APPROVED

MINUTES OF THE MEETING OF THE NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM BOARD AT THE OFFICES OF THE NEW JERSEY DEPARTMENT OF BANKING AND INSURANCE TRENTON, NEW JERSEY December 18, 1996

Members present: Larry Glover, *Chair*; Leon Moskowitz, *Vice Chair* (DOBI); James Donnellan (Prudential); Nan Fiorentino (DOHSS); Justin Fiedler (BCBSNJ); Charlotte Furman (Anthem Health and Life); Eileen Gallagher (NYLCare); Linda Ilkowitz (Guardian); Amy Mansue (HIP of New Jersey); Bryan Markowitz; Eric Wilmer (Celtic Life); Dutch Vanderhoof; Bonnie Wiseman (DOHSS).

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

I. Call to Order

L. Glover called the meeting to order at approximately 9:45 a.m. K. O'Leary announced that notice of the meeting had been published in three newspapers and posted at the Department of Banking and Insurance ("DOBI") and the Office of the Secretary of State in accordance with the Open Public Meetings Act. A quorum was present.

II. Public Comments

No public comments were offered.

III. Minutes

* *L. Moskowitz made a motion to approve the draft* ***executive session*** *minutes of the November 20, 1996 Board meeting, as amended. A. Mansue seconded the motion, and the motion was approved unanimously by voice vote.*

* *D. Vanderhoof made a motion to approve the draft minutes of the November 20, 1996 meeting, as amended. J. Fiedler seconded the motion, and the motion was approved unanimously by voice vote.*

IV. Report of the Policy Forms Committee

W. Sanders reported that the Policy Forms Committee had met on December 11, 1996 to review optional benefit rider filings and other matters. He referred to the document attached hereto as Exhibit 1 regarding the recommendations of the Policy Forms Committee, and described the riders submitted.

** A. Mansue made a motion to accept the recommendation of the Policy Forms Committee with respect to the optional benefit rider filing from **American Preferred Provider Plan**, listed on Exhibit 1 as rider 1, to find the filing complete and in substantial compliance. L. Ilkowitz seconded the motion, and the motion was approved unanimously by voice vote.*

** E. Gallagher made a motion to accept the recommendation of the Policy Forms Committee with respect to the optional benefit rider filing from **American Preferred Provider Plan** , listed on Exhibit 1 as rider 2, to find the filing complete and in substantial compliance. A. Mansue seconded the motion, and the motion was approved unanimously by voice vote.*

** D. Vanderhoof made a motion to accept the recommendation of the Policy Forms Committee with respect to the optional benefit rider filing from **American Preferred Provider Plan** , listed on Exhibit 1 as rider 3, to find the filing complete and in substantial compliance. E. Gallagher seconded the motion, and the motion was approved unanimously by voice vote.*

** A. Mansue made a motion to accept the recommendation of the Policy Forms Committee with respect to the optional benefit rider filing from **First Option**, listed on Exhibit 1 as rider 1, to find the filing complete and in substantial compliance. D. Vanderhoof seconded the motion, and the motion was approved unanimously by voice vote.*

** D. Vanderhoof made a motion to accept the recommendation of the Policy Forms Committee with respect to the optional benefit rider filing from **First Option**, listed on Exhibit 1 as rider 2, to refer the filing to the Department of Banking and Insurance as a rider of decreasing value. L. Moskowitz seconded the motion, and the motion was approved unanimously by voice vote.*

** D. Vanderhoof made a motion to accept the recommendation of the Policy Forms Committee with respect to the optional benefit rider filing from **First Option**, listed on Exhibit 1 as rider 3, to refer the filing to the Department of Banking and Insurance as a rider of decreasing value. L. Moskowitz seconded the motion, and the motion was approved unanimously by voice vote.*

** D. Vanderhoof made a motion to accept the recommendation of the Policy Forms Committee with respect to the optional benefit rider filing from **First Option**, listed on Exhibit 1 as rider 4, to find the filing complete and in substantial compliance. J. Fiedler seconded the motion, and the motion was approved unanimously by voice vote.*

The Board discussed whether a discount toward vision benefit services could be provided via an optional benefit rider. The Board concluded that such a benefit was not an insurance benefit and should not appear in a rider, but that a carrier could provide a discount for certain benefits.

