New Jersey Small Employer Health Insurance Program ("SEH")
April 28, 1993 Meeting
Offices of Department of Insurance
Trenton, New Jersey

As Amended

Board members in attendance: M. Lopes -- NJBIA (Ch), J. Bellingham - NJ BC/BS, M. Willoughby - NJRMA, K.Robinson - Chubb, V. Wicks - HIP/Rutgers, A. Bossi - The Prudential, J. Eick - The Travelers, D. Swords - Aetna, L. Moskowitz - DOI, E. Crandall - Guardian, N. Featherstone - DOH.

I. Call to Order/Roll Call

A quorum being present, Chair Lopes called the meeting to order at approximately 9:50 a.m. A copy of the Agenda and a roster of attendees is on record and maintained by the Department of Insurance ("DOI").

II. Review of Minutes

Minutes of the April 14 meeting, as amended, were distributed. Minutes of the April 21 meeting were distributed and discussed. Several amendments were agreed upon and, as amended, were approved. Final copies of the amended April 21 minutes will be distributed at a future meeting.

III. Report from Individual Health Insurance (IHC) Board

Mr. Moskowitz reported that there was an increased feeling of confidence by the IHC Board that they can meet the goal of having plans in the market by July. The IHC Board has been looking to the SEH Board to take the initiative on developing the three "middle" plans and has concentrated its attention to date on developing plans based on the federal HMO Act provisions and the basic health plan set forth in the New Jersey statutes.

The IHC Board is finalizing its Plan of Operations and hopes to have something ready soon. The IHC Board also adopted a resolution, similar to the letter sent by the SEH Board, urging legislative leadership to pass technical corrections legislation to close what both boards believe are loopholes that could impair their ability to assure compliance with the reform goals of the Acts establishing the IHC and SEH Programs.

A technical subgroup of the IHC Financial Committee has been working steadily to develop procedures for the required notification and other technical matters related to assessments and loss determinations.

The IHC Board hopes to coordinate with SEH regarding the May 19 joint meeting at which the boards hope to take comments from the public. Chair Lopes said she would speak to IHC Chair Charles Wowkaneck and intends to bring a plan for the May 19 meeting to next week's Board meeting.

After discussion, the Board also agreed that a record should be kept of the May 19 testimony. Upon motion clearly made, seconded (K. Robinson, M. Willoughby) and unanimously approved the Board authorized the hiring of a court reporter to take minutes for the May 19 proceedings and resolved to take an assessment to pay for such.

The Board agreed that, pending an assessment, those carrier members of the Board willing to pay for the stenographic services could receive credit toward the subsequent assessment.

IV. Discussion of Old Business

A. Benefit Plan Discussion

Anne Bossi distributed a chart prepared by a subgroup of HMO representatives, which was the product of several meetings and which was discussed at the April 27 IHC Board meeting.

Ms. Bossi explained that the goal of the HMO subgroup was to develop several plan options consistent with the federal HMO act, as well as with the IHC and SEH acts. The chart presumes plan benefits and exclusions generally consistent with the other benefit plans being developed. Thus, the chart put together by the HMO subgroup highlights the various copays possible for the three options set forth.

The Board reviewed each of the elements of the chart to clarify what was intended.

The Board discussed their concern with the lack of prescription drug coverage. Recognizing that prescription drugs are an extremely costly item of coverage, the Board nonetheless, after discussion, felt it was important to include the benefit in some way. The Board agreed that adding them by way of rider would likely lead to costly antiselection. After lengthy discussion, the Board agreed that further effort should be undertaken to include prescription drug coverage in all plans, except the statutory basic health plan where the benefits for such are already set by law, whereby prescriptions would be covered subject to a deductible or copay with an outpatient maximum.

