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
June 7, 1995

Members present: Maureen Lopes, Chair; Pamela Dickson (DOH); Jim Donnellan (Prudential); Stephen Fischl, M.D.; Charlotte Furman (Home Life); Linda Ilkowitz (Guardian); Chanell McDevitt/Leon Moskowitz (DOI); Debbie Cieslik (BCBSNJ); Amy Mansue (HIP of New Jersey); Dutch Vanderhoof.

Others present: Kevin O'Leary, Executive Director; Wardell Sanders, SEH Program Assistant Director; Ellen DeRosa, IHC Program Assistant Director; DAG Valerie Bollheimer (DOL); DAG Josh Lichtblau (DOL).

I. Call to Order

M. Lopes called the meeting to order at approximately 9:40 a.m. and announced that notice of the meeting had been published in three 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

M. Lopes announced that a member of the audience had asked the Board if it had taken a position on a bill introduced by Assemblyman Bagger which bill would allow revisions to nonstandard plans between now and March 1, 1996. She announced that the Board had not taken a position on the bill, noting that the bill had not yet been heard in Committee.

II. Minutes

* *A. Mansue made a motion to approve the second draft of the minutes of the May 3, 1995 meeting. C. Furman seconded the motion, and the motion was approved unanimously by voice vote.*

[S. Fischl arrived at the Board meeting.]

** C. Furman made a motion to approve the draft May 17, 1995 minutes, as amended. A. Mansue seconded the motion, and the motion was approved unanimously by voice vote.*

** C. Furman made a motion to approve the draft executive session minutes of the May 17, 1995 meeting. L. Ilkowitz seconded the motion, and the motion was approved unanimously by voice vote.*

III. Report of the Policy Forms Committee

M. Lopes distributed copies of a memorandum regarding suggested language for the definition of "coverage" to be incorporated in N.J.A.C. 11:21-3.2(d), which rule sets forth the filing requirements for optional benefit rider filings. She explained that the definition would permit carriers to file riders which described the types and extent of services and supplies described in the "Covered Charges," "Covered Charges with Special Limitations" and "Exclusions to Covered Charges" sections of the policies, as well as changes to the deductibles, coinsurance, copayments and coinsured charge limits set forth in the standard plans. She further noted that the proposed language would not permit carriers to alter statutory definitions and provisions such as eligibility requirements and preexisting condition provisions. [L. Moskowitz replaced C. McDevitt as the DOI's representative]. After some discussion, the Board asked DAG Bollheimer to do a survey of existing law to determine how other law define "coverage." M. Lopes said that the Policy Forms Committee would look at previously filed optional benefit rider filings for further guidance.

The Assistant Director reported that the Policy Forms Committee had reviewed an optional benefit rider filing from MetLife, which proposed rider would alter the prescription drug coverage to the standard HMO contract. He reported that the Policy Forms Committee recommended a finding of incomplete and not in substantial compliance for failure to include the certification required by rule, failure to indicate the provisions of the standard form which were being altered, and noted that there were matters which might represent benefit decreases.

** J. Donnellan made a motion to accept the recommendation of the Policy Forms Committee regarding the optional benefit rider filing submitted by MetLife for the reasons set forth above. D. Vanderhoof seconded the motion, and the motion was approved unanimously by voice vote.*

The Assistant Director reported that the Policy Forms Committee had reviewed an optional benefit rider filing from New York Life, which proposed riders to plans C and D would utilize a coinsurance cap rather than the coinsurance charge limit. He reported that the Policy Forms Committee recommended that the filing not be accepted because the rider included numerous provisions which represented benefit decreases, and recommended that the carrier be instructed to file the rider with the DOI or remove the benefit decreases and refile with the Board.

** J. Donnellan made a motion to accept the recommendation of the Policy Forms Committee regarding the optional benefit rider filing submitted by New York Life for the reasons set forth above. D. Vanderhoof seconded the motion, and the motion was approved unanimously by voice vote.*

M. Lopes referred the Board to a handout of proposed policy form changes dated May 31, 1995. She noted that the Board would not be voting on final changes to the forms, and that all proposed changes would need to be examined together in order to evaluate their collective impact on the cost of the policies. She further noted that the Board may not be able to meet the next OAL proposal deadline, and that the rulemaking timetable may not provide carriers with sufficient time to begin use of the revised policy forms by January 1, 1996. L. Moskowitz noted that the statute provides for the narrowing of the permissible rating ban to 2:1 on January 1, 1996, and that, if possible, the revised policy forms and the new rating requirements should dovetail. M. Lopes indicated that changes to the PPO/POS pages would be filed in a separate rule proposal.

The Board discussed the following changes (numbered in the order presented in the handout).

