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 21, 1995

Members present: Maureen Lopes, Chair; Dana Benbow, Vice Chair (Prudential); Nancy Fiorentino (DOH); Stephen Fischl, M.D.; Charlotte Furman (Home Life); Linda Ilkowitz (Guardian); Hank Meisner (BCBSNJ); Leon Moskowitz (DOI); Paulette Ryan (NYLife); Fred Title (HIP of New Jersey); David Turner (Aetna); Dutch Vanderhoof.

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

I. Call to Order

M. Lopes called the meeting to order at approximately 9:55 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 Comment Session

Harry Witsen of Medical Benefit Services asked the Board whether a college student, studying out-of-state, and over the age of 25 would be eligible for an individual health benefits plan. The Executive Director responded that eligibility for individual coverage requires persons to be living in the State for at least six months out of the year.

III. Minutes

* *C. Furman made a motion to approve the draft minutes of the June 7, 1995 meeting as amended. L. Ilkowitz seconded the motion and the motion was approved by voice vote, with D. Benbow, P. Ryan, and F. Title abstaining.*

* *C. Furman made a motion to approve the draft executive session minutes of the June 7, 1995 meeting. L. Moskowitz seconded the motion and the motion was approved by voice vote, with D. Benbow, P. Ryan, and F. Title abstaining.*

IV. Report of the Policy Forms Committee

The Assistant Director reported on the optional benefit rider filings and utilization review filing reviewed by the Policy Forms Committee as described in the "Recommendations of the Policy Forms Committee," handout, attached hereto as Exhibit 1. He indicated that certain optional benefit rider filings would need to be discussed after the Board considered the definition of "coverage."

A. Final Agency Determinations on Rider and Utilization Review Filings

** L. Moskowitz made a motion to accept the recommendation of the Policy Forms Committee with respect to Rider 1 filed by First Option Health Plan as set forth in Exhibit 1. D. Vanderhoof seconded the motion, and the motion was approved by voice vote with L. Ilkowitz abstaining.*

** D. Benbow made a motion to accept the recommendation of the Policy Forms Committee with respect to Riders 1, 2, and 4 filed by John Hancock Mutual Life as set forth in Exhibit 1. L. Moskowitz seconded the motion, and the motion was approved unanimously by voice vote.*

** F. Title made a motion to accept the recommendation of the Policy Forms Committee with respect to Riders 1, 2, 3 and 4 filed by Sanus Health Plan of New Jersey as set forth in Exhibit 1. C. Furman seconded the motion, and the motion was approved by voice vote with P. Ryan abstaining.*

** L. Moskowitz made a motion to accept the recommendation of the Policy Forms Committee with respect to the utilization review filing filed by John Hancock Mutual Life Insurance as set forth in Exhibit 1. D. Benbow seconded the motion and the motion was approved unanimously by voice vote.*

B. Definition of "Coverage"

The Assistant Director discussed a memorandum dated June 21, 1995 to the Board regarding the definition of "coverage" in the context of optional benefit rider filings. The memorandum included a list of items that were either included in optional benefit rider filings or which might be included in such filings. The Assistant Director noted that the first section of items on the list (Deductibles, Coinsurance, Copayments, Coinsurance Charge Limits, and Coinsurance Caps) had been incorporated into many filings and that there had been no disagreement that such items should be considered "coverage" and the Board agreed. The Board also agreed that the second section of items listed in the memorandum (Type/extent of coverage addressed in: Covered Charges , Covered charges with Special Limitations, and Exclusions to Covered Charges sections of the forms) should be considered "coverage."

The Board then considered riders amending statutory and regulatory definitions of the policy forms. The Assistant Director indicated that the Board had received riders proposing to increase statutory and regulatory eligibility and eligibility for continuation of coverage. Noting that all riders to the standard forms would be subject to modified community rating, guaranteed issuance, and all other elements of reform in the law, the Board agreed that riders of increasing actuarial value which altered statutory and regulatory definitions should be considered "coverage" and acceptable as riders. L. Moskowitz noted that riders of decreasing actuarial value which proposed changes to statutory or regulatory revisions would likely be considered unacceptable under the Department's review.

The Board then considered riders proposing inclusion of features such as supplemental accident, deductible waiver, common accident and deductible carry-over. S. Fischl expressed a concern that such riders might have the effect of confusing consumers. B. Vehec expressed a concern about the use of the word "supplemental" in the supplemental accident benefit. While the concept of a supplemental accident benefit is standard in the industry, the Board agreed to describe the benefit using other terms. After some discussion the Board agreed that the statutory provision permitting carriers to file optional benefit riders would not prohibit such riders. The Board also discussed Medicare supplement policies. The Assistant Director noted that the statute excludes "Medicare supplement" policies from the definition of "health benefits plan." E. DeRosa noted that the policy forms include a Medicare as Secondary Payor provision, depending on the size of the group. After some discussion, the Board agreed that riders narrowly drawn to amend the Medicare coordination provisions of the policy forms might be acceptable. L. Moskowitz indicated that this issue might need further discussion.

