APPROVED
MINUTES OF THE MEETING OF THE
NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM BOARD
AT THE OFFICES OF THE NEW JERSEY DEPARTMENT OF INSURANCE
TRENTON, NEW JERSEY
MAY 3, 1995

Members Present: Maureen Lopes, Chair; Dana Benbow (Prudential); Deborah Cieslik (BCBSNJ) Nancy Fiorentino (DOH); Stephen Fischl, M.D.; Charlotte Furman (Home Life); Linda Ilkowitz (Guardian); Leon Moskowitz (DOI); Paulette Ryan (New York Life); Amy Mansue (HIP of New Jersey); Dutch Vanderhoof; Melanie Willoughby

Others Present: Kevin O'Leary, Executive Director; Ellen DeRosa, IHC Program Assistant Director; DAG Valerie Bollheimer (DOL)

I. Call to Order

M. Lopes called the meeting to order at 9:40 a.m. and announced that notice of the meeting had been published in three New Jersey newspapers and posted at the Department of Insurance and the Office of the Secretary of State in accordance with the Open Public Meetings Act. A quorum was present.

II. Public Comments

No member of the audience indicated a desire to address the Board.

III. Report of the Policy Forms Committee

M. Lopes reported that the Policy Forms Committee had met several times regarding possible modifications to the policy forms. Comments offered during the Public Comment Session which was held on March 22, 1995, issues staff identified as concerns to consumers and/ or carriers, as well as carrier provided comments had been considered. The committee compiled a list of comments along with some limited recommendations as to actions, copy attached. Such list would serve as the basis for Board discussion. M. Lopes stated that unless a Board member expressed an interest in discussing the issues for which the committee had recommended no change, the Board would not discuss such issues. She asked that the Board give the committee a sense as to which items, if any, the Board believed warranted change.

She said the committee would bring specific text back to the Board, addressing those area(s) the Board identified as areas to change. M. Lopes proposed that the specific language be given to some actuaries to determine cost impact. M. Lopes noted that the Board should be cost conscious and may not want to add significant cost to the standard plans. L. Moskowitz suggested that costly additions may be added using one of the riders

the Board has available . M. Lopes suggested that optional benefit riders were also a possibility. L. Moskowitz noted that optional riders were not available with the IHC program.

(The numbers in the list that follows coincide with the numbers on the attached list.)

1. Routine Footcare

M. Lopes stated that the IHC policies include broader coverage for routine footcare than the SEH policies. It was noted that the IHC Policy Form Committee is evaluating the IHC language to determine whether it accommodates the medically necessary circumstances that were addressed in the testimony from podiatrists.
The Board agreed that the current SEH exclusion should be modified. The Board will evaluate existing IHC language and /or modified language suggested by the IHC Policy Forms Committee to determine which language should be included in the SEH forms.

2. Acupuncture

No change recommended by Committee / No Board Discussion.

3. Christian Science Exclusion

M. Lopes reported that she had spoken with Pam Dickson (DOH) and learned that the facilities were not licensed. N. Fiorentino added that there were no licenses for Christian Science Nurses or Practitioners. L. Moskowitz asked whether carriers offering non-standard plans offered coverage for Christian Science. D. Benbow said that coverage is routinely included in plans issued in the large group market. N. Fiorentino recalled that the oral testimony suggested that the request was to be able to add the coverage by rider. A. Mansue asked how a rider could provide coverage rendered by unlicensed providers in unlicensed facilities. D. Cieslik suggested that the rider could address applicable areas, and accomplish coverage. L. Moskowitz said that use of an optional benefit rider would be a solution. D. Benbow noted that such action would not make any judgment as to medical necessity. A. Mansue added that Medicaid fee for service plans covered Christian Science treatments.
The Board agreed that the Board should consider the release of a Bulletin which would state that this kind of optional benefit rider could be submitted.

