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 January 22, 1997

Members present: Gale Simon/Bob Vehec, *Vice Chair* (DOBI); James Donnellan (Prudential); Justin Fiedler (BCBSNJ); Charlotte Furman (Anthem Health and Life); Eileen Gallagher (NYLCare); Linda Ilkowitz (Guardian); Amy Mansue (HIP of New Jersey); Bryan Markowitz; Michele O'Doherty (Celtic Life); Dutch Vanderhoof.

Others present: Wardell Sanders, SEH Program Assistant Director; DAG Josh Lichtblau (DOL).

I. Call to Order

The Assistant Director 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 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

** A. Mansue made a motion to approve the draft minutes of the December 18, 1996 Board meeting, as amended. C. Furman seconded the motion, and the motion was approved unanimously by voice vote.*

[B. Markowitz and D. Vanderhoof arrived]

IV. Report of the Policy Forms Committee

The Assistant Director reported that the Policy Forms Committee had met on January 15, 1997 to review optional benefit rider filings and other matters. The Assistant Director described the riders submitted and referred to recommendations of the Committee which are set forth in Exhibit 1.

** L. Ilkowitz 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. J. Fiedler seconded the motion, and the motion was approved by voice vote, with M. O'Doherty abstaining.*

** J. Donnellan 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 find the filing complete and in substantial compliance. C. Furman seconded the motion, and the motion was approved by voice vote, with M. O'Doherty abstaining.*

The Assistant Director reported that First Option had submitted a revised vision rider as requested by the Board. The revised rider had removed a description of a discount for certain vision benefits. No action was required by the Board.

** A. Mansue made a motion to accept the recommendation of the Policy Forms Committee with respect to the optional benefit rider filing from **Fortis**, listed on Exhibit 1 as rider 1, to find the filing incomplete and not in substantial compliance. J. Donnellan seconded the motion, and the motion was approved by voice vote, with M. O'Doherty abstaining.*

** E. Gallagher made a motion to accept the recommendation of the Policy Forms Committee with respect to the optional benefit rider filing from **Fortis**, listed on Exhibit 1 as rider 2, to find the filing incomplete and not in substantial compliance. C. Furman seconded the motion, and the motion was approved unanimously by voice vote, with M. O'Doherty abstaining.*

The Assistant Director reported on the progress of the development of a dual contract. He reported that Ellen DeRosa had completed work on the underlying HMO contract and that changes had been made to incorporate COBRA changes required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), State statutory requirements, and modifications that were incorporated in developing the Board's HMO/POS contract. He noted that she was turning her attention on the standard indemnity forms, and would then proceed to develop linking language. L. Ilkowitz informed the Board that the Assistant Director had sent a letter to CIGNA, a carrier that is interested in marketing a dual contact, outlining the proposed structure of the standard dual contract. She reported that CIGNA had informed her that it supported the proposed structure for the plan. L. Ilkowitz noted that it was the Board's intention to proceed with the drafting of the dual contract in an expedited fashion.

The Assistant Director reported that the Committee had considered whether the Board should begin drafting changes to the standard HMO and HMO/POS contracts to provide for some level of direct access to specialists. The Committee, noting the present workload for Ellen in redrafting the forms, recommended that the Board not make

changes to permit open access to specialists under the standard forms at this time. The Assistant Director also reported that the Department had approved Physicians Health Services open access rider. A. Mansue indicated that as long as the Board and the Department were willing to permit open access riders in the small employer market, that there would be no need to propose alternate language in the standard forms for open access to specialists at the present time. After some discussion, the Board agreed.

V. Legislative Report

B. Markowitz reported that the Assembly Insurance Committee held a hearing on January 9, 1997 to consider A-2261, a bill which would allow nonstandard plans in the individual market, reduce the permissible stop loss attachment points, permit self-employed individuals to participate in the small employer market, and would eliminate the assessment mechanism. The hearing lasted until 6:15 p.m. He reported that the only witnesses that were called were those speaking in favor of the bill. The Assistant Director reported that the Executive Director was present and had intended to speak in opposition to the bill, but was never called to testify. B. Markowitz reported that it was his understanding that there was not enough support for the bill to be reported out of Committee. A. Mansue noted that she believed that there was no visible support in the Senate for the bill. G. Simon reported that the Commissioner had forwarded her recommendations for modifications to the individual market to the Governor's Office.

