dearth of affordable individual health insurance coverage (also known as "non-group" coverage). At the time, under State law, Blue Cross and Blue Shield of New Jersey was "the health insurer of last resort" for the individual health insurance market, and, therefore, bore a disproportionate share of the losses

> associated with that market. Those losses drove up the cost of the policies to the point that many residents could no longer purchase health care for themselves and their families.
>
> The purpose of the Reform Act was to create a market that would provide affordable individual health care coverage to self-employed and unemployed residents as well as others who did not have the option of purchasing employer-based or group health coverage. The Act created the IHCP, which mandates that all health insurance carriers "offer individual health benefits plans" as a condition of issuing health insurance in this State. The aim of the IHCP is to spread the cost of providing individual coverage among New Jersey's entire health care insurance industry, thereby making that coverage more available and affordable to consumers not insured by group policies. In order to achieve that aim, the IHCP creates incentives for all carriers to write individual policies.
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> [In re N.J. IHCP's Readoption, supra, 179 N.J. at 573-74 (citations and footnotes omitted).]

See also id. at 573-78; In re Individual Health Coverage Program Final Admin. Orders Nos. 96-01 and 96-22, 302 N.J. Super. 360, 363-64 (App. Div. 1997) (quoting Health Maint. Org. of N.J., Inc. v. Whitman, 72 F.3d 1123, 1124-26 (3d Cir. 1995) (further discussion of the Act's background and purpose).

Under the statute, each health insurance carrier, as a condition of issuing health benefit plans in New Jersey, must either "offer individual health benefit plans . . . on an open enrollment, community-rated basis," N.J.S.A. 17B:27A-4(a), or

pay an annual assessment to reimburse carriers that wrote a disproportionate share of individual health policies for their net losses, N.J.S.A. 17B:27A-12(a)(2), after subtracting any full or pro-rata exemption received, N.J.S.A. 17B:27A-12(d).

The IHCP Board administers reimbursements and apportionment of losses in the individual health care market among all health insurers in proportion to their total market share of the overall health insurance market. N.J.S.A. 17B:27A-12. The Board's initial 1996 loss assessments were calculated using N.J.S.A. 17B:27A-12, which has since been amended.[3] The statute effective in 1996 and applied by the Board on December 15, 1997 read:

> The board shall establish procedures for the equitable sharing of program losses among all members in accordance with their total market share as follows:
>
> a. (1) By March 1, 1993 and following the close of each calendar year thereafter, on a date established by the board:
>
> (a) every carrier issuing health benefits plans in this State shall file

[3] The statute was amended by L. 1997, c. 146 § 6, effective July 1, 1997. See L. 1997, c. 146 § 29. It is not suggested that the statutory amendment applies to any year before 1997. Rather, appellants argue that the subsequent case law relating to the 1998 amended regulations should apply to all reconciliations and assessments after the date of decision, regardless of the original assessment date. As we discuss in greater depth later in this decision, the implementing regulations for the 1997 legislation were not promulgated until 1998.

with the board its net earned premium for the preceding calendar year ending December 31; and

(b) every carrier issuing individual health benefits plans in the State shall file with the board the net earned premium on policies or contracts . . . and the claims paid and the administrative expenses attributable to those policies or contracts. If the claims paid and reasonable administrative expenses for that calendar year exceed the net earned premium and any investment income thereon, the amount of the excess shall be the net paid loss for the carrier that shall be reimburseable [sic] under this act. . . .

(2) Every member shall be liable for an assessment to reimburse carriers issuing individual health benefits plans in this State which sustain net paid losses for the previous year, unless the member has received an exemption from the board pursuant to subsection d. of this section and has written a minimum number of non-group persons as provided for in that subsection. The assessment of each member shall be in the proportion that the net earned premium of the member for the calendar year preceding the assessment bears to the net earned premium of all members for the calendar year preceding the assessment.

(3) A member that is financially impaired may seek from the commissioner a deferment in whole or in part from any assessment issued by the board. . . . If an assessment against a member is deferred in whole or in part, the amount by which the assessment is deferred may be assessed against the other members in a manner consistent with the basis for assessment set forth in this section. . . .

. . . .

