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 February 19, 1997

Members present: Larry Glover, *Chair*; Leon Moskowitz/G. Simon, *Vice Chair* (DOBI); James Donnellan (Prudential); Justin Fiedler (BCBSNJ); Nan Fiorentino (DOHSS); Charlotte Furman (Anthem Health and Life); Linda Ilkowitz (Guardian); Amy Mansue (HIP of New Jersey); Bryan Markowitz; Michele O'Doherty (Celtic); Sherrie Price (NYLCare); 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

The Executive 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. Election of Board Members

The Assistant Director announced that there would be an election for three Board seats. He announced that carriers on the Board or in the audience could provide in-person ballots for the election. He indicated that the results of the election would be announced at the end of the meeting.

IV. Minutes

** D. Vanderhoof made a motion to approve the draft minutes of the January 22, 1997 Board meeting, as amended. C. Furman seconded the motion, and the motion was approved unanimously by voice vote.*

V. Report of the Policy Forms Committee

The Assistant Director reported that the Policy Forms Committee had met on February 11, 1997 to review optional benefit rider filings and other matters. The Assistant Director described the rider submitted.

** L. Moskowitz made a motion to accept the recommendation of the Policy Forms Committee with respect to the optional benefit rider filing from* ***First Option*** *(providing that covered charges incurred in the last three months of a calendar year would be applied toward the following year's cash deductible) to find the filing complete and in substantial compliance. D. Vanderhoof seconded the motion, and the motion was approved unanimously by voice vote.*

The Assistant Director reported that the Policy Forms Committee reviewed the draft policy form changes for both the indemnity plans and the HMO and HMO/POS plans set forth in Ellen DeRosa's package of materials dated January 24, 1997 and agreed with most of the changes set forth in the draft. The Assistant Director identified the significant items discussed by the Committee and items which required changes from Ms. DeRosa's original draft. With respect to the standard indemnity forms changes, the Assistant Director reported:

- The Committee noted that the clarifications to the Medicare Alternate Deductible in which there is a Coordination of Benefits rather than a "carve out," be explained clearly in the rule proposal so that carriers understand how to treat expenses incurred by a covered person who is eligible for or entitled to Medicare Parts A and B.
- The Committee discussed the inclusion of language concerning plan transfers in the "Incontestability" provision of the policy. After some discussion. the Committee recommended that the language be removed.
- The Committee recommended that the dependent participation provision be removed from the forms consistent with the Board's prior decision to prohibit dependent participation requirements.
- The Committee recommended that the language in the provision regarding contribution requirements be modified to remove the distinction between contributory plans and noncontributory plans.
- The Committee discussed whether there should be coverage for non-accidental injuries, such as injuries sustained in a suicide attempt. The Committee agreed to take the issue to the Board.

With respect to the issue of dependent participation, L. Moskowitz asked if the Board had in fact decided to prohibit carriers from using a dependent participation requirement. After some discussion, the Board noted that it had determined that the law did not permit carriers to use of a dependent participation requirement. The Board noted that the prohibition on the use of a dependent participation requirement applied to all carriers, not merely indemnity carriers. The Board noted that carriers may not have been aware that the Board had concluded that dependent participation requirements could not be used. After some discussion, the Board agreed that a bulletin should be issued to carriers informing them that dependent participation requirements would be prohibited beginning for new issues and renewals occurring on or after June 1, 1997.

The Board discussed whether there should be coverage for non-accidental injuries, such as suicides. C. Furman noted that it did not seem prudent to provide coverage to a person who was injured while engaged in illegal conduct, such as a person who became ill as a result of the illegal use of cocaine. After some discussion, the Board agreed that references to "accidental" injuries be removed. E. DeRosa noted that the plans did include an exception for injuries sustained while committing a felony (See exclusion in contracts for "[S]ervices or supplies because the Covered Person engaged, or tried to engage, in an illegal occupation or committed or tried to commit a felony.")

With respect to the standard HMO contract, the Assistant Director reported:

- The Committee noted that the definition of "emergency care" contained in the new HMO regulations may require a modification to the standard HMO contract.
- The Committee discussed the inclusion of new text regarding the refusal of treatment. The text had been added by the Assistant Director to address the concerns of a medical ethicist, as set forth in a letter to the IHC Board in 1994 (a copy was distributed to the SEH Board during the January 1997 meeting). J. Donnellan noted that the new text did not mirror the language that the IHC Board finally adopted for its HMO contract. He recommended, and the Committee agreed, that the compromise language developed by the IHC Board be used in the SEH contract.

The Assistant Director reported that the Policy Forms Committee considered draft linking language to the standard A through E plans and the HMO plan set forth in Ellen DeRosa's package of materials dated January 24, 1997 and agreed with most of the changes set forth in the draft. The Assistant Director identified the significant items discussed by the Committee and items which required changes from Ms. DeRosa's original draft.

