New Jersey Small Employer Health
Excess Insurance Program ("SEH")
August 4, 1993 Board Meeting
Trenton, New Jersey
Offices of The Department of Insurance

I. Call to Order/Introductory Remarks

A quorum being present, Vice Chair Melanie Willoughby opened the meeting at approximately 9:40 a.m. She noted the meeting was subject to the Open Public Meetings Act and that all required notices had been published and filed in the appropriate manner.

II. Report of Plan of Operations Subcommittee

Copies of minutes, amended as approved for the May 26, July 7 and July 14 meetings were distributed. Copies of the July 21 minutes were distributed and discussed. In addition to a few typographical corrections, changes were suggested to indicate the Finance Committees report involved a proposal rather than an action item that the issue of an appropriate reinsurance mechanism should be studied by the Board or an appropriate committee thereof. Upon notice duly made (A. Bossi) and seconded (J. Eick), the Board unanimously voted to adopt the minutes with the changes suggested. A copy of the minutes as amended will be distributed at a subsequent meeting.

III. Report of the Finance Committee.

Ms. Bossi reported that the Committee had met last week with Jim O'Connor, Milliman & Robertson, to discuss his preliminary findings based on the study of the SEH benefit plans for which he was retained by the Board. She introduced Mr. O'Connor to the Board, noting that his oral report to the Board today would be followed in the near future by submission of a draft written report for the Board's review.

Mr. O'Connor reported that his actuarial evaluation of the proposed plan designs looked at claim costs from the perspective of the plan designs being delivered through unmanaged and managed care delivery systems. He defined his rating period for purposes of the study as January 1 - December 31, 1994 with a claim period midpoint of July 1, 1994. He assumed a 15% trend.

The experience sources for his study were the Milliman & Robertson Health Care Guidelines (July, 1993 ed.), which are pricing tools his firm has compiled for approximately 25 years, the PHCS system associated with the HIAA, and small group carrier information the firm has compiled based on New Jersey demographics.

Mr. O'Connor further described certain limitations or qualifications on the study results. His findings are based on a specific set of demographics so to the extent a given carrier has a different age/gender mix, the costs could vary. Carriers also differ in many ways in terms of their typical market and business operations. Moreover, no guarantees can be made that actual claim costs will emerge in the same way the study sets forth. He further noted the small group market is actually two distinct markets with different characteristics -- groups with 15 lives and under and those in the 15-30 range -- and that carriers writing the smallest or "mini-group" market will find it a very distinct market.

Mr. O'Connor spent a good bit of time reviewing the benefit designs of Plans A-E and made a number of observations as he went along. Most of his comments were based on the Plan language from the July 14 version and it was noted that some changes had been made after that.

In addition to some routine or technical drafting suggestions, he recommended the definition of preventive care be made more specific and that benefit maximums be listed in the plan schedule pages rather than within specific contract provisions in the forms themselves.

While he had a number of suggestions on Plan A, his principal observation was that the Plan needed to clarify the scope of coverage by hospital clinics to prevent circumvention of the Plan's intent to restrict outpatient coverage. Mr. O'Connor reviewed the impact of demographic characteristics (age, gender, family status and geographic area) and the monthly claim costs of the plans in both unmanaged and managed care settings. He said he assumed statewide New Jersey averages and a guaranteed issue environment. Mr. O'Connor also examined the relationship of deductible options on the claim costs.

Under managed care, he reviewed the use of utilization review, provider discounts, and the use of managed networks. Claim cost reductions based on utilization review depend considerably on the intensity of the reviews and the carrier's ability to impose the penalties for non-compliance. A carrier's administrative ability to perform UR effectively can impact its usefulness in controlling costs and the prevailing medical practices in a given area are critical. Despite its prior DRG history, New Jersey overage hospital length of stay is greater than the national average, although frequency is lower.

Mr. O'Connor noted that provider discounts do not necessarily equate to managed care networks. Critical factors in determining whether they will impact costs: the carrier's market share, how will the carrier negotiates, and the intensity of the competition (payors and providers) in the area. He also described how the study had looked at New Jersey as dividing into three main areas: North, Central and South. While South New Jersey appears to have the lowest claims costs in the State, several board members and Mr. O'Connor agreed that each area has variation in it and that the division was more for illustrative purposes.

Mr. O'Connor reviewed the various health care services covered by the Plans and described how the various costs were distributed based on types of service. He worked from "covered medical expenses" before application of coinsurance, copays or deductibles.