G. Simon also noted that the Department was continuing to work on statutory changes necessary to conform State law with the HIPAA. She further noted that the Assistant Director would be compiling a filing on behalf of the Department for submission to the federal government for an alternate State mechanism in the individual market. The Assistant Director reported that he was also drafting amendments to the small employer and individual statutes, and that he would provide a copy of the drafts to the Boards when completed.

VI. Report of the Assistant Director

The Assistant Director reported that he had sent absentee ballots to carriers for the three Board seats up for election at the February 19, 1997 meeting. He reported that nominations had been received for Jim Leonard, Curtis Macysyn, and Kevin Monaco for the seat of a person representing small employers, and for Anthem Health & Life, Celtic Life, Garden State Hospitalization Plan, Oxford Health Insurance, and United States Life for the two seats for a carrier whose principal insurance business is in the small employer market.

The Assistant Director reported that the Board packets included a list of riders of decreasing value approved by DOBI. J. Fiedler asked that the Board be provided a copy of the DOBI list as part of its monthly Board packets. L. Ilkowitz asked G. Simon about one of the riders on the list to see if it was consistent with the requirement that plan not

have a coinsurance differential of greater than 30 percent. G. Simon agreed to look into the matter.

The Assistant Director referred to a draft insert for the SEH Buyer's Guide which provided guidance to consumers on MSAs. Board members made comments to the draft. The Assistant Director asked Board members to provide him with any additional comments within one week. The Board members agreed that completion and publication of the insert should not be delayed until the next Board meeting.

With respect to outreach, the Assistant Director reported that he spoke on December 12, 1996 to the Monmouth/Ocean County Chapter of the New Jersey Association of Health Underwriters, and on January 21, 1997 to the Northwest Jersey Chapter of the Association of Health Underwriters. He reported that he also appeared as a guest on WMTR radio on a show entitled "For Your Benefit" on January 7, 1997.

Lastly, the Assistant Director reported that the Board packets included a copy of a letter from a Dr. Robert Olick, a doctor/attorney, and medical ethicist, who had provided suggested modification to the IHC HMO contract's provisions regarding refusal of treatment. He noted that Ellen DeRosa was incorporating some of the comments from the letter in her review of the SEH HMO contract. J. Donnellan cautioned that the IHC Board's language was the result of a compromise of many different perspectives and that the IHC may not have accepted all of the suggested modifications. He urged that the Board consider the letter carefully and noted that it may be wise to have the IHC forms mirror the SEH forms.

VII. Report of Wenzel & Company

J. Gorman reported on the cost of printing three surveys versus printing one survey. He noted that since the content of the guides differed, there would be no economy of scale, and in effect, that printing three different guides would cost three times as much as printing one guide. He further noted that rates for Bergen County captured nearly all of the HMOs in the market.

A. Mansue suggested that the issues raised should be considered by the Marketing Committee before they are brought to the Board. The Assistant Director agreed to arrange for a Committee meeting prior to the next Board meeting.

VIII. Report on behalf of the Executive Director

The Assistant Director presented an expense report attached hereto as Exhibit 2.

** J. Donnellan 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 Assistant Director reported that the audit was still being held up over reconciling the DOBI's cash balance with the Board's book balance. L. Ilkowitz asked what was causing the delay. J. Donnellan noted that L. Moskowitz had agreed to seek a resolution of the matter. A. Mansue noted that the State budget process had begun, resulting in time restraints for certain state employees. She further indicated that while reconciling the books was an important goal, there comes a time when it may be important to forget about the reconciliation and to accept the audit without the reconciliation.

The Assistant Director reported that the Executive Director had placed advertisements in three newspapers for an accountant, and had posted notices in State offices. He reported that the response was overwhelming, with over 100 responses received.

IX. Report of the Legal Committee

The Assistant Director reported that the Legal Committee met, via telephone conference, on January 17, 1997 and discussed a number of issues.