4. Chelation Treatments

M. Lopes reported that the Medical Society re-evaluated their comment and believed that the current benefit was appropriate. The Buyer's Guide text should be revised to be consistent with the text included in the policy forms.
The Board agreed that current policy form text required no change.

5. Preventive Allowance

No change recommended by Committee / No Board Discussion.

S. Fischl asked if nutrition counseling was covered and if it would be part of the preventive benefit. It was noted that the forms included an exclusion for nutritional

counseling and related services. A. Mansue said that HMOs view nutritional counseling as critical. L. Moskowitz said that if it were medically necessary, it should be covered. S. Fischl said there are protocols for necessary nutrition counseling.
Upon receipt of additional information, the Board would consider to what extent, if any, nutrition counseling should be covered.

6. Smoking Cessation

D. Cieslik reported that BCBSNJ data indicated that about 6% of prescription drug costs in the large group market were attributable to smoking cessation, with about half, 3%, being for the nicotine patch. D. Benbow said that it could be added under the preventive benefit, and that it would be unresponsive to not provide some manner of coverage. Even if added under the preventive benefit there would be some price increase as a result of additional usage of the preventive $300 benefit allowance. He noted that there would be long term benefits. C. Furman asked if the benefit could be limited to once per lifetime. N. Fiorentino said it took 2.8 attempts to quit, on average, and D. Vanderhoof observed that there was no real risk of abuse.
The Committee will draft language to add smoking cessation supplies and programs to the preventive benefit. Patches could be obtained under the preventive benefit, but would not otherwise be available as a prescription benefit.

7. Non-Prescription Supplies

M. Lopes provided suggested language to the Medical Society for comment. She awaits reply.
The Board will evaluate the proposed language.

8. Expand Coverage for Psychiatric Disorders

N. Fiorentino explained that there was an objective process that enabled the identification of persons who would need more treatment than the limited benefit in the plans would provide. For most persons, the current benefit would be sufficient.
The Board recommended no change to the current benefit.

9. Expand Therapy Services

M. Lopes reported that there were entities, such as schools, that offered therapy services. So, therapy benefits were not limited to what private sector policies provided. She did not want to pull people out of government programs. A. Mansue said there was a difference between developmental disabilities which were chronic, and acute needs that may be met with rehabilitation. D. Benbow suggested that acute needs may be handled via alternate treatment provisions L. Moskowitz asked N. Fiorentino to get the federal definition of developmental disability for the Board to review.
The Board recommended no change at present, but will be open to new data.
K. O'Leary asked for a resolution to begin executive session at 10:40 a.m..
L. Moskowitz offered a motion that the Board enter Executive Session. D. Cieslik seconded. The Board voted unanimously to enter Executive Session

The Public Meeting resumed at 11:10 a.m. (D. Benbow left the meeting after the Executive Session.)

10. Domestic Partners as Eligible Dependents

M. Lopes said that any discussion on this issue should be deferred until after it had been reviewed by other state agencies.

The Board recommended no text changes at this time.

11. Abortion

No change recommended by Committee / No Board Discussion.

12. Therapeutic Manipulation in HMO Plan

The Board agreed to clarify the HMO Policy form to specify that 30 visits per calendar year were covered.

13. Out of Country Exclusion

A. Mansue stated that with respect to HMO plans, the subscriber must reside in the service area. Three situations were identified which would cause an insured person to be legitimately out of the country:

- travel
- student
- employee temporarily outside the US on a business assignment

L. Ilkowitz commented that most problems probably occurred when the person was in a country that had a national health system D. Smith (member of the audience from Chubb Life) interjected that her company had raised the question. Their concern was primarily with persons who leave the country to seek medical treatment.

The Committee will draft language to allow limited coverage for persons out of the country.

