APPROVED AS AMENDED 11/15/95
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
September 27, 1995

Members present: Maureen Lopes, Chair; Dana Benbow, Vice Chair (Prudential); Debbie Cieslik (Blue Cross); Stephen Fischl; Linda Ilkowitz (Guardian); Nancy Fiorentino (DOH); Charlotte Furman (Home Life); Leon Moskowitz (DOI); Susan Peters (Aetna); Fred Title (HIP of New Jersey); Dutch Vanderhoof; Melanie Willoughby.

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

I. Call to Order

M. Lopes called the meeting to order at approximately 9:35 AM 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

No comments were offered.

III. Minutes

** D. Vanderhoof made a motion to approve the draft minutes of the August 16, 1995 meeting, as amended. M. Lopes seconded the motion, and the motion was approved by voice vote with F. Title, L. Ilkowitz, and D. Cieslik abstaining.*

** D. Vanderhoof made a motion to approve the draft minutes of the August 16, 1995 executive session meeting. M. Lopes seconded the motion, and the motion was approved by voice vote with F. Title, L. Ilkowitz, and D. Cieslik abstaining.*

** D. Cieslik made a motion to approve the draft minutes of the September 12, 1995 meeting, as amended. D. Vanderhoof seconded the motion, and the motion was approved unanimously by voice vote.*

** D. Vanderhoof made a motion to approve the draft minutes of the September 12, 1995 executive session meeting. L. Ilkowitz seconded the motion, and the motion was unanimously by voice vote.*

** C. Furman made a motion to approve the draft minutes of the September 12, 1995 public hearing. L. Ilkowitz seconded the motion, and the motion was approved unanimously by voice vote.*

IV. Medical Savings Accounts

M. Lopes referred to a draft report regarding Medical Savings Accounts ("MSAs") in the Board packets. She noted that the report was in response to the statutory requirement for the Board to report to the Legislature on MSAs. L. Ilkowitz indicated that MSAs present complicated issues and that the draft report may not address all the issues which it should. She suggested inclusion or reference to a report of MSAs published by the Academy of Actuaries.

[M. Willoughby and S. Fischl arrived.]

L. Moskowitz said that in the absence of federal legislation regarding MSAs, any action in New Jersey would be premature. He noted that if the federal government enacted legislation, then New Jersey would be in a position to review the impact of MSAs in the small employer market. After some discussion, the Board agreed that any study of MSAs in New Jersey at this time would be premature and would be of little or no use to the Legislature. The Board asked the Executive Director to draft a letter to the Legislature to that effect, with a copy of the study by the Academy of Actuaries attached, and asked that Board members review the letter before it was sent.

[S. Peters arrived.]

V. Legislative Report

M. Lopes reported that the Governor had conditionally vetoed the SEH clean up bill due to the provision for tort immunity for Board members and the retroactivity provision. She indicated that the bill would likely see passage sometime at the end of the year.

M. Lopes noted that A3123, the "Garrett Bill" had been proposed but not officially introduced. She indicated that this status allowed the sponsor to modify the bill before introduction. She reported that Assemblyman Garrett had organized a meeting of interested parties to discuss the bill on October 10, 1995. With respect to the specific amendments in the Garrett Bill, M. Lopes indicated that it was her impression that the issue of community rating was one in which the Board had agreed to disagree. The Board then discussed specific issues raised by the Garrett Bill.