With respect to dental and vision riders, the Assistant Director noted that the definition of "health benefits plan" excludes "dental only" and "vision only" policies. D. Benbow expressed a concern about the Board becoming involved in the regulation of dental and vision coverage. The Assistant Director noted that filings received to date had ranged from comprehensive type coverages to riders adding minimal benefits. L. Moskowitz indicated that riders adding some benefits might be permissible. M. Lopes asked what criteria the Board would use to determine whether a dental or vision rider filing was appropriate. L. Moskowitz said that the Department could provide the Board with standards. The Board also considered whether riders should be permitted to change the scope of networks. The Board agreed that this is a licensure issue and should not be incorporated into the definition of "coverage." The Assistant Director was instructed to draft a rule proposal for submission to the Policy Forms Committee. Lastly, the Board asked DAG Lichtblau for guidance on riders which had no impact on the actuarial value of the standard plans.

C. Final Agency Determinations on Remaining Rider Filings

** L. Moskowitz made a motion to reject the optional benefit rider filing submitted by CIGNA/Connecticut General set forth in Exhibit 1 because the rider would appear not*

to increase the actuarial value of the standard plans without a carryover deductible provision, and to include in the Board's notification letter that carriers must offer the standard plans independent of all riders. D. Turner seconded the motion, and the motion was approved unanimously by voice vote.

* *D. Vanderhoof made a motion to find Rider 3 filed by John Hancock Mutual Life as set forth in Exhibit 1 complete and in substantial compliance. H. Meisner seconded the motion, and the motion was approved by voice vote with L. Moskowitz abstaining.*

The Board instructed staff to send a letter to First Option noting that riders changing the scope of networks are not considered changes in "coverage" and should be filed with the Department and the Department of Health, the entities for responsible for network approval.

The Board recessed from 11:05 am to 11:15 am.

D. Draft Policy Form Changes

M. Lopes distributed a revised timeline for policy form changes. The timeline set a hearing date for changes, to be held in conjunction with the IHC Board, in the afternoon of September 12, 1995, rescheduled the September Board meeting from September 20 to September 27, and assumed an effective date of policy changes of January 1, 1996. She indicated that staff would mail the proposed policy form changes to Board members early next week, and asked the carrier members to price each proposed change and send materials regarding the impact on prices to the Bob Vehec of the Department of Insurance. M. Lopes indicated that the Board would review policy changes every two years. S. Fischl recommended that future reviews include an examination of medical necessity, so that the policy forms are consistent with accepted health policy.

M. Lopes referred the Board to a handout dated June 21, 1995 regarding policy form changes. The Board discussed the following changes (numbered in the order presented in the handout).

1. Coverage for Nicotine Dependence Treatment: The proposed text restricted the definition of "Behavioral Therapy." The Board agreed to the proposed change.
2. Routine Footcare: The Board agreed to use the text based on Medicare Guidelines but took out the word "neurological."
3. Fertility coverage: The Board agreed to use the draft language provided by Jim Donnellan in his June 7, 1995 memorandum which sets forth the coverage required for federal qualification. Board members representing an HMO were asked to determine if the suggested language presents any legal issues. F. Title said that if this coverage is added to the HMO standard contract, the Board should consider requiring its inclusion in plans A through E in order to maintain a level playing field. C. Furman noted that another option would be to include coverage only in plan E, since that plan is the benefit

equivalent of the standard HMO plan. H. Meisner asked if the coverage in the indemnity plans would require preapproval. M. Lopes asked carriers to price this coverage with and without preapproval.

4. *Therapeutic Manipulation and Physical Therapy:* C. Furman reported that Home Life had done a claims run and had found no problem with the present language. L. Ilkowitz reported that Guardian also had no issue with the present language. The Board agreed that it would not consider a change.

5. *Out of Country Coverage:* The Board agreed to language that would limit coverage for full-time students studying out-of-country to only students enrolled "and attending an accredited school in a foreign country subject to [Carrier] review."

6. *Mandatory offers:* M. Lopes asked carrier members how mandatory offers were treated by carriers pre-reform. L. Ilkowitz indicated that Guardian normally included mandatory offers in its plans. D. Benbow indicated that Prudential would usually make mandatory offers available at the employer's next renewal. After some discussion, the Board agreed to develop standard language and give carriers the option to include the standard language in all of their forms, or offer optional riders. The Board agreed that carriers would have to treat all plans and all delivery systems the same in choosing to include mandatory offers in the plans or in choosing to use riders. M. Lopes indicated that the Board would distribute a bulletin providing carriers with guidance on how to provide mandatory offers prior to January 1, 1996, the expected effective date of proposed changes to the policy forms.