- C. Furman noted that the explanation of brackets should make clear that a carrier may not use an indemnity plan sold through or in conjunction with a selective contracting arrangement as the "indemnity" part of a dual contract. The Committee agreed with her recommendation.

- The Committee noted that the HMO interaction language in the indemnity plans would need to be modified in light of the dual contract arrangement where an employee would be both a certificateholder under an indemnity contract and an evidence of coverage holder under an HMO policy certificate.

The Assistant Director reported that the Committee also considered amendments to the application form. The revised draft would permit, but not require, an HMO and affiliated non-HMO carrier to use a single application form.

The Board discussed the timing of the forms changes for new issues and renewals. The Board also discussed whether carriers would be required to reissue plans or whether they could accomplish changes through the use of a compliance and variability rider. C. Furman and L. Ilkowitz noted that reissuing plans could be an expensive process for some carriers. The Board also discussed the impact of the Health Insurance Portability and Accountability Act of 1996 on the standard forms. After some discussion, the Board agreed that the Policy Forms Committee should address implementation issues for the forms changes.

** D. Vanderhoof made a motion to approve for proposal the draft changes to the policy forms and application. L. Moskowitz seconded the motion, and the motion was approved unanimously by voice vote.*

VI. Report of the Marketing Committee

The Executive Director reported that the Committee met via telephone conference on January 30, 1997. The first issue discussed was the creation of the premium comparison survey. He noted that the publication of three 1996 premium surveys for three counties created confusion. He reported that the Committee concluded that it would be less costly and less confusing to publish one set of rates, and that this could be accomplished easily since all HMOs reported rates for Bergen County.

** M. Willoughby made a motion to publish a single premium comparison survey with rates based on employers located in Bergen County. J. Fiedler seconded the motion, and the motion was approved unanimously by voice vote.*

The Executive Director reported that the Committee recommended that the 800 number for the SEH Buyer's Guide be listed in the "Blue Pages" under the Department of Banking and Insurance. He reported that the cost of publishing the number would be about $400 per year.

** L. Ilkowitz made a motion to approve the expenditure of funds to publish the 800 number for the Buyer's Guide in the "Blue Pages" of New Jersey telephone books. D. Vanderhoof seconded the motion, and the motion was approved unanimously by voice vote. [Met 2/3rds supermajority requirement]*

VII. Report of the Assistant Director

The Assistant Director reported the results of the election for the three Board seats. The totals are set forth below, winners in bold.

Name	Votes
Small Employer Representative	
Jim Leonard	12
Curtis Macysyn	2
Kevin Monaco	8
Small Employer Carrier	
Anthem	12
Celtic	11
Garden State	4
Oxford Insurance	6
U.S. Life	10

The Assistant Director reported that the Board packets included a list of riders of decreasing value approved by the Department of Banking and Insurance. He indicated that he would include this report in all future Board packets.

The Assistant Director referred to draft bulletin 97-SEH-01 addressing the payment of benefits under the standard small employer health benefits plans. He asked for comments by February 26, 1997. A. Mansue provided some clarifying comments to the draft bulletin.

The Assistant Director reported that the Board packets included a list of carriers that had filed Exhibit BBs with the Board. He noted that Americaid of New Jersey HMO had been added to the list. He also reported that the Department of Banking and Insurance had received a notice of withdrawal from John Alden. L. Ilkowitz noted that John Alden was also withdrawing from other states' small employer markets.

Lastly, the Assistant Director reported that the MSA insert for the SEH Buyer's Guide had been completed and was being distributed through the 800 number.

VIII. Report of the Executive Director

The Executive Director presented an expense report attached hereto as Exhibit 1.

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

The Executive Director reported that progress had been made toward completion of the audit. He noted that the Department of Banking and Insurance had provided information necessary for the completion of the audit to the Executive Director.

The Executive Director reported that most carriers had responded to their assessment bills. He reported that the Board had received over $500,000 in payments. He noted that when the audit is finalized, he will be ready to recommend refunds.

The Executive Director reported that the Assembly Insurance Committee had scheduled a hearing on Assembly Bill 2661, but that the hearing was cancelled. He reported that there was a new substitute being drafted and that he had not seen the draft. He reported that he had heard that the bill would: not allow one life groups in small group market; provide the Commissioner with the authority to lower stop loss retention limits; modify the assessment mechanism; remove the Commissioner's discretion to mix the experience of association and non-association plans together for rating and loss ratio purposes; move to modified community rating in the individual market; and modify the loss ratio rules to consider additional items as "benefits."

D. Vanderhoof asked if the Commissioner's recommendations on amendments to the IHC Act had been made public. G. Simon noted that the recommendations were currently at the Governor's office.

The Executive Director reported that the Department of Banking and Insurance had filed a letter with the federal government that it intended to file an alternative mechanism for its individual market pursuant to HIPAA.