> c. Payment of an assessment made under this section shall be a condition of issuing health benefits plans in the State for a carrier. Failure to pay the assessment shall be grounds for forfeiture of a carrier's authorization to issue health benefits plans of any kind in the State, as well as any other penalties permitted by law.
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> [N.J.S.A. 17B:27A-12 (1996).]

As an alternative to paying the assessment, a carrier that elected to offer individual health benefits plans could request "an exemption from the assessment and reimbursements for losses" by agreeing to cover and then enrolling a proportional share of the individual coverage market, as determined by the Board. N.J.S.A. 17B:27A-12(a)(2); 17B:27A-12(d). The level of required compliance under an exemption was phased in until the Legislature amended the Act in 1997 and required full coverage of the proportional share. See N.J.S.A. 17B:27A-12(d); L. 1997, c. 146, § 6(11)(d)(6). Thus, for purposes of the 1996 loss assessments, if a carrier met 100% of its proportional share or target goal, it received a full or total exemption from the assessment. N.J.S.A. 17B:27A-12(d)(6) (1996). If the carrier fell short of its target number, the carrier was assessed "by the board on a pro rata basis for any differential between the minimum number established by the board and the actual number

enrolled or insured by the carrier." N.J.S.A. 17B:27A-12(d)(5) (1996).

In addition, as it stood in 1996, the Act declared that no carrier was liable for an assessment that "exceed[ed] 35% of the aggregate net paid losses of all carriers[,]" and any shortfalls would be distributed among the other non-exempt carriers. N.J.S.A. 17B:27A-12(e) (1996).[4]

[4] The full section, prior to deletion, read:

> 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.
>
> [N.J.S.A. 17B:27A-12(e) (1996), repealed by L. 1997, c. 146, § 6.]

Thus, the purpose of the assessment was "to reimburse carriers issuing individual health benefits plans in this State which sustain net paid losses for the previous year, unless the member has received an exemption from the board pursuant to [N.J.S.A. 17B:27A-12(d)] and has written a minimum number of non-group persons as provided for in that subsection." N.J.S.A. 17B:27A-12(a)(2) (1996).

Significantly, in language that has not been amended since 1996, the Legislature vested the Board with regulatory authority to "establish procedures for the equitable sharing of program losses among all members in accordance with their total market share." N.J.S.A. 17B:27A-12 (emphasis added). Acting on this authorization, in 1993, the Board adopted various regulations to implement the original 1992 Act. Among other things, these regulations recognized the 35% limitation on assessments provided for in Section 12(e) of the Act -- that is, that no carrier would pay more than 35% of the total IHCP reimbursable losses. 25 N.J.R. 4183 (Sept. 7, 1993); 25 N.J.R. 4196 (Sept. 7, 1993) (adopting N.J.A.C. 11:20-9.5(e)). The regulations also provided the good-faith marketing component to the assessment process that was in effect in 1996. N.J.A.C. 11:20-9.5(b)(2) (1993) (adopted in 25 N.J.R. 4196 (Sept. 7, 1993)), renumbered N.J.A.C. 11:20-9.5(f) (26 N.J.R. 1296 (Mar. 21, 2004); 26 N.J.R. 1509-12 (April 4, 1994)); see also N.J.A.C. 11:20-9.6 (1996)

(last amended prior to 1996 in 26 N.J.R. 4193-94 (Oct. 17, 1994)). Moreover, the regulations, in another subsection unchanged since before 1996, made clear that any carrier requesting either a full or pro-rata exemption had to agree "not to seek reimbursement" for all losses in that calendar year. N.J.A.C. 11:20-9.2(b)(3); see 25 N.J.R. 4195 (Sept. 7, 1993).

In December 1997, the Board calculated the 1996 IHCP total loss assessments based on the regulations as they stood at the time, as detailed above.[5] Under those regulations, N.J.A.C. 11:20-2.17 established the specific formula for assessing IHCP losses to members and set forth how the assessment would be calculated. 26 N.J.R. 1508-09 (April 4, 1994) (adoption); 26 N.J.R. 1200-02 (Mar. 7, 1994) (proposal). The Board also established what became known as "the second-tier assessment" to compensate for any shortfalls that would occur due to the Act's now-repealed provision in Section 12(e) that maxed out carrier's liability once an assessment reached 35% of the aggregate net paid losses of all carriers filing and required that other non-exempt carriers make up any shortfalls. 26 N.J.R. 1508 (Apr. 4,

[5] N.J.S.A. 17B:27A-12(a)(2) provided that "[t]he assessment of each member shall be in the proportion that the net earned premium of the member for the calendar year preceding the assessment bears to the net earned premium of all members for the calendar year preceding the assessment." This was amended in 1997 to a two-year calculation.

