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 October 22, 1997

Members present: Larry Glover, *Chair*; Jane Majcher, *Vice Chair* (DOBI); Karen Dickinson (HIP of New Jersey); Joan Fusco (BCBSNJ); Charlotte Furman (Anthem Health and Life); Eileen Gallagher (NYLCare); Linda Ilkowitz (Guardian); Jim Leonard; Bryan Markowitz; Leon Moskowitz, (DOHSS); Lee Ann Specht (Prudential); Dutch Vanderhoof; Eric Wilmer (Celtic).

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

I. Call to Order

L. Glover 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

L. Glover asked if any person attending the meeting wished to offer any comments. No comments were offered.

III. Minutes

* *L. Moskowitz made a motion to approve the draft minutes of the September 17, 1997 Board meeting, as amended. J. Leonard seconded the motion, and the motion was approved by voice vote, with E. Gallagher and D. Vanderhoof abstaining.*

* *L. Moskowitz made a motion to approve the draft minutes of the September 24, 1997 Board meeting, as amended. L. Ilkowitz seconded the motion, and the motion was approved by voice vote, with B. Markowitz, E. Gallagher, J. Leonard, D. Vanderhoof and E. Wilmer abstaining.*

IV. Report of the Policy Forms Committee

E. DeRosa reported that the Committee met on October 15th and 20th to discuss optional benefit riders and other matters. She described the riders submitted and noted the Committee's recommendations.

A. AtlantiCare

Rider 1: Amends the standard HMO plan, with $15, $5 and $10 copay options to provide a once per 12 month vision exam benefit, subject to the same copayment as the plan being amended, and an allowance of $100 per 24 month period for glasses and lenses.
Recommendation: Complete and in substantial compliance.

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

B. New York Life

Rider 1: Amends POS Plan C with $20 copayment and $1000 deductible, to: allow direct access to network providers; add a copayment limit of $1000/person, $2,000/family; and replace the coinsured charge limit with a $3000/person, $6000/family out of pocket maximum.
Recommendation: Complete and in substantial compliance.

Rider 2: Amends POS Plan C with $15 copayment and $500 deductible, to: allow direct access to network providers; add a copayment limit of $600/person, $1200/family; and replace the coinsured charge limit with a $3000/person, $6000/family out of pocket maximum.
Recommendation: Complete and in substantial compliance.

Rider 3: Amends POS Plan C with $20 copayment and $300 deductible, to: allow direct access to network providers; add a copayment limit of $1000/person, $2,000/family; and replace the coinsured charge limit with a $3000/person, $6000/family out of pocket maximum.
Recommendation: Complete and in substantial compliance.

Rider 4: Amends POS Plan C with $20 copayment and $500 deductible, to: allow direct access to network providers; add a copayment limit of $1000/person, $2,000/family; and replace the coinsured charge limit with a $3000/person, $6000/family out of pocket maximum.
Recommendation: Complete and in substantial compliance.

Rider 5: Amends POS Plan D with $10 copayment and $500 deductible, to: allow direct access to network providers; add a copayment limit of $600/person, $1200/family; and replace the coinsured charge limit with a $1500/person, $3000/family out of pocket maximum.
Recommendation: Complete and in substantial compliance.

Rider 6: Amends POS Plan D with $10 copayment and $500 deductible, to: allow direct access to network providers; add a copayment limit of $600/person, $1200/family; and replace the coinsured charge limit with a $2000/person, $4000/family out of pocket maximum.
Recommendation: Complete and in substantial compliance.

Rider 7: Amends POS Plan D with $20 copayment and $500 deductible, to: allow direct access to network providers; add a copayment limit of $1000/person, $2000/family; and replace the coinsured charge limit with a $1500/person, $3000/family out of pocket maximum.
Recommendation: Complete and in substantial compliance.

Rider 8: Amends POS Plan D with $20 copayment and $500 deductible, to: allow direct access to network providers; add a copayment limit of $1000/person, $2000/family; and replace the coinsured charge limit with a $2000/person, $4000/family out of pocket maximum.
Recommendation: Complete and in substantial compliance.