He reported that the first issue discussed was whether carriers in the small employer market should be paying benefits for hospital charges consistent with the Prevailing Healthcare Charges System Profile. This question had arisen based on a complaint filed with the DOBI. He noted that the SEH Finance Committee had met and recommended that the DOBI require the carrier in question to pay either actual charges or consistent with the HIAA database as set forth in N.J.A.C. 11:21-7.14. The Finance Committee further recommended that the regulation be modified to explicitly state that balance billing is not permitted. The Legal Committee agreed with the recommendation of the Finance Committee, but added that the Finance Committee should expeditiously determine whether the HIAA hospital profile is workable and, if not, what alternative profile should be used. J. Donnellan noted that the Finance Committee had not made a determination of whether the HIAA database provided a sound basis for paying benefits. He further noted that most carriers are paying either a negotiated rate or based on actual charges. G. Simon recommended that the DOBI proceed against the carrier based on the recommendation of the Committees, and further recommended that a bulletin be sent to carriers reminding them of the Board's regulation with respect to the payment of benefits. The Board agreed that a bulletin was appropriate.

The Assistant Director reported that the second issue discussed 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 agreed that, pursuant to the SEH Act, there is no legal basis for limiting or denying credit for qualifying previous coverage toward a pre-x period applicable to a late enrollee. Moreover, the Committee noted that HIPAA would likely prevent the Board from seeking statutory changes to its law to deny credit for qualifying previous coverage to late

enrollees. D. Vanderhoof asked what would happen if the previous coverage did not provide benefits for the preexisting condition. The Assistant Director advised that the Legal Committee did not discuss the issue of a benefit-for-benefit comparison.

[B. Vehec replaced G. Simon as the DOBI representative]

The Assistant Director reported that the third issue discussed was whether an HMO may 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." The Assistant Director reported that the Committee clarified that its recommendation was that the rates for a standard HMO or standard HMO/POS contract must be based on the location of the small employer as stated in N.J.A.C. 11:21-7.15, but that an approved out-of-State plan issued by an HMO to out-of-State employees of a New Jersey small employer would not be subject to N.J.A.C. 11:21-7.15, and thus may be based on the location of the insured's PCP. After some discussion, the Board agreed with the Committee's analysis.

The Assistant Director reported that the fourth issue discussed by the Committee was whether an eligible employee serving an employer's waiting period (as specifically permitted pursuant to N.J.A.C. 11:21-7.9(c)), would be counted for purposes of determining the size of the group, and whether they would be counted against the employer for purposes of meeting the carrier's participation requirements. The Committee concluded that an employee serving under a waiting period would be counted as an "eligible employee" for purposes of determining the size of the group, and would be counted as an eligible employee not "participating" under the plan for purposes of meeting the carrier's participation requirements. A. Mansue noted that the goals of the statute should be remembered, and that an employer could always waive its waiting period. L. Ilkowitz asked about the application of HIPAA to this issue. The Board agreed that the Assistant Director should look into this matter in his analysis of HIPAA.

The Assistant Director reported that the fifth issue discussed was whether a carrier may request tax information for groups of 2-5 eligible employees but not for groups of 6-49. He reported that the Committee concluded that a carrier may collect tax information as it sees fit. However, a carrier may not use the collected information for an inappropriate purpose. J. Donnellan noted that inappropriate use of tax information should be a market conduct issue. The Board agreed that it should monitor how carriers were using tax information.

The Assistant Director reported that the sixth issue discussed was whether "brother-sister controlled groups" meet the definition of "affiliated companies" under N.J.A.C. 11:21-7.2. He reported that the Committee concluded that the Board may not give out advice on a case-by-case basis as to whether a group meets the regulatory definition of an "affiliated company." The regulation, the Committee believed, provided the necessary guidance.

X. Executive Session

** C. Furman made a motion to move into executive session for the purpose of discussing personnel matters. L. Ilkowitz seconded the motion, and the motion was approved unanimously by voice vote.*

The Assistant Director announced that there would be no matters for discussion after the executive session.

Board staff were not present during the executive session.

XI. Close of Meeting