** A. Mansue made a motion with respect to the optional benefit rider filing from **First Option**, listed on Exhibit 1 as rider 5, to find the filing complete and in substantial compliance but that the provisions regarding discounts for certain vision benefits must be removed. D. Vanderhoof seconded the motion, and the motion was approved unanimously by voice vote.*

** J. Fiedler made a motion to accept the recommendation of the Policy Forms Committee with respect to the optional benefit rider filing from **Physicians Health Services**, listed on Exhibit 1 as rider 1, to find the filing complete and in substantial compliance. D. Vanderhoof seconded the motion, and the motion was approved by voice vote, with L. Ilkowitz abstaining.*

** L. Moskowitz made a motion to accept the recommendation of the Policy Forms Committee with respect to the optional benefit rider filing from **Physicians Health Services** , listed on Exhibit 1 as rider 2, to find the filing complete and in substantial compliance. D. Vanderhoof seconded the motion, and the motion was approved by voice vote, with L. Ilkowitz abstaining.*

** L. Moskowitz made a motion to accept the recommendation of the Policy Forms Committee with respect to the optional benefit rider filing from **Physicians Health Services**, listed on Exhibit 1 as rider 3, to find the filing complete and in substantial compliance. J. Fiedler seconded the motion, and the motion was approved by voice vote, with L. Ilkowitz abstaining.*

The Assistant Director reported that Committee had discussed the responses to the survey of HMO carriers regarding the issue of copayments for nonprescription supplies. The responses appear on Exhibit 1. The responses did not provide a clear mandate for the Board.

V. Report of the Assistant Director

The Assistant Director referred to the adopted 1997 annual notice of SEH Board meetings filed with the Secretary of State and printed in three New Jersey newspapers. He also referred to the nominations for the three Board seats up for election in February

of 1997. He noted that he had received nominations for Celtic Life, Oxford Health Plans, and Physicians Health Services with the deadline for receiving nominations set for January 5, 1997. L. Moskowitz asked DAG Lichtblau to look into the issue of whether Physicians Health Services could serve on the Board in light of its marketing arrangement with the Guardian.

The Assistant Director referred to a letter that he had written to CIGNA, the only carrier to notify the Board that it was interested in marketing an HMO/POS dual contract. The letter outlined the Board's intended structure for the plans.

The Assistant Director also referred to SEH Bulletin 96-SEH-09 providing carriers with guidance on the creation of high deductible plan options for use with MSAs. D. Vanderhoof asked if nonstandard plans could be modified to create a high deductible plan for use with an MSA. L. Moskowitz responded that nonstandard plans could be so modified.

The Assistant Director referred to draft bulletin 96-SEH-10 providing carriers with guidance on the individual stop loss limit as codified at N.J.S.A. 17B:27A-17; he asked for any comments to the draft bulletin by December 24, 1996. The Executive Director noted that he had responded to a letter from Assemblyman Garrett on this issue and that he had not received any further communications on this issue from Assemblyman Garrett.

The Assistant Director referred to handouts on the market totals of the third quarter 1996 enrollment reports. The report showed a slight decrease in enrollment from the second quarter of 1996, but still represented a substantial increase in enrollment from the previous year (about 5%). E. Wilmer noted that nationally the number of persons covered under HMO plans was decreasing, but that the SEH Program number showed an increase in the number of persons covered under HMO plans. L. Moskowitz suggested that E. Wilmer obtain information from the Department's Managed Care Bureau. The Assistant Director noted that proposed regulatory amendments to the SEH Program would require carriers to indicate whether the A-E Plans were issued through a selective contracting arrangement as well as information about HMO/POS plans. L. Moskowitz recommended that the Board develop an annual report once the enrollment numbers for 1996 were completed.

Lastly, the Assistant Director reported that he provided Department officials with a memorandum on the changes to the SEH Act which will be required as a result of the passage of the Health Insurance Portability and Accountability Act of 1996. He encouraged Board members to provide him with any comments.

VI. Report of the Marketing Committee

The Assistant Director reported that the Marketing Committee met on December 13, 1996. He referred to a handout of draft language for inclusion in the SEH Buyer's Guide providing some information for consumers on Medical Savings Accounts ("MSAs"). E. Gallagher suggested that self-employed individuals should be referred to the IHC Buyer's Guide. L. Ilkowitz expressed a concern about listing the carriers in the insert. The Executive Director noted that the purpose of the insert was to deflect unnecessary calls to the SEH Board. He indicated that the insert could be updated monthly and would not present an administrative problem for the staff. D. Vanderhoof suggested that interested parties be directed to brokers as well as to tax consultants, accountants, and carriers. The Executive Director noted that the reference to a person's ability to draw on the account to pay for non-qualified benefits be removed, as the tax benefit is not available for such withdrawals. B. Markowitz asked if the insert could list "qualified medical expenses." The Board agreed that the insert should not provide that level of detail. E. Wilmer suggested that the term "account" be removed when referring to the 750,000 participant limit. L. Glover asked staff to redraft the insert and to present it to the Board at the next meeting.