1994) (adopting N.J.A.C. 11:20-2.17(c)(2) as it read in 1996). Moreover, carriers could be granted a deferral from the assessment and have their assessment amounts "apportioned to other members based on their respective adjusted market shares." 26 N.J.R. 1508 (April 4, 1994) (adopting N.J.A.C. 11:20-2:17(c)(3)).[6]

At the time of the original 1996 loss assessments, all carriers, except those granted a deferral from the assessment, were responsible for paying the first or preliminary assessment unless the Board had granted them a full exemption. 26 N.J.R. 1508-09 (Apr. 4, 1994) (adopting N.J.S.A. 11:20-2.17 as it read in 1996). Carriers that received a pro-rata exemption were only responsible for a pro-rata assessment amount. Ibid. In either case, under the pre-1997 Act, a carrier was not liable for any part of their assessment that exceeded 35% of the total reimbursable net paid losses for that calendar year. Ibid. Any shortfall that was created from these exemptions or from the 35% limitation was redistributed by a second-tier assessment, and all carriers that received a full or pro rata exemption were not liable to pay that assessment. Ibid. As a result, any shortfall created was continually redistributed among the other

[6] Portions of the 1994 version of N.J.A.C. 11:20-2.17, which was still in effect in 1996, are quoted in In re N.J. IHCP's Readoption, supra, 353 N.J. Super. at 506-07.

carriers until those members reached the 35% limit or the total reimbursable net paid losses for that calendar year were fully assessed. See ibid.

As already noted, in 1997, the Legislature amended the loss sharing portion of the Act by (1) changing the assessment cycle to a "two-year calculation period" beginning on March 1, 1999 or other date set by the Board, L. 1997, c. 146, § 6(6)(11)(a)(1); (2) removing N.J.S.A. 17B:27A-12(e)'s 35% limitation on any carrier's share of IHCP losses, L. 1997, c. 146, § 6(6)(11)(e); and (3) deleting N.J.S.A. 17B:27A-12(d)(6)(a)-(c)'s exemption phase-in, L. 1997, c. 146, § 6(6)(11)(d)(6)(a)-(c).[7]

In 1998, the Board re-adopted its regulations with amendments. 30 N.J.R. 3289 (Sept. 8, 1998) (adoption); 30 N.J.R. 2581 (July 20, 1998) (proposal). In doing so, the Board made minor changes to N.J.A.C. 11:20-9.6's good-faith marketing requirement. 30 N.J.R. 3305 (Sept. 8, 1998); 30 N.J.R. 2599 (July 20 1998). However, it also retained the second-tier assessment and the requirement that carriers granted an exemption could not request reimbursement embodied in N.J.A.C. 11:20-2.17. 30 N.J.R. 3300-01 (Sept. 8, 1998); 30 N.J.R. 2592-94 (July 20, 1998). The 35% limitation on assessments was

[7] The Legislature also amended other portions of the Act various times after 2000, but those changes do not affect the issues before us.

eliminated in light of the statutory amendment. See 30 N.J.R. 3301 (Sept. 8, 1998); 30 N.J.R. 2593 (July 20, 1998).

CIGNA and related carriers appealed from the regulations as amended and readopted in 1998, and we invalidated the second tier assessment. In re N.J. IHCP's Readoption, supra, 353 N.J. Super. at 525-26. In doing so, we relied on the 1997 amendment of the Act eliminating section 12(e), which had given the Board authority to allow carriers with pro-rata exemptions to completely avoid the second-tier assessment:

> In this connection, we also note that in deleting N.J.S.A. 17B:12A-12(e), the Legislature deleted reference to the fact that carriers receiving pro rata exemptions "shall be deemed to have received an exemption [for purposes of making up the shortfall] 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, § 11, repealed by L. 1997, c. 146, §6, eff. July 1, 1997.
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> . . . .
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> As we have noted, although N.J.S.A. 17B:27A-12(e), 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, N.J.S.A. 17B:27A-12(d)(5). They must also contribute to reimbursement of the shortfall, particularly in light of N.J.S.A. 17B:27A-12(a)(2).