The Executive Director reported that he was in the process of interviewing applicants for the accounting position. He noted that he had received over 100 applications and had interviewed about 12 individuals. He indicated that he hoped to select someone in the next two weeks. He noted that the Board had previously approved the funding for the position.

With respect to outreach, the Executive Director reported that he would be meeting with a representative of the Urban Institute, a Washington, D.C.-based research group, on New Jersey's health insurance reforms. He also said he would be speaking in March to the Life Underwriters of Southern New Jersey, and two physicians groups at the Commissioner's request.

IX. Report of the Legal Committee

The Executive Director reported that the Legal Committee met via telephone conference on February 14, 1997. The first issue discussed was whether a terminated employee would be eligible for State continuation if there were no longer any persons covered under the plan as employees. For example, in the context of a 3 person group, with one employee covered under the plan and two valid waivers, if the one person

covered under the plan was terminated, could he/she elect State continuation? The Executive Director reported that the Committee examined that language of N.J.S.A. 17B:27A-27d(1), and whether that provision would permit or prohibit continuation under the circumstances described above. The Committee concluded that the statute would not require a carrier to provide continuation under the circumstances described in the question. The Executive Director noted that staff consideration of the issue after the Committee meeting, which took place with additional information, may have an impact on the Committee's conclusion.

** A. Mansue made a motion to remand the issue back to the Legal Committee for further consideration. J. Fiedler seconded the motion, and the motion was approved unanimously by voice vote.*

The Executive Director reported that the Committee considered whether New Jersey continuation would require continuation of other types of coverages, such as stand alone dental coverage? The Committee concluded that the State continuation provision of the law set forth at N.J.S.A. 17B:27A-27 permitted only the continuation of health benefits plans. D. Vanderhoof asked if dental riders could be continued. The Board agreed that any approved rider to a health benefits plan would be subject to State continuation provisions.

The Executive Director reported that the Committee had considered a letter from a carrier asking the Board to reconsider its position that a small employer may purchase multiple plans from the same carrier. The carrier noted that employees who have the opportunity to chose either an HMO or an HMO/POS plan will chose the HMO/POS plan only if they expect to use out-of-network benefits. The carrier noted that the increased out-of-network usage would increase the cost of the HMO/POS plan. The Executive Director reported that the Committee concluded that the legal analysis remained the same, however, the Board may reconsider the policy issue of whether employers should be permitted to purchase multiple plans. L. Ilkowitz asked that the Board reconsider whether to make multiple plan offerings permissive. A. Mansue opposed the suggestion noting that the restriction did not make sense in a guarantee issue environment. She further noted that an action by the Board to restrict employer access to multiple plans and multiple delivery systems would not be viewed favorably by the Legislature or small employers.

The Executive Director reported that the Committee considered whether the rules regarding the replacement of health benefits plans, set forth at N.J.S.A. 17B:27A-50, apply to persons who want to replace their existing coverage with a high deductible plan for use with a MSA? He noted that a carrier had asked that, if the requirement applied, could there be a waiver for employers wishing to take advantage of the tax advantages of the federal law as has been permitted in the individual market. He reported that the Committee concluded that the statutory requirement referenced above applies to all health benefits plans, including high deductible plans used in conjunction with an MSA. The Board, therefore, cannot issue a waiver that would be contrary to this clear statutory

language. Accordingly, the Committee believed that the Board must not take the action requested.

G. Simon raised an issue regarding the filing of nonstandard riders of decreasing value with the Department of Banking and Insurance. She noted that the Department had approved riders to create high deductible plans that would qualify for the tax advantages under the federal law if used in conjunction with a qualified Medical Savings Account (MSA). She indicated that the Department's approval of such riders did not condition the issuance or renewal of the high deductible plans on the obtaining a qualified MSA. The Board asked if the Department of Banking and Insurance would approve all riders increasing the deductible on the standard plans. G. Simon indicated that there would be some limitation on the level of deductibles, and that all riders would be subject to the Commissioner's review to determine, on a case-by-case basis, if they should be disapproved for one of the reasons set forth in statute.

The Executive Director thanked Melanie Willoughby for her work for the SEH Program. He noted that she had served on the Board since its inception in 1993.

X. Executive Session

** M. Willoughby made a motion to move into executive session for the purpose of discussing enforcement actions and discussing possible litigation matters. D. Vanderhoof seconded the motion, and the motion was approved unanimously by voice vote.*

[J. Donnellan left the meeting]

XI. Assessment Appeals

** D. Vanderhoof made a motion to deny the Pension Life Insurance Company of America's appeal of its assessment. M. Willoughby seconded the motion, and the motion was approved unanimously by voice vote.*

** M. Willoughby made a motion to approve the Business Men's Assurance Company of America's appeal of its assessment. D. Vanderhoof seconded the motion, and the motion was approved unanimously by voice vote.*

XII. Close of Meeting

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