Nonstandard Plans

M. Lopes reminded the Board of the SEH Act's current requirements with respect to nonstandard plans. She noted that as of March 1, 1996, no nonstandard plans could be issued or renewed. She further noted that nonstandard plans were required to compete on a level playing field with standard plans in terms of guaranteed issuance, guaranteed renewability, preexisting conditions limitations, rating requirements, and loss ratio requirements. C. Furman noted that the current prohibition on altering nonstandard plans had presented administrative problems. She suggested that the law be amended to either permit nonstandard plans to be altered, or to prohibit them altogether. D. Vanderhoof noted that the inability to amend nonstandard plans to provide them through PPO or POS arrangements had the consequence of pricing many of the plans out of the market. F. Title indicated that he would prefer to see a market where nonstandard plans could not be sold or renewed. He noted that A. Mansue had presented, for discussion purposes, a compromise position in which existing nonstandard plans could be renewed but the sale of nonstandard plans to new groups would be prohibited. D. Benbow said that the purpose of the IHC and SEH Acts was to bring rationality to the respective markets, noting that the Legislature took a more aggressive approach with the small employer market by prohibiting the continuation of nonstandard plans. C. Furman said that the primary goal of the SEH Act was to provide for accessibility of coverage, and that it would be best to let the market speak and permit the continuation of nonstandard plans with the ability to amend those existing nonstandard plans. D. Benbow noted that carriers do not have the ability to cancel nonstandard plans. L. Ilkowitz said that it was unclear to her whether small employers wanted to change to standard plans. M. Lopes responded that she had found that many small employers had already converted, and that many of the ones that had not converted had indicated that they did not know about the standard plans, while a few indicated that they did not want to be told by the State what products they could purchase. Tom Smith of the Department of Insurance noted that the continuation of nonstandard plans presented adverse selection problems. D. Vanderhoof said that optional benefit riders realistically did not provide enough flexibility in the market because many specific benefits which employers would want would be cost prohibitive.

Associations

D. Benbow indicated that he believed that association business should not be treated differently. F. Title and L. Ilkowitz indicated that they agreed. M. Willoughby asked if it would be appropriate if associations could be permitted to offer nonstandard plans, but require them to meet certain benefit levels. D. Benbow responded that this was akin to standardized plans. He further noted that associations would be able to offer new standard plans on the same basis as carriers. L. Moskowitz noted that a federal bill permitting purchasing cooperatives in the states could drastically effect the small employer market in New Jersey.

Stop Loss Coverage

M. Lopes noted that the Garrett Bill would lower the stop loss retention limits set by the Board by regulation. L. Ilkowitz noted that this would create an unlevel playing field and predicted that it would present significant problems in the market place. The Board agreed.

Authority of the SEH Board

L. Moskowitz indicated that the Department was developing a position on the issue of the Board's authority. He indicated that there was a belief that the Commissioner should be the administration's voice on all insurance matters. He noted, however, that the Department and the Board had generally reached a consensus on all important matters, and indicated that he did not anticipate any points of contention between the Department and the Board in the near future. He noted that this was, in a general sense, the position of the Administration. He noted that the SEH Act may not need amendment to reflect this protocol. He further noted that this position was consistent with the agreement reached between the Department and the Board regarding enforcement matters. D. Vanderhoof asked how other State boards operated within other Departments. L. Moskowitz responded that an analogy might not be useful since the SEH Board, in contrast to most other State Boards, had rulemaking authority.

The Board briefly discussed the draft ethics manual. The Board agreed to vote on the draft at its next meeting. C. Furman indicated that she had questions about the draft. M. Lopes said that Board members should contact the Executive Director before the next meeting to discuss specific provisions in the draft ethics manual.

VI. Report of the Policy Forms Committee

M. Lopes indicated that she had developed a list of approved riders which she would distribute at the next Board meeting.

The Board then discussed draft responses to comments received to its rule proposal regarding amendments to the policy forms. The Board discussed each response and voted on each response separately. Attached hereto as Exhibit 1 is a copy of the draft adoption, as amended at the meeting, with the votes on each response indicated in the margin.

The Assistant Director reported that the Policy Forms Committee had met to review optional benefit rider filings. Attached hereto as Exhibit 2 are the recommendations of the Committee with respect to those filings.

** D. Cieslik made a motion to accept the recommendation of the Policy Forms Committee to find the filing from Colonial Life complete and in substantial compliance. C. Furman seconded the motion, and the motion was approved unanimously by voice vote.*

** D. Benbow made a motion to accept the recommendation of the Policy Forms Committee to find the filing from First Option complete and in substantial compliance. D. Cieslik seconded the motion, and the motion was approved by voice vote, with L. Ilkowitz abstaining.*

** C. Furman made a motion to accept the recommendation of the Policy Forms Committee to find the filing from HMO Blue complete and in substantial compliance. D. Vanderhoof seconded the motion, and the motion was approved by voice vote, with D. Cieslik abstaining..*

** L. Ilkowitz made a motion to accept the recommendation of the Policy Forms Committee to find the filing from John Alden complete and in substantial compliance. D. Vanderhoof seconded the motion, and the motion was approved unanimously by voice vote.*

VII. Report of Executive Director

The Executive Director reported that the bookkeeper hired to put the IHC and SEH Program books together for the audit had nearly completed the IHC books, and would begin working on the SEH books immediately thereafter. He indicated that he expected the bookkeeper would spend approximately two weeks on the SEH books, and that he would be working with the Board's Finance Committee on the audit. The Executive Director reported on assessment collections, noting that the response from carriers had been excellent. The Executive Director then discussed the expense report attached hereto as Exhibit 3.