Ms. Bossi noted that the consensus of the HMO subgroup was that one of the options set forth on the chart should be the standard plan that all would be required to offer and that the others would be options carriers would be permitted to offer in addition to the standard. She indicated the Column B ($15 copay) option was generally seen as the best

plan to serve as the standard. She also noted that a fourth option, for a $5 copay, was also raised and favored by some. The Board discussed how many of the options already under discussion should be required as part of the required five and also how to take into account the various delivery systems that could be used to provide the required coverages and any options. The Board also discussed the possible use of riders to enhance some of the five benefit plan coverages. It was generally agreed that the cost-sharing provisions for the standard plan set forth on the HMO chart would have to be adapted to accommodate indemnity delivery systems through some sort of equivalent cost-sharing approach. In addition, network based delivery systems would require some provision for coinsurance differentials to be used. The Attorney General's Office was asked to provide guidance on what the Act says with respect to the required five plans and the use of various delivery systems to implement the coverage.

Ms. Bossi agreed to develop a matrix incorporating all the plans discussed to date that will attempt to frame the use of copays, deductible benefit plan designs, and delivery systems.

Antitrust/Pricing

Mr. Moskowitz expressed interest in having some idea of the cost spread across all plans. Several carrier representatives expressed concern that any process of providing the Department or the Board with cost estimates for any or all of the plans developed to date not violate antitrust law.

After discussion, the Board agreed to ask the Legal Committee to consider whether there could be any antitrust problems if carriers were to furnish cost estimates for the various plans to the Department so that DOI actuaries could put together price ranges for Board discussion, which ranges would not indicate the name of any individual company's price figures or otherwise allow individual identification. Carriers were asked to supply the basic information to the Department before next week's meeting and the Legal Committee was asked to advise the DOI immediately whether such information might present antitrust concerns if discussed at a public Board meeting. The DOI agreed to send out the actuarial assumptions to be used by all carriers and the Chair agreed to send out an outline of benefit plan assumptions to be used.

Covered Services

The Board discussed a number of possible covered services. While actual contract language is to be developed by the Drafting Subcommittee chaired by Emily Crandall, the Board agreed on several details regarding some of the services. They agreed that questions raised about how to cover various nutritional services under home health care coverage should be handled by tracking the existing statute relevant to them. The Drafting group was asked to consider how to handle certain special nutritional services (TPN), ie at what point might these services no longer be part of the medical care associated with covered home health care nursing services and, instead, more appropriate for consideration elsewhere.

Similarly, the Drafting group was asked to develop options to define whether to cover air ambulance coverage at all or to cover it with provisions for appropriate use.

The Drafting group was asked to set forth options for transplant coverage. The Board discussed whether to list specific items to be covered, specific items to be excluded, use of general wording to address experimental or investigational matters, and use of objective standards or bodies like the federal AHCPR.

Similar requests were made for the Drafting group to develop options for the Board to consider regarding coverage for: blood/blood products, durable medical equipment, and prosthetic devices. While concerned with overuse as a diagnosis, the Board agreed not to list TMJ as a separate exclusion, agreeing it was more appropriate to allow carriers to judge medical necessity on a case by case basis.

B. **Standardized language decision matrix**

Emily Crandall reported that the Drafting group was scheduled to meet on May 3 to determine how best to develop contract wording to cover benefit and non-benefit provisions. Their hope is to develop a basic format suitable for any adaptations needed to accommodate all delivery systems, individual as well as small group coverage, and any other matters so that the plans for both programs can be comparable.

Ms. Crandall hopes to prepare, based on their work, a matrix that will identify options identified by the Drafting group for board resolution.

V. Proposed legislation

Resolution of MEWA Issues. Melanie Willoughby reported that she and others had met with Laurine Purola, legislative staff, to discuss the draft technical amendments bill and that Ms. Purola agreed that the legislation would include MEWAs under the SEH act, close other loopholes, and address other technical matters such as the time periods for the SEH Board's work.

VI. Report of Claim Form Subcommittee

Maureen Lopes reported that the Subcommittee would meet after next week's meeting at 2:00 pm to discuss electronic data interchange. A representative of the New Jersey Institute of Technology is scheduled to attend.

Close of Meeting

The meeting was adjourned by Chair Lopes at approximately 3:00 pm.

Recorder of minutes:
Jim O'Connor, The Prudential
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