MINUTES OF THE MEETING OF THE
NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM BOARD
AT THE OFFICES OF THE
NEW JERSEY DEPARTMENT OF BANKING AND INSURANCE
TRENTON, NEW JERSEY
September 5, 2008

Members participating: Thomas Collins; Gary Cupo; Darrel Farkus (United/Oxford); Sandy Herman (Health Net); Margaret Koller; Ulysses Lee (Guardian) William Manning (Aetna); Gale Simon (DOBI); Christine Stearns; Jim Stenger; Neil Sullivan (Horizon); James Sweeney (CIGNA); Tony Taliaferro (AmeriHealth); Joseph Tricarico (DHSS); Dutch Vanderhoof.

Others participating: Ellen DeRosa, Executive Director; Rosaria Lenox, Program Accountant; DAG Vicki Mangiaracina (DLPS); Chanell McDevitt, Deputy Executive Director, Neil Vance (DOBI).

I. Call to Order

E. DeRosa called the meeting to order at 10:05 A.M. E. DeRosa announced that notice of the meeting had been published in two newspapers and posted at the Department of Banking and Insurance ("DOBI"), the DOBI website, and the Office of the Secretary of State in accordance with the Open Public Meetings Act. A quorum was present.

II. Public Comments/Display of Rider Premium

J. Stenger had invited representatives of HealthCONNECT to discuss the issue of presenting rates/premiums for standard plans and riders separately. J.P. Galaris, HealthCONNECT's Director of the Northeast Region, said he believes HealthCONNECT currently is the only vendor that puts all carrier information in one place in an electronic format for use by producers, and that he believes about 90% of all business is conducted using HealthCONNECT.

Following lengthy discussions, it was clear most "base" plans presented to HealthCONNECT are not unridered standard plans, but are bundled packages which include a standard plan with one or more rider options (for example, the drug card option for prescription drugs). "Additional" riders may be shown as available, with pricing displayed on a benefit-by-benefit basis.

Some Board members argued there are no standard plans anymore, but N. Vance stated all carriers file rates annually for the statutorily-required premium comparison survey showing the premium for three sample groups in three selected counties for each standard plan, and whether the premiums for the survey have to be developed manually, it is proof that the standard plans exist and carriers have the ability to price them in their purest form. Some Board members asked how each carrier's base plans, as displayed on HealthCONNECT, differ from the standard plans, but the question could not be answered.

It was agreed that all carriers using HealthCONNECT must provide the company with the rates for the standard plans the carrier offers (which can be no less than three as of 2009). Further,

HealthCONNECT stated it would include language in its disclaimers stating that the rates for the standard plans are available, so that producers – by comparing the standard plan rate and the base plan rate – can determine the rate for the rider(s) bundled into the base plan.

Break from 12:00 to 12:15 P.M.

II. Expense Report

E. DeRosa presented expenses for September totaling $3,169.17.

D. Vanderhoof made a motion to approve payment of the expenses identified on the September expense report. T. Taliaferro seconded the motion, and the Board voted unanimously in favor of the motion.

III. Review of Draft Rule and Policy Form Amendments

The Board reviewed the draft proposal. The Board discussed and/or agreed to the following with respect to the rules and policy forms:

1. All carriers must offer Plan A;
2. The maximum out-of-pocket limit for the HMO Plan using deductibles and coinsurance should be increased to reflect the DOBI rule changes at N.J.A.C. 11:22-5 (to $7,500);
3. Carriers should submit rider filings taking into consideration a 60-day review period for the Board, in light of the Board's bi-monthly meetings;
4. The rules for good faith marketing of IHC plans as a condition of participation in the SEH market would be established by the IHC Board;
5. Carriers would be required to meet the definition of "carrier" in the IHC statutes for purposes of determining appropriate participation in the IHC market (i.e., affiliated carriers would be treated via the IHC laws, and not every carrier offering SEH plans must also offer IHC plans if an affiliate is already satisfying that requirement).
6. Carriers that are not currently offering in the IHC market must either file to do so or file for withdrawal from the SEH market within 60 days following the effective date of the law. The question arose of how to treat carriers barred from re-entry because of a withdrawal from the IHC market within the last 5 years. It was noted the 5-year ban is both a State and Federal requirement. Some Board members argued that carriers legally prohibited from re-entry could continue in the SEH market until the five-year ban from the IHC market expires, and then choose whether to participate in the IHC market or withdraw from both IHC and SEH. Other Board members saw no discretion in the law based on a carrier's prior business decision. The Board suggested requesting the United States Department of Labor to waive the five-year ban in this circumstance;
7. Language to address the provision of orthotic and prosthetic appliances in accordance with P.L. 2007, c. 345, and to reimburse for the appliances using Medicare rates;
8. Revisions to substitute "allowable charge" for the "reasonable and customary" definition;
9. Revisions to clarify that civil union partners and domestic partners do not have COBRA rights;
10. Revisions to clarify that civil union partners and domestic partners are not treated the same as a spouse when considering the Medicare-as-secondary-payer law following eligibility for Medicare by reason of age or disability; and

11. Revisions to change the Over-Age dependent eligibility provisions to allow any evidence of prior creditable coverage establish eligibility and to extend the period for eligibility to age 31, pursuant to P.L. 2008, c. 38.

There was discussion regarding policy provisions requiring a parent to have elected regular dependent coverage in order to add an over-age dependent. It was suggested the provisions should recognize circumstances in which regular dependent coverage may have been waived because dependents are covered under alternative plans or policies, and not prevent the parent from adding the over-age child in those instances.

The Board agreed another meeting would be necessary before the Board's regularly-schedule meeting on October 22nd. The meeting date and notice would be provided later.

E. DeRosa explained she would use the Board's expedited rulemaking process with a 60-day comment period (after Governor's Counsel's review). She noted there would be a public hearing.

A question arose as to whether the Board needed to address disclosures of producer commissions, as required by P.L. 2008, c. 38, but it was acknowledged the rule is under DOBI's jurisdiction, not either the SEH or IHC Board's.

IX. Public Comments

There were no public comments.

X. Close of Meeting

G. Cupo offered a motion to adjourn the Board meeting. B. Manning seconded the motion, and the Board voted unanimously in favor of the motion.

[The meeting adjourned at 1:10 P.M.]