[Id. at 525-26 (footnote omitted).]

However, we expressly declined to apply our decision to "the assessments made prior to [1998] or its 'two-year calculation period.'" Id. at 526. We also expressly declined to address the prior 1996 loss assessments, but permitted a further challenge before the Board. Id. at 497 n.2. Moreover we upheld the good-faith marketing regulation. Id. at 520-23.

In In re N.J. IHCP's Readoption, supra, 179 N.J. at 580, the Supreme Court agreed with our ruling striking down the second-tier assessment in the Act as amended in 1997. The Court declared that it was "clear" that the agency action was inconsistent with the Act. Id. at 580-81. Justice Albin explained that the Act "does not square with giving carriers that fail to write their target number of individual policies a full exemption from the second-tier assessment." Id. at 581. The Court wrote:

> We agree with the appellate panel's thorough analysis of the infirmity of the second-tier regulation. The Reform Act provides that in given circumstances health insurance carriers issuing individual policy coverage are entitled to reimbursement for their losses. Those reimbursements are funded through assessments levied on "every" healthcare carrier unless the carrier has received an exemption from the Board pursuant to N.J.S.A. 17B:27A-12d as a result of issuing its minimum number of non-group policies. Those carriers writing their "minimum number" of individual policies are entitled to a full exemption from the first

assessment pursuant to the statute, N.J.S.A. 17B:27A-12d(6), and a full exemption from the second-tier assessment pursuant to the regulation, N.J.A.C. 11:20-2.17(c). Under the Reform Act, all other carriers are subject to either pro rata or full assessments. N.J.S.A. 17B:27A-12d(5).

. . . .

The current regulatory scheme permits carriers writing at least fifty percent of their target number of individual policies to receive a pro rata exemption on the initial exemption, N.J.A.C. 11:20-9.5(f)(1), and a complete exemption on the second-tier assessment, N.J.A.C. 11:20-2.17(c)(1)(ii). Thus, non-exempt carriers that write less than fifty percent of their target number and who fail to convince the Board that they marketed individual policies in good faith, are left to shoulder the entire burden of the second-tier assessment and, therefore, a disproportionate amount of the program losses. The language of the Reform Act does not square with giving carriers that fail to write their target number of individual policies a full exemption from the second-tier assessment.

A regulation that exempts carriers that meet only fifty percent of their goals from any second-tier assessment, while requiring certain carriers meeting forty-nine percent and less of their goals to bear the entire cost, is not in line with the legislative authority that mandates an "equitable sharing of program losses" among all carriers. The Reform Act provides for carriers to receive pro rata assessments based on the difference between the number of individual policies they were required to write and the number of policies actually written. The regulation is completely at odds with that statutory formula and, thus, cannot be sustained.

> Moreover, the regulation arguably works as a disincentive to an insurance carrier to write 100 percent of its target enrollment because that carrier gains a second-tier assessment exemption by meeting only fifty percent of its goal. That result is contrary to the legislative aim of encouraging carriers to write policies in proportion to their fair share of the market.
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> [Id. at 581-82 (citations and footnotes omitted).]

However, the Court expressly limited its decision to "the present methodology that restricts the class of carriers subject to the second-tier assessment in a manner contrary to the Reform Act[,]" noting that it "affirm[ed] the Appellate Division's invalidation of N.J.A.C. 11:20-2.17 as amended effective August 7, 1998." Ibid. (emphasis added). The Court also reversed our judgment as to the good-faith-marketing regulations and invalidated them. Id. at 583.[8]

III.

