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
June 18, 1997

Members present: Jane Majcher, *Vice Chair* (DOBI); Justin Fiedler (BCBSNJ); Charlotte Furman (Anthem Health and Life); Eileen Gallagher (NYLCare); Linda Ilkowitz (Guardian); Amy Mansue/Karen Dickensen (HIP of New Jersey); Bryan Markowitz; Leon Moskowitz, (DOHSS); Dutch Vanderhoof; Eric Wilmer (Celtic Life).

Others present: Wardell Sanders, *Interim Executive Director*; Ellen DeRosa, *IHC Program Assistant Director*; Pearl Lechner, *Program Development Assistant*; DAG Josh Lichtblau (DOL).

I. Call to Order

The Interim Executive Director called the meeting to order at approximately 9:45 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.

The Interim Executive Director announced that Jim Donnellan was leaving Prudential and as a result could no longer participate as the Prudential representative on the SEH Board. He read a letter from J. Donnellan. J. Donnellan indicated that Prudential has not yet named his replacement but intended to do so shortly.

II. Minutes

** B. Markowitz made a motion to approve the draft minutes of the June 5, 1997 Board meeting, as amended. A. Mansue seconded the motion, and the motion was approved unanimously by voice vote, with J. Fiedler, C. Furman and J. Majcher abstaining.*

** L. Moskowitz made a motion to approve the draft minutes of the May 21, 1997Board meeting, as amended. L. Ilkowitz seconded the motion, and the motion was approved by voice vote, with J. Fiedler, J. Majcher, and E. Wilmer abstaining, and D. Vanderhoof voting against the motion.*

** A. Mansue made a motion to approve the draft minutes of the June 5, 1997 executive session Board meeting. L. Moskowitz seconded the motion, and the motion was approved by voice vote, with J. Fiedler, C. Furman, J. Majcher, and E. Wilmer abstaining.*

III. Report of the Policy Forms Committee

The Interim Executive Director reported that the Committee met on June 11, 1997 to discuss optional benefit riders and other matters. He described the riders submitted and noted the Committee's recommendations.

He noted that the first filing from AtlantiCare included a rider amending the standard HMO plan by eliminating the Hospital Inpatient Copayment.

** A. Mansue made a motion to accept the recommendation of the Policy Forms Committee to find the filing complete and in substantial compliance. E. Gallagher seconded the motion, and the motion was approved unanimously by voice vote.*

He noted that the second filing was from Mission Health Plans. He noted that the first rider amended the HMO contract by providing for direct access to a Network Specialist Doctor without referral from a member's PCP. L. Moskowitz expressed some concern about the rider such as this which he believed modified the delivery system and indicated that the Departments of Banking and Insurance and Health and Senior Services should review the rider. After some discussion, the Board agreed that the letter finding the filing complete should indicate that the Commissioner of Banking and Insurance has the ability to disapprove any rider that is inappropriate for one of the reasons specified in N.J.S.A. 17B:27A-19i, and that a member of the Board expressed some concern about the rider and that the carrier should consult with the Department of Banking and Insurance before issuing the rider.

** A. Mansue made a motion to accept the recommendation of the Policy Forms Committee, as amended to reflect the Board's concerns, to find the filing complete and in substantial compliance. L. Moskowitz seconded the motion, and the motion was approved unanimously by voice vote.*

He noted that the second rider from Mission Health Plans was similar to the first rider except that it amended the standard HMO/POS plan.

** A. Mansue made a motion to accept the recommendation of the Policy Forms Committee to find the filing complete and in substantial compliance. L. Moskowitz seconded the motion, and the motion was approved unanimously by voice vote.*

The Interim Executive Director noted that E. DeRosa had drafted a bulletin on MSA high deductible riders and had received comments from C. Furman, DAG

Lichtblau, and Joan Fusco from Blue Cross. He noted that the Board packets included a copy of the revised draft. He asked for comments by Friday, June 20th.

The Interim Executive Director reported that the Committee had considered the issue of whether carriers could or should be permitted to use formularies to limit coverage for prescription drugs under the standard A-E health benefits plans, the HMO plans, or the standard optional benefit riders. He noted that the standard health benefits plans provide benefits for prescription drugs so long as they are medically necessary and appropriate and prescribed by a provider acting within the scope of his or her license. The standard forms do not mention the use of formularies. He noted that staff had received inquiries from carriers, brokers, and consumers regarding the use of formularies by several carriers in both the individual and small group markets. G. Simon noted that the DOBI had concerns about the use of formularies in the large group market and had rejected three filings from indemnity carriers in the large group market. The Interim Executive Director noted that the Board had two issues: how to handle existing complaints, and whether to amend its regulations or forms to accommodate formularies. A. Mansue noted that although formularies were being used nationwide, she knew of only one HMO that was approved to use formularies in New Jersey. She suggested and that this may be a different issue under an HMO plan, since PCP under contract with the HMO control the drugs that are prescribed. She further noted that the HMO would allow for use of non-formulary drugs when medically necessary and appropriate. After some discussion, the Board agreed that the Policy Forms Committee, with the addition of a representative from HIP, should meet to do some investigation and help frame the issues for the Board, and that staff should draft a bulletin advising carriers that they are not permitted to use formularies under the standard forms, that the Board was looking at the issue of whether or not they were appropriate, and include a survey with the bulletin.