1. The proposed text deleted references to individual satisfaction of family deductible and family coinsurance cap. The Board agreed to make no changes to the proposed text.
2. The proposed text clarified Specified Special Care Unit charges. The Board agreed to make no changes to the proposed text.
3. The proposed text clarified the definition of "Co-Payment" with regard to the Emergency Room Co-Payment. The Board agreed to make no changes to the proposed text.
4. The proposed text added the definition of "Nicotine Dependence Treatment." M. Lopes noted that the definition was provided by the DOH. S. Fischl expressed a concern that "Behavioral Therapy" could encompass unproven or ineffective treatments. The Executive Director suggested that the phrase "for the management of nicotine dependence" be moved within the definition immediately following USFDA approval criteria. The Board also agreed to move the phrase "tobacco abstinence" to follow "in promoting."
5. To the Point of Service provisions, the proposed text removed the variability from the text concerning self referral for gynecological visits, and narrowed the limitation on direct referral to allow for self-referral for non-surgical gynecological care and routine pregnancy care. D. Cieslik raised a concern that permitting a woman to self refer more than once a year might increase inappropriate utilization. After some discussion, the consensus reached was to not limit self referral to once per year.
6. The proposed text modified the deductible and co-insurance to discuss an aggregate family accumulation. The Board agreed to change the "medical expenses to "Covered Charges."

[P. Dickson left the meeting]

7. The proposed text clarified the Special Care Unit benefits and the nature of the Emergency Room Co-Payment. The Board agreed to make no changes to the proposed text.
8. The proposed text specifically identified oral contraceptives as covered. Noting that some prescription contraceptives were not administered orally, the Board agreed to remove the word "oral."

S. Fischl raised the issue of mammograms being performed in substandard facilities. M. Lopes indicated that the DOH would be asked for its input on this issue.

9. The proposed text included language from the proposed SEH clean-up bill which addresses prior coverage which would be considered for the purposes of continuity. The Board agreed with the proposed text change with the addition of a restriction that prior coverage be delivered or issued for delivery in the United States.
10. The proposed text added a limited benefit for foot care. Some members of the Board expressed a concern that the relaxation on the exclusion for "Routine Foot Care" was worded too broadly, and would relax the exclusion more than the Board had intended. L. Ilkowitz suggested limiting coverage to persons diagnosed with diabetes. After some discussion, the Board agreed to seek guidance on this issue from the Access Program and to ask E. DeRosa to review the testimony provided by the Podiatrist to determine whether Medicare guidelines would offer additional direction.
11. The proposed text added nicotine dependence treatment to the preventive care covered charge. The Board agreed to make no changes to the proposed text.
12. The proposed text modified the non-prescription supplies exclusion and added an exclusion for nicotine dependence treatment. The Board agreed to make no changes to the proposed text.
13. The proposed text deleted the smoking cessation exclusion which, pursuant to the proposed changes, appeared as nicotine dependence treatment. The Board agreed to make no changes to the proposed text.
14. The proposed text added an exclusion for services or supplies received outside of the Untied States except under certain circumstances. Bob Vehec of the DOI raised the issue of how the "review and renewal" provision of the proposed change for students studying out-of-country would be administered. After some discussion, the Board agreed to have carrier members look into how they would verify student status.

S. Fischl noted that the current exclusion for services or supplies "for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair" was an issue under review by the AMA. M. Lopes indicated that the Board should consider removing the exclusion.

[The Board recessed from 11:50 am until noon.]

The Board discussed the addition of coverage for nutritional counseling to the Covered Charges with Special Limitations section of the policy forms. The proposed

benefit would subject the coverage to carrier pre-approval. The issue arose as to whether this coverage should be available to persons not morbidly obese. The plans currently provide coverage with respect to persons who are morbidly obese. The Board noted that the proposed change highlighted the sometimes conflicting philosophies held by indemnity carriers and HMOs. After some discussion, A. Mansue agreed to take the proposed language to the HMO association for comment.

The Board discussed coverage for fertility services, noting that federally qualified HMOs were required to provide some fertility services coverage. A. Mansue noted that if this coverage must be added to the standard HMO plan, the Board should consider inclusion of the same coverage in the indemnity plans. J. Donnellan noted that the Board had intended to create a level playing field between indemnity carriers and HMOs when it drafted the standard policy forms and HMO contract. A. Mansue agreed to look at the list of exclusions of infertility services proposed by J. Donnellan in his June 7, 1995 memorandum to M. Lopes, and whether the list would jeopardize federal qualification. The DOI agreed to examine the list in light of state qualification requirements. M. Lopes asked the Board members from indemnity carriers to research the cost of including coverage for infertility services in the standard indemnity plans.

The Board discussed the overlap between Therapeutic Manipulation and Physical Therapy coverage. The Board agreed that the carrier members of the Policy Forms Committee would further consider this issue and report to the Board at its next meeting

M. Lopes noted that the recent passage of a law regarding Autologus Bone Marrow Transplants which law required the "mandatory offering" of certain coverage raised the issue of mechanically how the Board should address the obligations imposed upon carriers under the law. She noted that the Policy Forms Committee had discussed using a standard rider optional benefit approach or alternatively including the benefit in all of the standard plans. She noted that the rider approach would present a problem since the riders would likely be priced very high because of the potential for adverse selection. After some discussion , the Board agreed that it should make sure that the Legislature is aware of the practical difficulties that "mandatory offer" bills present to the SEH Board. M. Lopes said that the Policy Forms Committee would consider the matter further.

