NEW JERSEY SMALL EMPLOYER HEALTH
EXCESS INSURANCE PROGRAM (SEHP)
APRIL 7, 1993 BOARD MEETING
TRENTON, NEW JERSEY
OFFICE OF THE DEPARTMENT OF INSURANCE

AS AMENDED

I. Call to Order/Introductory Remarks

A quorum being present, Chair Lopes called the meeting to order at approximately 9:45 a.m. A copy of the Agenda and a roster of Attendees is on record and maintained by the Department of Insurance (DOI). Minutes of the March 31, 1993 meeting were distributed. Several amendments were made and as amended, the minutes were approved.

II. Responding to Inquiries from Public and Press

The Chair suggested that it would be helpful to have some document issued by the Board to explain to the press as well as insurance producers what the Small Employer Health Excess Insurance Program is all about. There is apparently a great deal of confusion and misinformation in the individual market. It was suggested that the Marketing Committee handle this issue. All members approved having this issue handled by the Marketing Committee.

III. Review of Proposed Legislation

Laurine Purola returned to discuss with the Board technical corrections legislation. A thorough discussion was held and it was the sense of the Board Members that there should be no loop-holes or exceptions. All groups and associations, including MEWAs which include groups of less than 49 members but more than one member, should be covered by the program. Riders, deductibles, the 75% participation rule and the requirement of all carriers to offer an HMO type benefit were also discussed. The Board decided that it would like to express its view on the legislation as a matter of record, asking that language be drafted to implement its sense of how the technical amendments should read. It also requested an opportunity to review the amendments beforehand if possible, but if not, determined it would not testify as a Board regarding the amendments.

On motion duly made, with all directors voting yes the Board approved the following communication to the Legislature:

1. There should be no exclusions of carriers which enroll small groups whether they be classified as associations or MEWAs. The statute was meant to and should be clarified to regulate insurance companies rather than associations directly which insure any groups which have from 2 to 49 members.

2. The participation test shall be applied in the aggregate; that is, so long as 75% of a small group's employees are covered by one or more carriers, all requirements of the statute including guaranteed issue, should apply to all small employer carriers.

3. The Board supports adjustment of time restrictions in order to give the Board more time to act, including those applicable to renewal anniversaries.

4. All carriers participating in the small group market must offer all five benefit plans, including the HMO benefit plan, except that HMOs, whether federal or state qualified, are only required to offer the HMO benefit plan. Indemnity carriers must also offer all five plans even if they operate or have a health maintenance organization.

It was determined that it was not necessary to request any changes regarding the terms of the statute concerning flexibility of the Board to mandate copays, deductibles and riders.

IV. Discussion of Old Business

A. Benefit Plan Discussion

Chairman Lopes distributed certain materials including a document entitled "Decision Making Framework Small Employer Health Benefit Plans April 7, 1993", which has a chart regarding limitations for medically necessary treatment attached to it. Discussion centered around the mental and nervous condition provisions. It was stressed that the discussion was based on benefits rather than the delivery system. The chart has been amended to include the basic plan. It was recognized that costs would be a result of decisions regarding delivery system, benefits, exclusions, deductibles and cost sharing.

One suggestion was that of the five plans the first would be the basic, the second a wrap-a-round major medical plan, the third the mid-point, the fourth a rich traditional plan, and the fifth the HMO federally qualified plan.

There was concern that the discussion regarding benefits was not progressing. Additionally, concern was expressed that if insured employees could switch from plan to plan or from benefit level package to benefit level package within one benefit year, adverse selection would be fostered. There was also a sense that until the whole package is determined or resolved regarding benefits, no final decisions could be made.

As a result, the Deputy Attorney General was asked to investigate whether the Board has authority to institute a lock-in procedure whereby people could not switch plans within the benefit year. The consensus was that people should be restricted from switching benefit plans within a benefit year to avoid adverse selection. The Board tabled the benefit discussion and decided to resume same, assuming that the Board can limit selection during the benefit year by using a lock-in.

On motion duly made, seconded, and unanimously passed, it was resolved: 1) that the Board is in favor of having the power to exercise its discretion to mandate all five specified plans be locked-in for one year, and that members be permitted to switch carriers during that year only if they retain the same type or level plan albeit offered by a different carrier; 2) that if the legal conclusion is that the Board does not have the jurisdiction to require a lock-in, then the Clean-Up Bill should be amended before April 13 to include authorization to do so.

B. Plan of Operations Committee Report

Ann Bossi reported on the Plan of Operations. A working draft has been prepared and distributed for review. The working draft needs some additional substance, the question is how much more? Some additional items need to be included in the Plan of Operation before it is submitted to the Commissioner. In particular, the area of assessments needs to be addressed. The Plan of Operation outlines committees, their size, their purpose and in particular, what issues standing committees should be addressing as well as voting on the committees. She indicated that it was hoped that the Board would appoint the standing committees and move forward to attempt to complete the Plan of Operation by May. The Insurance Department's view is that anything that would dictate standards for uniform application throughout the industry needs to be in the Plan of Operation. It was stressed that the committees would only

recommend to the Board and that the working draft provides that no more than five directors could be on any committee. Other members could participate and technical advisors could advise the Board but only Members or Directors could vote. One suggestion was to either eliminate statutory definitions, or to say that those definitions were included for ease of reference only, and that statutory definitions controlled.

The following committees were constituted:

1. On motion duly made, seconded and unanimously approved, the Department of Insurance, Travelers, Prudential and Blue Cross were appointed to the Finance Committee, with Ann Bossi as Chair.

2. On motion duly made, seconded and unanimously carried, the following Directors were appointed to the Operations Committee: DOI, Travelers, Prudential and HIP/Rutgers Health Plan. No chairman was appointed but Victoria Wicks will convene the first meeting.

Additionally, discussion was held over the Legal and Marketing Committees but only DOI was appointed to them. All committees will receive additional members as appointed by the Chair. At the next meeting the committee membership will be completed and it is hoped that the committees will report back by the end of May. The Plan of Operations Subcommittee has provided a list of issues that ought to be considered by the committees.

C. Policy Form Committee

Jim O'Connor reported on the work of the Policy Form Committee, which will convene on April 12.

D. Claims Form Committee

Peter Hutchings reported on the discussions of the Claims Form Committee, and in particular the HCFA 1500 Form. Discussion centered on whether that form was sufficient or whether this Board should be devising its on form which would be more complete. No resolution was reached. The committee will be meeting again after the Board meeting. The Board will expect a report on the HCFA 1500 Form, how long it would take to make it completely acceptable to the Board, and whether modifying the form with instructions is advisable.

V. Press Briefing

It was determined that there would be a press briefing on April 29. No one will be authorized to speak for the Board up to that point. The Chairman will make available basic information about the Board's process and plans. It was hoped that the benefit plans would be devised by April 28. The Chairman encouraged all carriers to be present at the April 29 press briefing. Discussion was had about sending letters to the various legislative leaders regarding the Board's progress. It was also suggested that we consider the impact of the federal task force on health care.

VI. Close of Meeting

The meeting was adjourned at 3 p.m.

Recorder of Minutes:
Frederick S. Title, HIP/Rutgers Health Plan
(908) 560-9898