The Assistant Director reported that the Committee also discussed the development of 1997 premium comparison surveys. He noted that carriers were required to file premium information with the Department by November 1, 1996 for rates effective January 1, 1997. He reported that the Committee recommended that the survey delete information about the $20 HMO copay and, if necessary, the $5 HMO copay to make room for information about HMO/POS plans. He reported that the Committee also discussed the possibility of publishing only one survey, rather that surveys for three counties. He reminded the Board that the Department had collected premium information for three counties since some HMOs did not have approved service areas in certain counties. The result, he reported, was that persons for the other 18 counties often ask for information for those other counties. The Executive Director noted that the purpose of the surveys was to provide small employers with a relative pricing tool. Some Board members noted that there may be some value in publishing all three since the relative prices of the carriers would likely differ depending on the region. After some discussion, the Board asked Jim Gorman of Wenzel & Company to provide the Board with information about the cost savings of publishing only one report.

The Assistant Director reported that the Committee also reviewed the performance of Wenzel & Company. The Executive Director noted that the Committee was pleased by Wenzel & Company's performance, asked Wenzel to continue to provide the same good service in the future, and asked Wenzel & Company for input on how the Board may better target its audience.

VII. Report of the Executive Director

The Executive Director presented an expense report attached hereto as Exhibit 2. He noted that the expense for Legal Services from the Division of Law was $6000 below budget, on a quarterly basis.

** L. Moskowitz made a motion to accept the attached expense report. J. Fiedler seconded the motion, and the motion was approved unanimously by voice vote. [Met 2/3rds supermajority requirement.]*

The Executive Director reported that the audit was stalled in order to investigate the difference in the Board's accounts as recorded by the Department and as recorded by the Board. A. Mansue asked if the discrepancy was significant enough to investigate. The Executive Director noted that it was about an $8000 difference out of a yearly budget of $500,000.

The Executive Director reported that he had put a posting with State offices, three newspapers and an accounting journal announcing the accounting position.

The Executive Director provided the Board with a spreadsheet on the 1996-97 assessment. He said the assessment included a reconciliation of the 1994 and 1995 assessments, based on actual spending, actual 1996 spending and projected fiscal year 1997 spending.

The Executive Director reported that he testified before the Senate Commerce Committee on November 25, 1996 concerning S-1523 and the Assembly Insurance Committee on November 9, 1996 concerning A-2261. He reported that after the Assembly meeting he spoke with Blair Childs of the Americans for Responsible Reform ("ARR"), the sponsor behind the bill. The Executive Director said that Mr. Childs suggested that the Executive Director's testimony and comments were deceptive. The Executive Director invited the ARR to copy the Board's enrollment data and offered to comment on the ARR's information distributed to Legislators and others. After two requests by ARR for comments, the Executive Director wrote a letter to Mr. Childs commenting on ARR's materials and copied members of the Assembly and Senate Committees, the Commissioner, and the Board. The Executive Director indicated that he had not received a response from ARR. L. Ilkowitz commented that the letter was an excellent response to the Washington-based group. A. Mansue suggested that the Executive Director share the letter with the Legislative leadership too. L. Moskowitz asked if ARR had ever identified its source of funding. The Executive Director responded that he had no information on the group's funding, but indicated that his letter requested that information. The Executive Director reported that the hearings were very well attended and referred to press clippings covering the hearings.

With respect to outreach, the Executive Director reported that he had filmed a segment for New Jersey Network. B. Markowitz commented that he saw the clip. The Executive Director reported that he also filmed a clip for CNN Newsmakers broadcast on the Comcast Cable system to 1.2 million homes. He reported that he was filmed on New Jersey Journal, a show on the Philadelphia Fox station, with Sen. Matheussen and Bart Carter, a New Jersey broker, which was scheduled to air on January 5, 1997 at 8:00 a.m. D. Vanderhoof indicated that he would attempt to get some air time for the SEH Program on WMTR radio.

The Executive Director reported that the staff had received a large number of calls from consumers complaining about rate increases in their nonstandard plans issued by John Alden, and the fact that the plans added maternity coverage when they did not want such coverage. The Executive Director reported that John Alden had not filed rates for its nonstandard plans with maternity coverage incorporated in the plans, but rather used their filed rates for maternity coverage as a rider, thus creating steep increases in premium. The Executive Director sent a letter to Legislatures to assist their offices in handling these calls.