Other factors were also reviewed and discussed generally, including the required 75% minimum loss ratio, increased exposure to mini-groups, target loss ratios and premium rate considerations such as the use of case characteristics (rate banding phase out, age/gender, health status and experience rating).

The Board members agreed to send any comments on Mr. O'Connor's oral report to the Finance Committee for possible consideration in the draft written report Mr. O'Connor expects to complete in the near future. The Board also asked that any illustrative cost or premium figures be carefully explained so they will not be misunderstood. They also asked that he provide a range of figures that also factor in administrative and other likely expenses as well. Mr. O'Connor will also consider the impact if part-time employees (under 25 hours weekly) and retirees were covered.

IV. Report of the Interim Administrator

Ms. Donna Halligan, Interim Administrator gave a brief update on several points and indicated that either she or Jim Porter will be glad to provide regular reports at Board meetings as desired.

She noted 935 packages were mailed out to carriers and interested parties with the Board's benefit plan regulatory package. Cost per package is $4.10 ($6.10 outside U.S.) not including duplicating expenses. It was agreed that the Operations Committee would explore how much the Board could reasonably charge interested parties for duplication expenses.

Ms. Halligan suggested the Board establish an account for the receipt of any appropriate monies and the Board asked Mr. Bollheimer to follow up on this. Upon request by Ms. Halligan for guidance regarding maintenance of the mailing list, including the process for additions and deletions, the Board asked Ms. Halligan to write to the New Jersey Department of Treasury, which was determined to have the main disc that has been used to date, on behalf of the Board requesting a copy of the disc be sent to her so the administrator can have a permanent mailing list.

Finally, Ms. Halligan noted she was started to compile a list of the questions and comments that are coming in through the 800 number. The Board asked that the Interim Administrator continue to update these lists and to forward them to the Regulation Work Group on a regular basis. The Work Group will route comments and questions to the appropriate committee for review and comment and make recommendations to the Board from time to time based on such comments.

V. Plan of Operations

Ms. Willoughby reported that all committees had been asked, in addition to their regular reports, to review their charge as described in the Working Draft Plan and make any suggestions before it is finalized.

Communication Committee. Ms. Willoughby distributed draft materials prepared by the Committee to establish fair marketing standards for the Program and to develop a Buyer's Guide.

She described the Committee's proposal, copies of which will be on file with the minutes when finalized, emphasizing that the Committee wishes to establish uniform rules for how the Program is described and when materials should be distributed.

Several Board members expressed concern that distributing a detailed document for every proposal and renewal would be unnecessary and costly. The Board discussed various ways to meet the goal of wide dissemination of this Program information. They agreed the Buyers Guide should be sent to all employers in the State by the Board. They thought carrier materials should also be able to mention the existence of the Buyer's Guide as well.

A number of other suggestions were given to Ms. Willoughby on the draft proposal, which will be reviewed by the Marketing/Communications Committee. It was also suggested that enforcement procedures should be integrated with the existing mechanisms the Department of Insurance already has in place.

Ms. Willoughby also reported that the Committee agreed the Board should have a public relations/communication person and recommend to the Board that the process for retaining such services be initiated as soon as possible. Mr. Moskowitz described the similar retainer by the IHC Board. After discussion, a motion was duly made, seconded and unanimously approved authorizing the Committee to develop an RFP and solicit bids to retain a communications professional on a short term basis and further authorizing the Interim Administrator to pay up to $10,600 for a three month retainer, which amount would be credited to the Prudential in the same manner as other expenses of the Interim Administrator.

Legal Committee.

Mike Kaplan, NJBC/BS, gave Susan Connor's report ont he July 29 conference call they held. Draft minutes of that meeting were distributed just to the Board members but have not yet been finalized by the Legal Committee.

The Legal Committee recommended the following: 1) selection of Susan Connor, NJBC/BS, as chair; 2) approval of the proposed budget for services of the AG as

counsel to the Board, subject to several conditions: that the total budget amounts in the AG's July 7 memorandum be considered an amount allocated for services rather than an amount definitely to be spent; that monthly billings be submitted by the Attorney General; that major pending projects be reported by counsel on a weekly basis; and that the Board use the volunteer services of member company attorneys where possible and appropriate; and 3) that the charge of the Legal Committee was similar to that set forth in the draft IHC Plan of Operations. The Committee also seeks to invite hmo member participation on the Committee. Mr. Kaplan also noted Susan Connor had sent a letter to the Board concerning her recollections of a May 5 Legal Committee discussion on the issue of the use of medical underwriting during the transition period. Mr. McDevitt of the Department of Insurance stated that she did not share Ms. Connor's recollection and Jim O'Connor, Prudential, also noted he is not a member of the SEH Legal Committee and that he also had no recollection of the positon stated in the letter.