* *L. Ilkowitz made a motion to accept the recommendation of the Committee to find the filing complete and in substantial compliance. L. Specht seconded the motion, and the motion was approved, with E. Gallagher abstaining.*

C. United Healthcare

Rider: Amends the standard HMO plans to provide open access to all network providers.
Recommendation: Complete and in substantial compliance.

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

E. DeRosa reported that the Committee noted that optional benefit riders found to be complete may require modification as a result of later amendments to the standard health benefits plans. She reported that the Committee recommended that carriers be required to re-file the riders as new optional benefit riders, noting that any change to a filed form created a new form. She indicated that the Committee recommended that carriers should be advised of their responsibility to review previously submitted optional benefit riders and re-file them, as necessary, and that the Board should do a bulletin on the issue. It was noted that there were over 300 riders filed with the Board since 1994,

and that these re-filings will likely result in a substantial amount of work for staff and the Committee. In addition, L. Ilkowitz indicated Board determination letters on rider filings should include a statement that should future modifications to the standard forms impact on previously filed riders, the carrier will be responsible for re-filing the riders.

E. DeRosa indicated that some previously filed riders may have become unnecessary as a result of amendments to the plans. L. Moskowitz indicated that the Board should ask carriers to provide the Board with information about any riders that are no longer being offered as a result of amendments to the standard forms.

E. DeRosa reported that the Committee discussed the effective date of the proposed policy forms changes. She reported that the Committee recommended that the forms be effective for new issues and renewals on or after January 1, 1998, and that carriers be permitted to implement the text prior to January 1, 1998, if the carrier so elects. The Committee suggested that a Bulletin be sent to carriers to advise them of this option. Carriers would not be permitted to use a compliance and variability rider to accomplish the changes.

E. DeRosa reported that the Committee recognized that Exhibit BB, the Certification of Forms Compliance, would need to be revised if the Board adopted the rule proposal amending the policy forms.

E. DeRosa indicated that the Board had received comments on the policy forms rule proposal from two carriers. She provided the Board with a list of the comments and proposed responses approved by the Committee. She asked if the Board had any questions or concerns. D. Vanderhoof asked about a modification to the definition of an "eligible employee" in the employer certification to indicate that the employee must be "paid." It was noted that the purpose of the change was to conform it with the definition set forth at N.J.A.C. 11:21-1.2, and to protect the market from abuse. The Board discussed what would constitute a "paid" employee, and whether an employee could not draw a paycheck and be considered a paid employee. The Board agreed to forward the issue to the Legal Committee for consideration.

B. Markowitz, J. Leonard, and K. Dickinson expressed a concern about the proposal's inclusion of variable text to permit a carrier to continue to use an actively at work requirement as modified to preclude application of the requirement if the reason an employee was not actively at work was a health status-related factor. The proposed amendments had prohibited the use of an actively at work requirement where the reason that a person was not actively at work was due to a health status-related factor, but included variable text to permit a carrier to use an actively at work requirement for non-health status-related factors. The three Board members indicated that it would be unfair to prohibit an employee from enrolling because they were not actively at work because they were on a sabbatical or because they were on jury duty, for example. E. DeRosa noted that the actively at work requirement had always been in the standard health benefits plans, and that the proposed amendments severely restricted its application by

prohibiting the use of the requirement if a person was not at work due to a health status-related factor. She also noted that final federal regulations which have yet to be adopted may provide further clarity with respect to the degree to which an active work requirement may be imposed.

** E. Gallagher made a motion to approve the draft rule adoption of amendments to the standard health benefits plans, and to review further the issue of whether the forms should permit a carrier to use an actively at work requirement for non-health status-related factors. J. Leonard seconded the motion, and the motion was approved with B. Markowitz abstaining.*

V. Report of the Marketing Firm

W. Sanders reported that B. Kapulsky, the account executive for the SEH Board from Wenzel & Co., had left Wenzel & Co. He indicated that Kris Mattson would be the new account representative. He noted that Kris had been the supervisor of both of the previous account representatives from Wenzel and had been intimately involved with the work for the Boards.