** D. Benbow made a motion to approve the expense report. M. Willoughby seconded the motion, and the motion was approved unanimously by voice vote.* [Met 2/3rds supermajority requirement]

With respect to outreach, the Executive Director reported that he had spoken to a chapter of the NJAHU, and to approximately 40 persons at a WEB group in Parsippany. He introduced, Kris Mattson and Victor Washkevich of Wenzel and Company, the Board's new public relations firm. They distributed copies of a draft of a spreadsheet showing the carrier responses to the premium comparison survey. Ms. Mattson indicated that this was merely a first draft. Members of the Board recommended the following changes: that the carriers' 800 numbers be included, that the public relations firm name not appear on the final copy, that the date of the survey be included, and that the fictional group used for the survey be identified. The Board noted that it would have to consider how this should be distributed. M. Lopes indicated that further comments should go to the Executive Director.

The Executive Director referred to a handout of a draft rule proposal setting forth standards for the Board in its review of carrier filings to request to use a contribution

requirement of less than 10 percent. He noted that the draft rule requires carriers to provide evidence that the goal of increasing coverage was being hindered by a 10 percent contribution requirement. The Board agreed to take the draft amendment under advisement.

The Executive Director reported that the letter to the Governor regarding the Kennedy/Kassenbaum Bill went out as drafted. He noted that the bill had been reported out of committee.

The Executive Director informed the Board that the Governor's Office had notified all state agencies that it wanted at least seven days notice to review all significant rule proposals and adoptions.

VIII. Executive Session

** D. Benbow made a motion to resolve to enter executive session for the purpose of receiving advice from counsel. M. Willoughby seconded the motion, and the motion was approved unanimously by voice vote.*

IX. End of Meeting

** D. Benbow made a motion to end the meeting. L. Moskowitz seconded the motion, and the motion was approved unanimously by voice vote.*

American Society of Addiction Medicine

COMMENT 1: The commenter supported the proposed amendments to add coverage for nicotine dependence treatment. The Commenter noted that the proposed amendments used the terms "tobacco abstinence" and "tobacco addiction" in the definition of "behavioral therapy" and recommended that the terms be changed to "nicotine abstinence" and "nicotine addiction" in keeping with current usage in the field.

RESPONSE: The Board concurs with the commenter and has made the suggested changes. Nicotine is the substance to which people become addicted, whereas tobacco is merely a nicotine delivery mechanism . Therefore, the suggested change more accurately describes the concepts to which the Board intended to refer. [M. Lopes moved adoption, D. Benbow seconded, unanimous]

Nancy Bateman, Esq.

COMMENT 1: The commenter recommended that the Board, in addition to adding coverage for test strips for blood glucose, add coverage for lancets, a nonprescription device used for drawing blood to put on the test strips. The commenter noted that the test strips could not be used without the lancets, and that lancets do not have other practical uses.

RESPONSE: The Board agrees that lancets should be added to the list of Covered Services and Supplies. The Board agrees with the commenter that the device is absolutely necessary to diabetics and others, and notes that such additional coverage would have little impact on rates. The Board has also found that lancets and test strips are sold together in some cases. [D. Cieslik moved adoption, D. Vanderhoof seconded, unanimous]

Blue Cross and Blue Shield of New Jersey

COMMENT 1: The Commenter asked the Board if, as a result of the passage of P.L.1995, c.100, a bill requiring the mandatory offering of coverage for Autologous Bone Marrow Transplants ("ABMT") for the treatment of breast cancer, it was necessary to include a benefit for ABMT in Plan A. The commenter suggested that, if the Board does believe that ABMT coverage should be offered with Plan A, that the Board follow the decision of the Individual Health Coverage ("IHC") Program Board, and permit carriers to make a selection with respect to Plan A as whether to include such a benefit as part of the plan or to offer it as a rider to that plan, in addition to a selection with respect to Plans B through E.