The Board discussed the Second Opinion Notice requirement which provided for a 24 hour notification period. M. Lopes indicated that the Policy Forms Committee had discussed expanding the notification period to 72 hours. The Board agreed with the recommendation.

A. Mansue reported that HMOs were not currently offering pre-natal vitamins. The Board agreed not to add this coverage.

M. Lopes noted that D. Cieslik had raised the issue of whether the policy forms were confusing by not making the dependent provisions of the forms variable language. Without making these provisions variable, an insured could be confused by the references

to dependent coverage, when no coverage was being provided. C. Furman raised the issue of whether dependent coverage must be offered. The Board asked the Attorney General's Office for advice on this issue.

IV. Legislative Update

M. Lopes noted that the Senate had made changes to section 12 of S-2013, the SEH clean-up bill, by changing the phrase "risk adjustment mechanism" to "voluntary risk pooling" mechanism. She reported that the bill was voted unanimously out of the Senate Committee.

V. Report of the Assistant Director

The Assistant Director reported that the SEH rules were available on computer disk to carriers, brokers, and other interested parties at a cost of $10.

The Assistant Director reported that the DOI had recently adopted a rule regarding a premium comparison survey for the small employer market. He noted that the rule required carriers to file information with the DOI by July 1, 1995.

The Assistant Director explained a spreadsheet of the enrollment figures for the first quarter of 1995. He noted that standard plans represented nearly 32% of the market as of the end of the first quarter of 1995, and that carriers reported that 35% of the plans newly issued were to groups previously uninsured. He further reported that, after taking into account carriers who had failed to report in the last quarter, market totals showed an increase in 1815 plans from the prior quarter. He reported that the market totals showed increases in the total number of insureds from the last quarter, but he noted that carrier estimates of covered dependents were being reported inconsistently, and therefore, the numbers did not provide a useful guide in measuring changes in the small employer market. As an example, he noted that one carrier reported an increase of 300 small employer plans in force, but a decrease of over 32,000 persons covered, which decrease was due to a revision in how dependent coverage was measured.

VI. Report of the Executive Director

The Executive Director reported that the Attorney General's Office had presented an initial client reimbursement agreement to the Board with a $245,000 ceiling for costs. After some discussion with the Attorney General's Office, the Attorney General's Office lowered the ceiling in the proposed agreement to $132,000, with the condition that if unanticipated matters arose, the Board would renegotiate in good faith. L. Moskowitz noted that his earlier concern regarding this proposal was based on a desire to avoid the administrative cost of a second assessment. The Executive Director indicated that he was confident that, barring unexpected litigation, the $132,000 ceiling represented a reasonable figure.

** A. Mansue made a motion to approve the Attorney General's client reimbursement agreement. M. Lopes seconded the motion, and the motion was approved unanimously by voice vote.*

The Executive Director reported that Phoenix Home Life had filed both an Exhibit CC and a Request for Nonmember status. He recommended that the Request for Nonmember status be denied.

** J. Donnellan made a motion to disapprove the Request for Nonmember status filed by Phoenix Home Life. D. Vanderhoof seconded the motion, and the motion was approved unanimously by voice vote.*

The Executive Director explained a spreadsheet for a 1995 interim assessment, based on a budget of $310,000 for 1995 administrative expenses. He noted that, with the Board's approval, assessment bills would be sent to carriers in June.

** L. Moskowitz made a motion to approve an interim assessment based on the spreadsheet provided by the Executive Director. J. Donnellan seconded the motion, and the motion was approved unanimously by voice vote. [Met 2/3rds supermajority requirement]*

** A. Mansue made a motion to approve the expense report attached hereto as Exhibit 1. L. Moskowitz seconded the motion, and the motion was approved unanimously by voice vote. [Met 2/3rds supermajority requirement]*

VII. Operations Committee

M. Lopes recommended that the an Operations Committee be formed to serve the functions set forth in the Plan of Operation, including review of the audit report and review of staff job descriptions.

** C. Furman made a motion to appoint M. Lopes, D. Benbow, L. Moskowitz, S. Fischl and D. Turner to the Operations Committee. L. Ilkowitz seconded the motion, and the motion was approved unanimously by voice vote.*

VIII. Executive Session

** D. Vanderhoof made a motion to enter Executive Session for the purpose of receiving legal advice from counsel regarding the status of municipalities under the SEH law. D. Cieslik seconded the motion, and the motion was approved unanimously by voice vote.*

The Board returned from Executive session. M. Lopes indicated that staff would send letters regarding the status of municipalities under the SEH law to parties requesting such clarification.

X. Close of Meeting

* *D. Vanderhoof made a motion to close the meeting. L. Ilkowitz seconded the motion, and the motion was approved unanimously by voice vote.*