14. Assistant Surgeon

N. Fiorentino will review applicable regulations and report to the Board.

15. Family Deductible and Coinsurance

D. Cieslik reported that a change to an aggregate accumulation vs. the current individual satisfaction would increase rates C. Furman said her actuary estimated 1.5%. L. Ilkowitz said her actuary said the increase would range from 1% -3%, depending on the deductible option. C. Furman said there were lots of consumer complaints concerning the issue. She noted that the industry standard had been for an aggregate accumulation. L. Moskowitz suggested that the SEH plans copy the IHC plans which used an aggregate approach. P. Ryan suggested that maybe a 3X approach should be considered, with 2X as an option.

The Board recommended that the SEH plan text be modified to allow for a 2X aggregate accumulation of family deductible and coinsurance.

16. Coinsured Charge Limit

M. Lopes explained the 2 questions. First, should there be a family limit with respect to the coinsured charge limit? Second, should a lower limit be allowed? A. Mansue said that if there have been rider submissions to add a family limit, a family limit should be available under the standard plan.
The Board recommended that the policy forms be modified to allow for a $5,000 option in addition to the existing $10,000 limit, with a family limit set at either two times or three times the individual limit, to be examined for its impact on cost. An additional question concerning coinsurance was raised. The plans currently discuss coinsurance as the <u>insured's</u> share. Most other plans refer to the <u>carrier's</u> share in the forms.
No change will be made at this time.

17. Coinsurance after Copayment

After lengthy discussion as to how the proposed design would work, and the manner in which the standard forms currently allow the carrier to structure a PPO or POS plan with gatekeeper, the Board decided that no change should be made.

18. Direct Access to OB/GYN

The Board noted a trend away from referral with respect to the services of an OB/GYN.
The Board agreed to allow self-referral to an OB/GYN for OB/GYN services.

19. POS - Limit Hospital Confinement Copay to One per Admission

C. Furman noted that the plans were required to track the HMO plan. HMO plans specify a per day copay feature, limited to 5 days per confinement.
A. Mansue will review what HMO plans should be doing and report to the Board. The Board will also need to review the rate impact associated with any change.

20. Out Network Preventive - Deductible & Coinsurance

V. Bollheimer will review the wellness statute and report to the Board.

21. Attention Deficit Disorder (ADD)

N. Fiorentino will review. A. Mansue said a child study team evaluates and identifies ADD. There are many programs to assist with care and treatment. L. Moskowitz said ADD would be part of psychiatric benefits, and that the Board should not pick out specific diagnoses.
The Board will defer recommending any change until new information has been provided.

22. Nutritional Counseling

Previously discussed.

23. Autologous Bone Marrow Transplant and Associated High Dose Chemotherapy in connection with the treatment of Breast Cancer.
N. Fiorentino reported that the treatment was still considered to be experimental under NCI standards. The NCI continues clinical trials. D. Vanderhoof said there was a bill on the Governor's desk which would require that carriers make an optional benefit available which would cover NCI clinical trials as well as treatments as recommended by the American Society of Oncologists. N. Fiorentino agreed to investigate what that entails. *The Board will recommend action upon receipt of additional information.*

24. Grievances Procedures:
The Board agreed to include the HMO text in the indemnity plans.

25. List of Specialists in the HMO Contract
The Board agreed to remove the list.

Additional Items:

Oral Contraceptives
The prescription drug provision should be clarified as regards coverage for oral contraceptives. A. Mansue will investigate whether a similar allowance should be made for high dosage of folic acid vitamins.

Infertility
M. Lopes said that the standard HMO plans must provide benefits as outlined in state regulations. State regulations require benefits for supportive preventive health services, including family planning, infertility and children eye services. M. Lopes said that if the HMO plans must include then the indemnity plans should also. The regulation did not stipulate any required level of benefits
The Board will think about what level of benefit should be included. A. Mansue agreed to investigate this matter.

Goal
Before the next meeting, the Policy Form Committee will meet and draft language for the areas to be modified, based on Board recommendations.

D. Vanderhoof made a motion that he meeting be adjourned. D. Cieslik seconded. The Board voted unanimously to adjourn the meeting. The meeting was adjourned at 12:40 p.m.