RESPONSE: The Board notes that the commenter did not provide a legal argument or justification supporting the position that ABMT need not be offered with Plan A. In the absence of support that ABMT coverage need not be offered with Plan A, the Board will require that ABMT coverage be offered with Plan A.

The Board does agree with the commenter's suggestion to permit carriers to make a separate selection (one for Plan A, and one selection for Plans B through E) as to whether to meet the obligations of the law by incorporating ABMT coverage in the forms or, alternatively, by rider. The Board recognizes that as basic coverage providing chiefly hospitalization coverage only, it is prudent to permit carriers the flexibility to make a different selection with respect to Plan A. The proposal would have required carriers to make the same selection with respect to Plan A as it did

with Plans B through E. The Board notes that this change will impose the same requirements in the small employer market as exist in the individual market. [D. Benbow moved adoption, L. Moskowitz seconded, approved with D. Cieslik abstaining]

COMMENT 2: The commenter suggested that the Schedule of Insurance and Premium Rates in Plan A be amended to include ABMT coverage in the pre-approval sections under Daily Room and Board Limits.

RESPONSE: By way of clarification, the Board notes that prior to the passage of P.L.1995, c.100, Plans B through E and HMO already included a limited benefit for ABMT coverage, which benefit required prior approval. Plan A, on the other hand, did not provide any ABMT coverage. To provide for the coverage required to be offered by the passage of P.L.1995, c.100, the Board has proposed variable language (recognizing that carriers have a choice to offer the coverage as part of the Plan or as a rider) in Plans A through E and HMO. The variable language in Plans B through E and HMO permits a carrier to remove the existing limited benefit for ABMT treatment and to substitute the new benefit. The variable language in Plan A permits a carrier to include the new benefit as part of Plan A or as a rider. The new benefit, as reflected in the rule proposal, would not subject the benefit to carrier preapproval in any of the plans. The Board provides this background because it believes that the carrier may have been under the misimpression that Plans B through E require pre-approval of ABMT coverage.

The Board notes that it may be inappropriate to impose significant restrictions to a benefit that the Legislature has determined must be offered. In fact, P.L.1995, c.100 requires that ABMT coverage be offered on the same basis as any other illness. Furthermore, the Board notes that typically a person would be in the hospital when the benefit for ABMT coverage is accessed, and carriers have precertification procedures for hospitalization. For these reasons, the Board disagrees with the commenter's suggested change. [C. Furman moved adoption, D. Vanderhoof seconded, approved with D. Cieslik abstaining]

COMMENT 3: The commenter noted that the Definition of "Preventive Care" in Plan A included Nicotine Dependence Treatment, but the Summary of the proposal indicated that Nicotine Dependence had been included only in Plans B through E.

RESPONSE: The Board recognizes that the Summary section of the proposal inadvertently omitted Plan A when referring to the Plans to which proposed amendments had been made to the definition of "Preventive Care." The Board intended to include coverage for Nicotine Dependence Treatment in Plan A. [D. Vanderhoof moved adoption, L. Ilkowitz seconded, approved with D. Cieslik abstaining]

COMMENT 4: The commenter suggested that the Exclusions section of Plan A be amended under "Transplants" to note "except as otherwise included in this Policy" to accommodate those carriers offering ABMT coverage in the standard plan.

RESPONSE: The Board agrees that the suggested change is needed, but notes that the language must be variable, to accommodate those carriers that wish to offer ABMT coverage through a rider. [F. Title moved adoption, L. Ilkowitz seconded, approved with D. Cieslik abstaining]

COMMENT 5: The commenter suggested that the Schedule of Insurance and Premium Rates sections of Plans D and E be revised with respect to the Payment Limits for Charges for Preventive Care, to reflect the $500 per covered Person limit for a dependent child until age one.