K. Mattson reported that her office had written and placed an article titled, "Small Employer Health Benefits Program Ensures Cost-Effective Ways to Insure Small Businesses," in the September 1997 issue of *Mercer Business* magazine, a Mercer Chamber of Commerce publication. She reported that the article was updated and sent to other Chamber of Commerce publications throughout the State, with a personalized letter signed by the Interim Executive Director. She indicated that her office had done work on the Chamber mailing list provided to it to update the list.

K. Mattson reported that she drafted a news release providing information about the SEH Buyer's Guide, Rates Comparison Survey, and WEB site which were mailed to editors of 35 major weekly publications along with a personalized letter from the Interim Executive Director, and mailed only the press release to another 117 weekly newspapers.

She also reported that she and Shirlee Wenzel met with the Interim Executive Director to discuss and prioritize tasks. She indicated that her office was reviewing the Board's WEB site, and that it would begin working on updating the format for the SEH Buyer's Guide. L. Glover asked K. Mattson to provide the Board with a written report for each meeting, and to provide information about upcoming marketing activities. W. Sanders indicated that he would provide Wenzel's written report with all future Board packets.

VI. Report of the Finance and Operations Committee

W. Sanders reported that the Committee met on September 26, 1997 via telephone conference to discuss a number of issues. The first issued considered was a draft management representation letter to Deloitte and Touche, the auditors of the Program for

1994 and 1995. He indicated that the Committee reviewed the letter and recommended that it be signed.

** C. Furman made a motion to accept the recommendation of the Committee and approve the draft representation letter. B. Markowitz seconded the motion, and the motion was approved unanimously by voice vote.*

W. Sanders reported that the Committee reviewed the draft Program audit reports for 1994 and 1995, and he reported that the Committee recommended approval of the audit reports.

** J. Leonard made a motion to accept the recommendation of the Committee and approve the draft Program audits for 1994 and 1995. B. Markowitz seconded the motion, and the motion was approved unanimously by voice vote.*

W. Sanders reported that the third issued discussed by the Committee was that some carriers had reported different small employer net earned premium amounts in the Exhibit GG reports (the loss ratio reports required to be filed with DOBI by 8/1 of each year) and the Exhibit CC (the market share reports required to be filed with SEH by 3/1 of each year). He indicated that as a result of some questions raised with carriers, some carriers had filed revised Exhibit CCs for 1996 net earned premium. The issue was whether the revised reports, filed well after the March 1 deadline, should be used in the assessment calculation. He reported that the Committee's recommendations were as follows: (1) Do not use revised Exhibit CCs in the calculation of the assessment at this time, and proceed with the assessment based on the originally reported numbers; (2) Develop standards, in consultation with the DOBI, for the acceptance of revised reports, in the event that a carrier reports different net earned premium in the Exhibits CC and GG (3) Consider making reconciliations for mis-reported 1996 net earned premium as part of next year's assessment, (4) develop regulations, in consultation with the DOBI, that would trigger a carrier's responsibility to account for any significant discrepancies between the two reports, and to file revised reports if necessary. L. Specht said that the Exhibit CC and Exhibit GG reports may be filed by different persons; she suggested that the rules and Exhibits alert the carrier to the fact that there were two reports requesting the same information. L. Moskowitz indicated that it may be appropriate to consider whether to consolidate the reports. The Board agreed with the Committee's recommendations and indicated that it should consider these issues over the next few months.

W. Sanders reported that the Committee considered a draft of the assessment for 1997. He indicated that it included the Board's fiscal year1998 budget of $500,000 and included reconciliations for previous years, which included the Board's audited numbers for 1994 and 1995. He noted that the 1997 assessment still was based on unaudited Program costs for fiscal year 1996 and fiscal year1997. He reported that with the final audited numbers, the Board would be in a position to close out the 1994 and 1995 assessments and provide refunds to carriers that were owed money but no longer in the

small employer market. He noted that the draft assessment included a list of carriers who were due a refund from 1994 and 1995 that discontinued participation in the market the following year. W. Sanders reported that the 1997 assessment spreadsheet, which included reconciliations for previous years, showed refunds due to certain carriers. He reported that the Committee recommended the following: (1) Approve the 1997 assessment; (2) Approve the payment of refunds to those carriers due a refund from the Program for the 1994 and 1995 assessments that were not in the market the following year; and (3) Provide a notice to carriers still in the market who show a credit on the assessment because of reconciliation for previous years.