7. *Discontinuance and Replacement:* The Executive Director reported that the Legal Committee had concluded that the Discontinuance and Replacement regulations apply in the small employer market. Ellen DeRosa reported that plans A through E currently incorporate discontinuance and replacement rules, but that the standard HMO contract did not contain similar provisions. The Board concluded that the HMO contract should incorporate discontinuance and replacement provisions with appropriate modifications for HMO language.

8. *Children's Eye Examination:* Current DOH regulations require coverage for children's eye examinations, which the standard HMO contract currently excludes. The Board agreed to instruct staff to draft language to provide for coverage under both the HMO and indemnity products. The Board noted that the term "children" would have to be defined or explained.

9. *48 hour maternity:* A bill which had not yet been signed by the Governor, which would permit a mother 48 hour in-patient care, even when not medically necessary, if signed, would require modification of the forms. The Board agreed to alter the standard plans accordingly.

10. Grievance Procedure: The Board agreed to the draft language which would permits carriers the option of including the carrier's grievance procedure filed with the State when the plans include managed care options.

C. Furman inquired about changes to the form provision regarding exclusion for services or supplies for which a charge is not usually made. M. Lopes indicated that the Board would consider that change at a later time.

V. Legislative Report

M. Lopes reported that the Senate would vote on S-2013, the SEH clean-up bill, on Monday, June 26, 1995.

VI. Report of the Legal Committee

The Executive Director reported that the Legal Committee had begun drafting an ethics manual.

The Executive Director reported that the Legal Committee had discussed the issue of whether, consistent with the N.J.A.C. 11:21-7.6, the participation regulation, a small employer could purchase an indemnity plan as well as a PPO or POS product, and that the Legal Committee recommended that the issue be brought before the whole Board. L. Ekowitz expressed some concern about adverse selection problems. After some discussion, the Board agreed to permit small employers to purchase both an indemnity and managed care products. The staff was instructed to draft a rule proposal to accomplish this.

The Executive Director reported that the Legal Committee had addressed the issue of on what basis an employer could distinguish from among employees for purposes of offering coverage, meeting the contribution requirements, and establishing employee waiting periods. He read a draft letter developed pursuant to the Legal Committee's conclusion, which stated that while the SEH statute does not limit an employer in distinguishing from among employees, other state and federal laws do limit impermissible discrimination, and that employers distinguishing from among employees should do so based on classes of employees, which classes should be based on conditions pertaining to employment. DAG Lichtblau was asked to review the letter before the letter was distributed.

VII. Report of the Marketing Committee

M. Lopes reported that the Marketing Committee had received ten responses to the Request for Proposal for communication services. She indicated that the Committee planned to hold interviews with four respondents. She further indicated that the Committee planned to come to the next Board meeting with a recommendation.

VIII. Medical Savings Account

F. Title reported that A. Mansue had planned to report on Medical Savings Accounts, but could not attend the Board meeting.

IX. Report of the Executive Director

The Executive Director reported that he planned to send assessment notices out within a week. He also reported that, in consultation with DAG Maria Smyth, he had developed a contract for auditing services. He indicated that some minor details regarding the contract needed to be resolved with the auditors.

** F. Title made a motion to approve the expense report attached hereto as Exhibit 2. D. Benbow seconded the motion, and the motion was approved unanimously by voice vote.* [Met 2/3rds supermajority requirement]

The Executive Director reported on outreach activities. He reported that he had spoken at a meeting of the Mercer County Chamber of Commerce, had participated at the NAIC meeting on a task force addressing individual health care reform. He noted that he had been invited to attend a meeting sponsored by the National Academy for State Health Policy in Seattle, with the sponsor paying for travel and accommodations. Lastly, he distributed copies of a letter to the editor of the Trentonian which had been written by an individual in response to a prior letter to the Editor that he had written. He indicated that he would send a response to the letter.

X. Community Rating Hearing

L. Moskowitz reported that the Departments of Health and Insurance were holding a public hearing on the issue of community rating in the small employer market on June 29, 1995.

XI. Executive Session

M. Lopes told the audience that the Board planned to enter executive session and that it would not act on or discuss any matters after the executive session.

** L. Moskowitz made a motion to enter executive session for the purpose of discussing current litigation and personnel action. F. Title seconded the motion and the motion was approved unanimously by voice vote.*

XII. Close of Meeting