RESPONSE: The commenter is correct that the $500 per covered person limit for dependent children is missing from policy forms D and E. This provision is reflected correctly in the Certificates of Coverage, but was inadvertently omitted in the policy forms. The Board has made the suggested changes. [D. Benbow moved adoption, M. Willoughby seconded, approved with D. Cieslik abstaining]

COMMENT 6: The commenter wrote in opposition to the proposed change to the POS policy which change would permit a female covered person to self-refer to a gynecologist for nonsurgical gynecological care and routine pregnancy care. The commenter argued that such a change might impede a carrier's ability to properly perform care management functions, and might lead to the delivery of unnecessarily costly and possibly inappropriate care. The commenter suggested that if the change were maintained, it be made variable to permit those carriers that wished to maintain its current administration to do so.

RESPONSE: The Board rejected this comment. The Board considered this issue prior to proposal and determined that the proposed language was appropriate. It noted that since self-referral was limited to nonsurgical gynecological care and routine pregnancy care there was little or no risk of abuse. The Board believed that the ability to self-refer was sufficiently limited in scope to avoid inappropriate utilization. [F. Title moved adoption, C. Furman seconded, approved with D. Cieslik abstaining]

COMMENT 7: The commenter recommended that the definition of "Late Enrollee" be revised in the HMO contract, since there were no Employee coverage or Dependent coverage sections of the contract.

RESPONSE: While the comment is beyond the scope of the proposal, the Board agreed with the commenter that the definition of "Late Enrollee" in the HMO contract does contain inappropriate references. As a result, the Board agrees to make appropriate changes. [D. Benbow moved adoption, C. Furman seconded, approved with D. Cieslik abstaining]

COMMENT 8: The commenter recommended that the Covered Services and Supplies section of the HMO contract, under Prescription Drugs, be revised to add glucose test strips, and colostomy bags, belts and irrigators. The commenter noted that these additions would make the section consistent with the Board's stated intention to add these as covered supplies, and as is reflected in the proposal's amendments to the Non-covered Services and Supplies section of the contract .

RESPONSE: The Board concurs and adds the items, as well as lancets (to the Covered Services and Supplies section of the HMO contract. The omission was inadvertent. [L. Moskowitz moved adoption, D. Vanderhoof seconded, approved with D. Cieslik abstaining]

COMMENT 9: The commenter recommended that, in order to accommodate the "employee only" version of the policy forms, the Schedule of Insurance and Premium Rates for all plans be revised to accommodate this type of coverage.

RESPONSE: The Board concurs and has made appropriate changes. [L. Moskowitz moved adoption, D. Vanderhoof seconded, approved with D. Cieslik abstaining]

COMMENT 10: The commenter suggested that the Grievance Procedures sections of the PPO and POS forms be changed to note that a carrier not subject to N.J.A.C. 11:4-37 have its text approved by the Board rather than "by the applicable regulatory authority of the State of New Jersey" as the proposal indicates. The commenter asserted that the Department of Insurance had "no policy form approval authority with respect to reform plans," and as a result, it assumed that the reference to "applicable regulatory authority" referred to the Board.

RESPONSE: The Board disagrees with the commenter's suggested change. The Board did not mean to refer to itself as "applicable regulatory authority." The Board proposed the change in response to requests from carriers to include Grievance Procedure language which had been approved by the Departments of Health and Insurance in their review of selective contracting arrangements. While noting that service corporations may not be subject to N.J.A.C. 11:4-37, the Board has changed this provision upon adoption to state that "[i]f a carrier has had a selective contracting arrangement approved by the New Jersey Departments of Insurance and Health" it may include that approved Grievance Procedure language in the standard SEH forms. The Board believes that this change will clarify what it intended. Additionally, the Board notes that pursuant to N.J.S.A. 17B:27A-33, the Commissioner of Insurance does have approval authority over all reform plans. [D. Benbow moved adoption, C. Furman seconded, approved with D. Cieslik abstaining]

COMMENT 11: The commenter noted that the preface to the Medicare as Secondary Payor section of all the plans might confuse consumers in that only certain aspects of the federal rules are applicable to a small employer. The commenter cited as an example the fact that the End Stage Renal Disease rules that apply to groups of all sizes, while the working aged provisions apply only to groups of 20 or more.