As a result of events that required the Board to reevaluate the 1996 calendar-year IHCP loss assessments, the proportional loss assessment liability of each IHCP participant was affected. Thus, the Board, at its meeting on December 13, 2005, voted "to

[8] In light of our ultimate disposition on this appeal, we need not consider the proceedings and statutory and regulatory amendments that followed the Supreme Court's decision in In re N.J. IHCP's Readoption, supra, 179 N.J. 570, some of which are still pending before us.

use the existing 1996 assessment methodology for an interim reconciliation." Consequently, on March 9, 2006, the Board mailed each IHCP member an invoice reflecting a new 1996 assessment, which the Board called the "Interim Reconciliation - 1996 Assessment." Appellants remained part of the non-exempt group that had to pay the increased second-tier assessment, while intervenors Aetna and CIGNA related carriers received pro rata exemptions and did not have to pay the second tier. According to the Board's notice that accompanied the new assessments, the assessments were "called an Interim Reconciliation rather than a Final Reconciliation because there remains outstanding litigation relating to the 1996 assessment period."

Appellants and intervenors paid the interim reconciliation as they had done before. However, in individual protest letters to the Board dated between March 31, and April 3, 2006, appellants challenged the Board's methodology for calculating assessments and requested a hearing. As already noted, they argued that the Board erred by using the same methodology for calculating the loss assessments that had been invalidated by the Supreme Court in In re N.J. IHCP's Readoption, supra, 179 N.J. 570.

The Board consolidated the seven appeals but then denied appellants' challenges to the interim reconciliations and their

requests for a hearing in a written "Final Decision and Order" dated June 20, 2006. The Board explained that no hearing was necessary because the challenges did "not rest on any disputed adjudicative facts" and were "strictly legal in nature[.]" The Board also concluded that appellants' legal challenge was without merit. It declared: "[t]he 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."

First, the Board found that it had the authority to use a second tier, because both this court and the Supreme Court had "expressly permitted the inclusion of a 'second tier' calculation in the loss assessment" in In re N.J. IHCP's Readoption, supra, 179 N.J. 570. Second, the Board found that the second-tier methodology that it used in the 1996 interim reconciliation was valid, because In re N.J. IHCP's Readoption's invalidation of the second-tier methodology applied only to the 1998 regulations, as the decision was "based on the version of [the Act] that includes legislative amendments that were enacted in 1997."

The Board emphasized that the invalid post-1997 methodology significantly changed the loss assessment provisions that had previously been in place:

> The 1996 loss assessment and any subsequent reconciliations are governed by [the Act] in its pre-Chapter 146 form.[9] Chapter 146, however, made a significant change to [the Act]'s assessment provision by repealing [N.J.S.A. 17B:27A-12(e)].
>
> . . . .
>
> 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[P] 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 [IHCP] Board's apportionment . . . of the second-tier calculation among non-exempt [IHCP] members was invalid "in the absence of the 35% cap that no longer exists," [In re N.J. IHCP's Readoption, supra,] 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

[9] See L. 1997, c. 146.

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.
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> [[In re N.J. IHCP's Readoption, supra,] 353 N.J. Super. at 526 (emphasis added).]

Thus, the court recognized a distinction between the pre- and post-Chapter 146 versions of [the Act] and a sufficient ambiguity in the pre-Chapter 146 version (that is, N.J.S.A. 17B:27A-12e) to support the IHC[P] 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[P] 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[P] Board make up for a shortfall in assessment collections.

The IHC[P] Board had designed the second tier methodology at the inception of the [IHCP] 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[P] Board had the

> authority to allocate the second tier calculation among non-exempt carriers in 1996 and before, notwithstanding the court's later ruling.

The Board also found that, in our opinion in In re N.J. IHCP's Readoption, supra, 353 N.J. Super. 494, we "expressly held that its holding . . . did not apply to the 1996 loss assessment." The Board acknowledged that the Supreme Court had not spoken "directly to the issue," but pointed out that the Court had "affirm[ed] [our] ruling regarding the assessment methodology[,]" and had not set forth any language "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."