IV. Report of the Marketing Committee

The Interim Executive Director reported that the Committee met via telephone conference on June 5. He noted that the Committee discussed the distribution of the SEH Buyer's Guide. He noted that the Board had nearly exhausted its supply of Buyer's Guides. He also noted that some carriers and business organizations had requested copies from the Board. He spoke about reprinting the Buyer's Guide, but noted some concern since the Guide would soon become out-of-date as the federal law would come into effect and the Board's policy form changes would come into effect. After some discussion, the Board agreed that it should begin the process of redrafting the Buyer's Guide. The Board also agreed that it was cost effective for the Board to provide business organizations with free copies of the Buyer's Guide, so long as they provided them to their members free of charge. The Board agreed that it should print more Buyer's Guides to last through the end of the year. The Board also agreed that it would permit a carrier to print additional copies of the Buyer's Guide and the Premium Comparison Survey at the carrier's expense so long as the carriers agreed to go directly to the printer to copy the Buyer' not alter the text of the survey in any way; and not copy any portion of the survey in any advertisement or promotional material.

** E. Gallagher made a motion to approve the printing of up to 10,000 Buyer's Guides at a cost of no more than $5000. L. Ilkowitz seconded the motion, and the motion was approved unanimously by voice vote.*

The Interim Executive Director reported that the Committee discussed a need to meet in the near future to discuss marketing goals and to evaluate the work of Wenzel & Company. He reported that the Committee had scheduled a meeting for June 25th and that Wenzel & Company had been asked to give a progress report at the meeting.

V. Report of the Interim Executive Director

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

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

The Interim Executive Director reported that the staff had distributed copies of the Board's community rating study to the Governor and the Legislature as required by law. He noted that the Board's conclusion, based on a survey and historical market data, was that the Board supported the preservation of the current system of modified community rating and eliminating the provision of law that would impose community rating on the small employer market beginning on January 1, 1998.

The Interim Executive Director reported that the Senate Health Committee had voted to report S.2192 to the full Senate. He noted that the bill would make permanent the 2:1 modified community rating in the small employer market, amend the IHC and SEH Acts to conform with HIPAA, modify the individual loss assessment formula, establish a definition of "creditable coverage" consistent with the federal definition so that a person switching from a self-funded or government-funded group health plan to an individual plan would be granted credit toward coverage for a preexisting condition, and provided for market withdrawal in the individual market. B. Markowitz added that Assemblyman Felice had introduced the same bill in the Assembly as A.3115.

The Interim Executive Director discussed a memorandum addressing the Board's participation regulation. The memorandum included a draft survey which attempted to measure carriers' administrative difficulties in complying with the regulation and any adverse selection issues. C. Furman noted that she believed some of the survey's questions would be difficult or impossible for carriers to answer since she suspected that carrier administrative systems would not capture data to enable response. The Board recognized that but believed it important to still ask the questions. The Interim Executive Director asked that Board members contact him with any changes within one week, at which point the survey would be sent to carriers. The Interim Executive Director also

noted that brokers should be encouraged to provide information. L. Moskowitz asked the Interim Executive Director to share the responses with the Marketing Committee.

The Interim Executive Director reported that P. Lechner had developed a draft fiscal year 1998 SEH Program Budget. He noted that she had modeled the budget after previous budgets. P. Lechner discussed each of the lines on the draft budget.

** L. Moskowitz made a motion to approve the draft fiscal year 1998 budget. J. Fiedler seconded the motion, and the motion was approved unanimously by voice vote.*

The Interim Executive Director noted that the enrollment figures for the first quarter of 1997 had not been finalized, but noted that the initial figures showed a significant increase in enrollment.

With respect to outreach, the Interim Executive Director reported that he spoke to the Central Chapter of the New Jersey Health Underwriters. He also reported that E. DeRosa spoke at a conference sponsored by the Alpha Center in Washington, DC.

VI. Report of the Legal Committee

[A. Mansue was replaced by K. Dickensen.]