RESPONSE: The Board disagrees with the comment. The preface to the Medicare as Secondary Payor section indicates that it may not apply to the small employer which has purchased the plan. Like the section which addresses COBRA coverage, the intention of the Board was not to set forth the eligibility requirements, but rather to say what happened if the Medicare as Secondary Payor provisions were applicable. [D. Vanderhoof moved adoption, L. Ilkowitz seconded, approved with D. Cieslik abstaining]

COMMENT 12: The commenter noted that the heading of the Medicare as Secondary Payor section incorrectly referred to "Medicaid" rather than "Medicare."

RESPONSE: The Board concurs and has made the suggested change. [D. Benbow moved adoption, C. Furman seconded, approved with D. Cieslik abstaining]

First Option Health Plan

COMMENT 1: The commenter recommended that a provision be added to the HMO contract to require employees and dependents to reside within that HMOs' service area in order to be eligible for coverage. The commenter noted that the current form merely states that Employee coverage ends if the Employee moves outside of the service area. The Commenter made the comment in the context of the proposed clarification to the indemnity plans that coverage not be provided to persons outside of the United States, except under certain circumstances.

RESPONSE: The Board concurs with the commenter. Pursuant to N.J.S.A. 17B:27A-26a, an HMO is not required to offer coverage to a small employer not located within the HMO's approved service area nor to employees of small employers who do not work or reside within the service area. Because HMOs may choose not to offer coverage to certain groups or individuals, the Board has included language in the eligibility sections of the HMO contract consistent with the statute. References to an HMO's ability to deny coverage to groups or individuals outside of the HMOs approved service area are in brackets, in recognition of the fact that N.J.S.A. 17B:27A-26a does not prohibit an HMO from offering coverage to such groups or employees. [D. Cieslik moved adoption, M. Willoughby seconded, approved unanimously]

COMMENT 2: The commenter believed that the proposal's removal of the list of specialists services in the covered Services and Supplies section, and the removal of the parentheticals that deal with oral surgery benefits and dental x-rays, left it unclear as to whether a carrier is free to determine what oral surgery benefits to provide, including whether dental x-rays are excluded to the same extent as they were prior to the change.

RESPONSE: The removal of the list of specialist services has no impact on oral surgery benefits. Dental x-rays are excluded to the same extent as they were before the proposal. (See the Noncovered Services and Supplies section where it lists "dental care or treatment, including appliances, except as otherwise stated in this contract" and in the same section where it lists "extraction of teeth, except bony impacted teeth."). The purpose of the change was to clarify that specialist services not listed were covered.

The Board agrees that the removal of the parentheticals may lead to some confusion. Therefore, the items in the parentheticals have been incorporated in the Covered Services and Supplies section. [M. Lopes moved adoption,. D. Vanderhoof seconded, approved unanimously]

COMMENT 3: The commenter suggested that the standard HMO form clearly state that accidental injury to sound natural teeth be covered, whether or not there was a bony impaction, as this was mandated in most states.

RESPONSE: The comment is beyond the scope of the proposal. The Board noted that such coverage is not mandated in New Jersey. [M. Willoughby moved adoption, S. Peters seconded, approved unanimously]

COMMENT 4: The commenter asked why a list of standard exclusions related to prescription drugs is not included within the Non-covered Services and Supplies section of the HMO form.

RESPONSE: The comment is beyond the scope of the proposal as no change was made to this section of the policy forms. [M. Willoughby moved adoption, D. Vanderhoof seconded, approved unanimously]

COMMENT 5: The commenter indicated that the section addressing Pre-existing Condition Limitations is confusing with respect to the language that gives credit for the time an individual is covered under a previous plan. The commenter recommended that the forms be changed to clarify that the coverage of a condition is what gives rise to credit, not simply coverage of the person.

RESPONSE: The Board agrees that this provision may be misleading and has made changes to clarify credit for prior coverage consistent with N.J.S.A. 17B:27A-22. The Board believes that the language of N.J.S.A. 17B:27A-22 and the Legislature's intention with respect to credit for prior coverage is to provide credit toward a six month preexisting condition limitation period to those persons who had been previously covered under a prior health benefits plan to the extent that the previous plan provided coverage for the condition in question, in addition to any time a person had such a plan and had been in a benefit limitation period. [D. Benbow moved adoption, C. Furman seconded, approved unanimously]

New Jersey Optometric Association

COMMENT 1: The commenter recommended that the Board delete the exclusion of vision therapy in Plans C through E and HMO.