VIII. Report of the Legal Committee

The Executive Director reported that the SEH Program Legal Committee met, via telephone conference, on December 17, 1996. He indicated that the first issue discussed was whether carriers should pay benefits for hospital charges consistent with the Prevailing Healthcare Charges System Profile ("PHCS"). He noted that Committee members expressed concerns about having a measurement for the payment of benefits that differed from the individual market. The Committee also voiced concerns that the information set forth in the PHCS database for hospital charges may not have sufficient detail to provide carriers with a basis for paying benefits. Lastly, the Committee had concerns that the PHCS database may not have sufficient data to provide reliable information about charges in New Jersey. He reported that the Committee's recommendation was to defer a decision on the matter until it received more information from HIAA on the database for hospital charges. The Committee further recommended that the staff do a survey of how carriers were paying benefits for hospital charges. L. Moskowitz commented that when the Program started in 1994 it made sense to standardize payments based on the PHCS, but based on changes in the market brought about by increased coverage under managed care plans, use of the PHCS may be no longer wise. He suggested that a committee be formed to investigate this issue. N. Fiorentino informed the Board that Pam Dickson would be leaving the DOHSS, but that other persons at DOHSS could participate in the committee. L. Moskowitz asked staff to set up a meeting with Finance Committee members and DOHSS personnel. The Board agreed that the current complaint should be remanded back to the Legal Committee for a decision based on the Board's current regulations.

The Executive Director reported that the second issue addressed by the Committee was whether the SEH Board had the regulatory authority to limit or deny credit for "qualifying previous coverage" toward a preexisting condition limitation period if a "late enrollee" is still eligible to be covered under his or her existing plan. He reported that the Committee concluded that the answer was that it did not have such authority. D. Vanderhoof noted that his concern was that an individual could select against the standard plans by deciding when to switch to a small employer's plan. L. Moskowitz shared his concern that by permitting individuals to select when to participate in the small employer's plan raised underwriting concerns. A. Mansue indicated that the statute appeared to be clear that credit must be provided for prior coverage for late enrollees. The Assistant Director noted that the Health Insurance Portability and Accountability Act of 1996 may also require that credit be provided to late enrollees for prior coverage. The Board remanded the issue back to the Committee for further consideration in light of the underwriting concerns raised by the Committee's conclusion.

[J. Donnellan arrived.]

The Executive Director reported that the Committee considered the issue of whether an HMO should determine rates for a standard HMO/POS contract based on the location of the insured's PCP. He noted that N.J.A.C. 11:21-7.15 states that "[a] carrier shall determine which territory applies to a small employer on the basis of the address of the small employer's principal place of business." He reported that the Committee's conclusion was that if the issuing entity issues a plan to a New Jersey small employer for an out-of-State employee through that entity's affiliate in another state, then the plan issued for the out-of-State employee may be rated on a basis other than "the address of the small employer's principal place of business." L. Moskowitz was concerned that the issue was discussed without the benefit of input of DOBI actuaries. Further, he was concerned that the conclusion was permissive, that an HMO "may" be rated on a basis other than the location of the group. The Board asked that the issue be remanded to the Legal Committee for further consideration and that DOBI actuaries participate in the discussions.

The Executive Director reported that the Committee discussed the draft rule adoption, with proposed responses to comments received from Blue Cross and Blue Shield of New Jersey and First Option Health Plan. The draft rule adoption was primarily to bring the SEH Program regulations in line with the amendments to the SEH Act, P.L.1995, c.298 and P.L.1995, c.340. He reported that the Committee's recommendation was to approve the draft adoption. The Assistant Director provided some background on the adoption and discussed a few of the responses.

* *L. Moskowitz made a motion to adopt the draft rule adoption. A. Mansue seconded the motion, and the motion was approved unanimously by voice vote.*

IX. Other Matters

L. Glover thanked P. Dickson for her service to the Board. M. Willoughby announced that she would not be running for reelection for the Board, and said that she had enjoyed her seven years working on health care reform in New Jersey. The Board thanked M. Willoughby for her service.

The Executive Director referred to a staff evaluation form and asked Board members to respond by the next Board meeting.

The Board asked J. Donnellan for background on the issue of whether carriers should be required to collect a copayment for non-prescription supplies. He indicated that because HMOs have contracts with pharmacies, it may be difficult for some HMOs to collect a copayment. After some discussion, the Board agreed that the forms should be modified to create standardized options to permit copayments. It was further agreed that the SEH Buyer's Guide should make this option clear.

IX. Close of Meeting

* *A. Mansue made a motion to close the meeting. J. Fiedler seconded the motion, and the motion was approved unanimously by voice vote*