The Interim Executive Director reported that the Committee met via telephone conference on June 16, 1997. He reported that the first issue discussed was whether the SEH Board must develop a mechanism to provide information from HIAA's "Prevailing Healthcare Charges System Profile" ("PHCS") to consumers and other interested parties. He noted that a law publisher had contacted the Board asking the regulation be modified to provide guidance on obtaining PHCS information. He reported that the Committee instructed the staff to draft amendments to the Board's regulation incorporating the following principles: (1) clarify that the HIAA database is available *to carriers* by contracting HIAA; (2) indicate that carriers must provide the PHCS profile data for a specific "CPT" code to covered persons and the DOBI to the extent that a provider has either recommended or provided a service or supply to a consumer.

The second issue discussed by the Committee was based on a letter from an employee leasing company which asked whether it could offer small group coverage to its employees, and noted that it was aware of other employee leasing companies that offer self-funded plans to their employees, but steers some of its clients with bad health risks to the New Jersey small employer health benefits market. The question raises the issue of how one determines who is the "employer" for purposes of eligibility for health benefits plans where there is an employee leasing company involved. He indicated that the question also raised an enforcement issue. He reported that the Committee concluded that staff should advise the inquirer that an employer must meet the definition of a "small employer," i.e., an employer with from two to 49 eligible employees, to be eligible for

small group coverage. Staff should not be in the role of advising entities as to whether they meet the definition.

The third issue discussed by the Committee was whether the contractual provisions of a health benefits plans have an effect on an employer's ability to modify its waiting period. The Committee noted that the standard health benefits policies and contracts, which include the application form, contain a question that asks the employer to indicate the length of any employee waiting period. The standard forms also contain a provision which states: "This Policy may be amended, at any time, without the consent of the Covered Persons or of anyone else with a beneficial interest in it. This can be done through written request made by the Policyholder and agreed to by [Carrier]." The Interim Executive Director reported that the Committee concluded that the language in the forms may have an impact on an employer's ability to modify its waiting period. Under the standard forms, a carrier is permitted but not required to waive a waiting period prior to anniversary. The SEH Board's regulation which speaks to employer waiting periods, N.J.A.C. 11:21-7.8(c), permits the employer to select the waiting period at the inception and renewal of the plan. Employers always have the option to seek coverage from another carrier without a waiting period. D. Vanderhoof reminded that Board that it recently determined that employees serving a waiting period are "eligible employees" and count against the employer for purposes of meeting a carrier's participation requirements. D. Vanderhoof argued that the Board's regulations and policy forms should be amended to provide better guidance as to when and how an employer could modify its waiting period. The Board agreed and instructed staff to develop revised language.

The Interim Executive Director reported that the third issue discussed was based on a letter from a carrier regarding the Board's regulation regarding the payment of benefits, N.J.A.C. 11:21-7.14. He reported that the questions were as follows: (1) How should a carrier provide benefits for services provided under a new CPT code for which HIAA has not yet published data or for which insufficient data has been received by HIAA? (2) May a carrier adjust the 80th percentile value under HIAA where the carrier's analysis shows that the information in HIAA is inadequate? (3) Since the medical and surgical profiles are updated twice a year by HIAA and on a staggered schedule, does this mean a carrier must update its profiles four different times during the year? (4) "At present, the HIAA PHCS data does not include the HCFA Common Procedure Coding System level II codes for items such as ambulance, medical and surgical supplies, durable medical equipment, etc. HIAA intends to begin producing and publishing these values within the next year. Will these codes then be included as part of the HIAA standard in the regulations?" (5) "HIAA develops values where there are less than 10 data points, but these are not true 80th percentile values. Are we required to use these HIAA values for such outliers?" He report that the Committees conclusions were as follows: (1) Currently, carriers must provide benefits consistent with the Board's regulation. If no CPT Code exists, the carrier must pay actual charges. The Committee recommended that the regulation be further amended to permit carriers to reasonably interpolate a charge based on current CPT codes. (2) Carriers must pay based on the PHCS profile. Carriers are not permitted to impose a reasonableness test on the PHCS

profile. (3) Yes, carriers must update consistent with the Board's regulation. (4) The regulation speaks for itself. Carriers must use the HIAA profiles. (5) The regulation speaks for itself. Carriers must use the HIAA profiles.

The Interim Executive Director reported that the Legal Committee noted that the Board may want to consider evaluating whether to keep the existing standard for the payment of benefits. L. Moskowitz noted that he was not aware of any fee profile that would be more appropriate than PHCS.

VII. Executive Session

** L. Moskowitz made a motion to move into executive session to receive advice from counsel and to discuss enforcement issues. C. Furman seconded the motion, and the motion was approved unanimously by voice vote.*

VIII. Close of Meeting

The Board voted to issue Bulletin 97-SEH-06 on late enrollees with some modifications.

** E. Gallagher made a motion to end the meeting. D. Vanderhoof seconded the motion, and the motion was approved unanimously by voice vote.*