RESPONSE: The comment is beyond the scope of the proposal as no change was made to this section of the policy forms. [D. Benbow moved adoption, S. Peters seconded, approved unanimously]

Agency Initiated Changes [D. Cieslik moved adoption, M. Willoughby seconded, unanimous]

1. In the rule proposal, at N.J.A.C. 11:21-3.1(b) and in Plans B through D, the Board proposed providing carriers with an alternate method to calculate satisfaction of the family deductible limit and coinsurance cap. The proposed option provided that the family deductible limit must be satisfied by three persons on an aggregate basis, and the family coinsurance cap must be satisfied by two covered persons on an aggregate basis. The Board, however, intended to provide that the family coinsurance cap be satisfied by three covered persons on an aggregate basis. Accordingly, the rule adoption reflects the Board's intention.

In addition, the Board has made changes to N.J.A.C. 11:21-3.1(b) to add guidance on Plans A and E which had not been discussed in the rule. The language added on adoption merely reflects what is contained in the policy forms.

2. In the definition section of all of the plans, "Joint Commission" is amended to reflect its proper name, the Joint Commission on the Accreditation of Health Care Organizations.

3. The Board, in consultation with the Department of Insurance, has determined that the section in the policy forms providing a conversion right for divorced spouses is not necessary. The Board notes that the need for such a conversion right has been obviated by the changes to the individual market, which require carriers to offer coverage on a guaranteed issue. As a result, the section dealing with conversion rights for divorced spouses, and references to that right, have been removed in the adoption.

Full text of the adoption follows (additions to the proposal indicated in boldface with asterisks *thus*; deletions from the proposal indicated in brackets with asterisks *[thus]*):

N.J.A.C. 11:21-3.1

(a) (no change)

(b) In accordance with this chapter, members that offer small employer health benefits plans in this State shall offer all of the health benefits Plans A, B, C, D, and E as set forth in Exhibits A through F, in the Appendix, except as set forth in (c) below.

*1. Plan A shall contain a deductible of $250 per covered person:

i. and $500 per covered family, to be satisfied by two separate covered persons and a per person coinsurance cap of $5000; or

ii. and $750 per covered family, to be satisfied on an aggregate basis and a per person coinsurance cap of $5000.*

*[1.]**2* Plans B, C, and D shall contain the following annual deductible options to the small employer for each plan:

i. $250 per covered person and $500 per covered family; $500 per covered person and $1,000 per covered family; and $1,000 per covered person and $2000 per covered family. For all three deductible options, the family deductible limit must be satisfied by two separate covered persons *[, and the family coinsurance cap must be satisfied by two separate covered persons]* *. The per person coinsurance caps for Plans B, C, and D are $3000, $2500, and $2000 respectively. The family coinsurance caps for Plans B, C, and D are $6000, $5000, and $4000 respectively, which must be satisfied by two separate covered persons *; or

ii. $250 per covered person and $750 per covered family; $500 per covered person and $ 1,500 per covered family; and $1,000 per covered person and $3000 per covered family. For all three deductible options, the family deductible limit must be satisfied on an aggregate basis*[, and the family coinsurance cap must be satisfied by *[two]* *three* separate covered persons]. * The per person coinsurance caps for Plans B, C, and D are $3000, $2500 and $2000 respectively. The family coinsurance caps for plans B, C, and D, are $9000, $7500, and $6000 respectively, which must be satisfied on an aggregate basis.*

[2. Members offering Plan E shall offer only an annual deductible of $150.00 per covered person and $300.00 per covered family. The family deductible limit must be satisfied by two separate covered persons.]

*3. Plan E shall contain a deductible of $150 per covered person:

i. and $300 per covered family, to be satisfied by two separate covered persons, with a per person coinsurance cap of $1500, and a family coinsurance cap of $3000 to be satisfied by two separate covered persons; or

ii. and $450 per covered family, to be satisfied on an aggregate basis, with a per person coinsurance cap of $1500, and a family coinsurance cap of $4500 to be satisfied on an aggregate basis.*