The Board also concluded that appellants' challenge was filed "far out of time and [was] therefore procedurally defective." The Board explained that appellants could not challenge the new interim assessment, because they had not contested the preliminary assessment calculated in December 1997 and "in fact paid the assessment without protest[.]" In effect, the Board reasoned that appellants were equitably estopped from seeking any redress as to the interim assessments, explaining that equity required no relief, "[e]specially in this case, where the challengers are sophisticated and knowledgeable

members of a highly regulated industry[.]" The Board further noted that the new assessment had to be calculated with the same methodology used in the original assessment, because doing otherwise "would upset long-settled expectations, causing a significant and unanticipated shift in liability." It also concluded that appellants' actions were barred by laches, as they were "hard-pressed to claim ignorance of the assessment methodology that was used in 1996 because the assessment itself included a clear explanatory memorandum." The Board, however, acknowledged that its analysis "regarding timing" "might be different" if the challengers had "raised an issue that appeared for the first time in the interim reconciliation[.]" Finally, the Board found appellants' other contentions without merit and rejected them.

IV.

A.

Appellants contend that the Board erred by finding their challenges of the interim reconciliations untimely. They argue that they are contesting new assessments because of the Board's recalculation of the 1996 calendar-year IHCP loss assessments in 2007 which resulted in the additional assessments.

The Board argues, however, that appellants are challenging the IHCP's second-tier assessment methodology itself and points out that any reconfiguration or further amendment of the

assessment methodology would affect all of the IHCP members. Thus, the Board claims that, because appellants did not challenge that methodology when it was first used in issuing the 1996 assessments in December 1997, they cannot now challenge its use in an interim reconciliation of those 1996 assessments, even if the reconciliations were re-calculated in 2006. The Board further argues that allowing appellants to proceed with their current dispute over the second-tier methodology "would render meaningless the [regulatory twenty-day] time limit for appealing from a loss assessment" in N.J.A.C. 11:20-2.15. The Board acknowledges that it may be possible for a party to file a timely appeal to an interim reconciliation if the Board used a different assessment methodology than applied in the original assessment or if the member raised a specific factual error, such as in arithmetic, in the reconciliation. The Board contends, however, that those situations do not exist here, as appellants voluntarily paid the initial 1996 loss assessment, which was calculated using the same methodology as the interim reconciliation under review, so they cannot recover their payments due to the voluntary payment rule.[10]

[10] There appears no specific challenge to the amount of the interim reconciled 1996 assessments based on the Board's methodology.

We agree with the Board that each appeal could affect the assessments levied on other carriers regardless of their involvement in the appeal, and, in an effort to resolve the fundamental issue involved so that the assessment process can be brought to a close for the year in question, we consider the appeals as timely. We add, however, that, in this case, appellants filed their challenges to the interim reconciliation within the allotted regulatory time period. See N.J.A.C. 11:20-2.15(a) (any IHCP member "seeking to challenge the amount of an assessment must do so within 20 days of receiving the notice of the assessment . . . ."). That regulation cannot be limited only to the original assessment because, as the Board itself states, an alteration in one carrier's assessment will likely cause a change in assessments for all other carriers. Consequently, it is possible for a member to be satisfied with the initial assessment in a calendar year but to be dissatisfied with a later reconciled assessment for the same calendar year.

B.

As noted at the outset, appellants contend that the Board erred in using the second-tier methodology embodied in N.J.A.C. 11:20-2.17 as it stood in 1996 to calculate both the original 1996 loss assessments and the new interim reconciliations. They claim that the Board should have used a different methodology to recalculate the 1996 assessments and issue the interim

reconciliations in 2006 because the Supreme Court invalidated the IHCP's second-tier methodology in 2004. See In re N.J. IHCP's Readoption, supra, 179 N.J. at 579.[11] We reject this contention.

We start with the fundamental principle that we have a limited role in reviewing an administrative agency decision. In re Taylor, 158 N.J. 644, 656 (1999).

> The judicial role is restricted to four inquiries: (1) whether the agency's decision offends the State or Federal Constitution; (2) whether the agency's action violates express or implied legislative policies; (3) whether the record contains substantial evidence to support the findings on which the agency based its action; and (4) whether in applying the legislative policies to the facts, the agency clearly erred in reaching a conclusion that could not reasonably have been made on a showing of the relevant factors.
>
> [George Harms Constr. Co., Inc. v. N.J. Tpk. Auth., 137 N.J. 8, 27 (1994).]