Mr. Kaplan noted that New Jersey Blue Cross Blue Shield will oppose any SEH Board action to not allow the use of medical underwriting by challenging the regulation or by supporting legislation to eliminate the phase-in period.

Mr. Kaplan also stated that Ms. Connor's understanding of the SEH Act and the Board's earlier agreement regarding selective contracting arrangement puts her in the positon of opposing the Department's current proposed draft regulation on such arrangements.

The Board agreed to distinguish the opinions expressed by Mr. Kaplan on behalf of his company from the actual recommendations of the Legal Committee and thanked him for the report.

Ms. Bossi noted that if the August 20 filing date was to be met for the next series of SEH regulations, the Legal Committee should review the draft Plan once more to see if further changes are needed to allow Department approval.

At approximately 12:30 pm the Board voted to go into Executive Session to consider the proposed budget from the Office of the Attorney General.

The Baord resumed open session at approximately 1:30 p.m.

Operations Committee

Jim Eick reported that the committee plans to meet by conference call on August 5 to review the draft Plan of Operations, the change of the Committee and other appropriate items.

Reinsurance

This issue will be discussed at a further meeting.

Complaint Process

Ms. Mason, DOI, distributed a draft document offering suggestions for a complaint and appeals process for Program matters and asked members to forward comments to her as soon as possible.

VI. PPO Regulation

Ms. Mason reported that the draft regulation concerning selective contracting arrangements distributed to the Board would be proposed in the Register in the near future.

VII. Program Compliance

Ms. Crandall distributed a brief list of topics that the Regulation Drafting Work Group had identified as possibly requiring future Board action to assure reasonable and workable compliance with the SEH Program. Ms. Crandall briefly described the items listed, which include clarification of who is a small employer, participation and contribution issues, rating methodology conversion of existing groups, preexisting condition exclusions, effective date of coverage, usual & customary marketing procedures and other matters.

On most matters, the Work Group will continue to review them and develop language for the Board to review but several topics were discussed in more detail by the Board.

The Board discussed whether and how to cover part-time employees. Ms. Willoughby noted many of her members do have some part-timers covered now and she would hope that option could remain. Others argued that the uniformity of the Program could be weakened by leaving the inclusion of part-timers to the election of an employer and still others argued that covering them would be extremely costly and administratively difficult. The Board also discussed, if such employees were to be covered, whether separate rates could be established. After discussion, Mr. Robinson made a motion seconded by Ms. Willoughby asking Ms. Bollheimer of the Attorney General's Office, to examine whether part-time employees (under 25 hours per week) could be covered by the Program and, if so, whether rate differentials could be authorized where they are covered. The Board adopted the motion unanimously.

The Board also discussed whether they could establish criteria for the rating methodologies carriers must file and whether such criteria could determine which factors could or could not be used. Ms. Crandall noted the law is silent on the point and noted the legislative history supports the view that the Legislature intended a transition away from traditional insurance underwriting to community rating and that changes made when the bill was conditionally vetoed may have made that less explicit but that it was her view the Board should not support the use of medical underwriting. Ms. Bossi agreed with

Ms. Crandall's analysis and Mr. Title also went on record opposing the use of experience rating. The representative from New Jersey Blue Cross/Blue Shield said it was his view that the current law did allow for the use of experience rating and also argued that another key purpose of the law is to bring new entrants into the market. He felt the use of experience rating would help maintain a greater degree of affordability for some. Mr. Robinson noted that the Board should not do by regulation what was not done by legislation.

After considerable discussion, a majority of the Board agreed by straw vote that they would like to see experience rating precluded and thus a motion was duly made (A. Bossi) and seconded (E. Crandall) to ask Ms. Bollheimer to examine the Act to see if the Board could establish criteria for the rating methodologies to be used by carriers that would include age, gender and geography but preclude health information and provide such criteria to the Department of Insurance for their use as standards for reviewing rate filings. The Motion passed unanimously.

Before closing, Mr. Robinson raised the issue of whether anything in the Act or otherwise within the purview of the Board would prohibit the use of financing mechanisms whereby employers could arrange with a carrier for the employer to pay an initial amount of an employees claims up to some cap. Mr. Moskowitz noted he would be concerned about what would happen if the employer went bankrupt with claims incurred but outstanding. He agreed, however, to review the question and discuss the matter in more detail at a subsequent meeting.

The Board adjourned at 4:30 p.m.

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