Moreover, an agency regulation is presumed to be valid; "the burden is on the challenger to show either that the regulation is inconsistent with its enabling statute or is plainly arbitrary." In re N.J. IHCP's Readoption, supra, 179 N.J. at

[11] They also seek utilization of "the adjusted net earned premium" methodology adopted in 2006 with respect to post-1996 assessments. See N.J.A.C. 11:20-2.17 (2006); 38 N.J.R. 5387 (Dec. 18, 2006). As previously noted, the new regulations are being challenged in other cases now pending before us.

579; In re Adoption of Amendments to N.J.A.C. 6:28-2.10, 3.6 & 4.3, 305 N.J. Super. 389, 401-02 (App. Div. 1997). A court may not invalidate a regulation so long as it is "within the fair contemplation of the delegation of the enabling statute." N.J. Guild of Hearing Aid Dispensers v. Long, 75 N.J. 544, 561-62 (1978). Furthermore, the grant of authority to an administrative agency is to be liberally construed in order to enable the agency to accomplish its statutory responsibilities, and "courts should readily imply such incidental powers as are necessary to effectuate fully the legislative intent." Id. at 562.

However, this "presumption of validity does not attach if the regulation on its face reveals that the agency exceeded the power delegated to it by the Legislature." In re N.J. IHCP's Readoption, supra, 179 N.J. at 579. Further, "administrative regulation[s] . . . cannot alter the terms of a statute or frustrate the legislative policy." Med. Soc'y of N.J. v. N.J. Dep't of Law & Pub. Safety, 120 N.J. 18, 25 (1990). Although great weight is placed on the interpretation of legislation by the administrative agency to whom its enforcement is entrusted, an agency may not give itself authority not legislatively delegated. Cooper Univ. Hosp. v. Jacobs, 191 N.J. 125, 141 (2007).

The Board argues that "[t]he apportionment of the second[-] tier calculation . . . among non-exempt IHCP [members for the 1996 loss assessment and the interim reconciliations for that year] was within [its] statutory authority." We agree. The Supreme Court's decision in In re N.J. IHCP's Readoption, supra, 179 N.J. 570, invalidating N.J.A.C. 11:20-2.17 as to post-1996 calendar-year assessments, was, like our underlying opinion in that case, based on the Legislature's 1997 amendments to the Act. Simply stated, In re N.J. IHCP's Readoption does not apply to pre-1997 loss assessments. We expressly declined to apply our holding to pre-1997 calendar-year assessments, In re N.J. IHCP's Readoption, supra, 353 N.J. Super. at 526, and the Supreme Court affirmed our "invalidation of N.J.A.C. 11:20-2.17 as amended effective August 7, 1998," In re N.J. IHCP's Readoption, supra, 179 N.J. at 582. Moreover, there is no basis on which to conclude that regulations adopted or amended after adoption of the statutory amendments in 1997 should apply retroactively to 1996. Indeed, it would be inappropriate to apply the present second-tier regulation -- N.J.A.C. 11:20-2.17 (2007) -- to the submissions made under regulations existing in the year of the assessments under review here, which were initially calculated prior to the amendments based on the 1997 legislation.

In any event, the 1997 repeal of Section 12(e) is critical to an understanding of the issue before us. In re N.J. IHCP's Readoption recognized that the 1997 repeal of N.J.S.A. 17B:27A-12(e) created a distinction between assessments before and after 1997. The existence of Section 12(e) in 1996 saves the second-tier assessment regulation in effect when the Board calculated the 1996 assessments and the subsequent 1996 interim reconciliation, because it prevented unlimited second-tier assessments.

Appellants contend that the deletion of Section 12(e) is insignificant, because the 35% cap was never used by the Board and was therefore never needed by the IHCP. That may be so, but that fact does not affect the legislative scheme or the question of whether the regulations are consistent with the governing statute. See N.J.S.A. 17B:27A-12(d) (providing for an exemption, thus making a 35% cap significant).

V.

We uphold the Board's decision finding the second-tier methodology established by N.J.A.C. 11:20-2.17 as it provided in 1996 to be applicable to the 1996 interim reconciliations. We affirm the determination of the Board and remand for any further proceedings relating thereto.

I hereby certify that the foregoing is a true copy of the original on file in my office.
CLERK OF THE APPELLATE DIVISION