L. Moskowitz asked if Deloitte & Touche had audited or reviewed the assessment. P. Lechner reported that the assessment bases for 1994 and 1995 were audited. The auditors had not been asked to review the assessment spreadsheet. L. Moskowitz also asked whether amounts due to carriers included interest. W. Sanders reported that interest had not been calculated for each carrier. He noted that calculation of interest since the beginning of the Program for all carriers would be a formidable task, and that the amount of money involved was relatively small. W. Sanders said that he was unaware of any statutory or regulatory requirement that interest be calculated. P. Lechner noted that interest since the beginning of the Program amounted to about $30,000 and that interest would be credited toward future assessments.

[L. Specht left the meeting.]

VII. Report of the Interim Executive Director

W. Sanders presented the Board with an Expense report attached hereto as Exhibit 1. He reported that the report included an expense for the Attorney General's fees for the fourth quarter of fiscal year 1997 and an estimate for the first quarter of 1998.

** J. Leonard made a motion to approve the expense report. B. Markowitz seconded the motion, and the motion was approved unanimously by voice vote.*

W. Sanders reported that, as requested by the Board, he had checked with the DOBI to determine how many visitors there had been to the Board's WEB Site. He reported that the DOBI measured the number of visitors to its Home Page and each of its sections for a 6-day period, from October 1 through October 6. He indicated that the DOBI Home Page received 2,596 visitors; the Health Boards received 369 visitors, with another 194 visiting the IHC rates page and 72 visiting the SEH rates page. He noted that this was approximately 2000 visitors per month. W. Sanders said that the DOBI had promised to provide monthly analyses of visitors to the WEB page which he would share with the IHC and SEH Boards. D. Vanderhoof suggested that the Board consider modifying the WEB site to include the ability to ask questions or to provide comments. C. Furman noted that staff should have e-mail.

W. Sanders reported that the there had been a problem in compiling the enrollment figures, and that he would attempt to correct the problem and provide the Boards with enrollment information as soon as possible. D. Vanderhoof commented that the collection and publication of the data was taking too long, and that up-to-date information was essential for policymakers. W. Sanders indicated that he hoped to have the function of collecting and publishing the information brought in-house as soon as the Boards could hire a new employee. D. Vanderhoof suggested that carriers be required to link the current quarter's figures with the carriers' previously filed numbers.

W. Sanders reported that the Board's packets included the DOBI's draft standards for the use of formularies in plans issued through or in conjunction with a selective contracting arrangement. He instructed Board members to provide him with comments by October 27, 1997 which he would forward to the DOBI. He noted that if Board members needed additional time they should call him. J. Majcher noted that the DOBI had developed these draft standards largely in response to a request from the Board to act quickly.

W. Sanders reported that the Board packets included a draft bulletin on the effects of P.L.1997, c.146 and P.L.1997, c.192 on the individual and small employer markets. He asked for Board comments within 10 days. He said that both the IHC and SEH Legal Committee's would be provided with the draft for comment, and that he would issue the bulletin upon receiving guidance from the Legal Committees.

W. Sanders noted that the Board packets included a copy of the DOBI's press release on the filing of a suit against the National Association Preferred Providers and other entities. He noted that he had sent this press release to consumers and brokers who had called staff about the plan, and that his presentations to broker groups included a discussion of the litigation.

W. Sanders reported that the SEH regulations would need substantial revision to reflect the changes in the law as a result of the enactment of P.L.1997, c.146. He also indicated that the Buyer's Guide would need to be revised as a result of the changes in the law, and that he planned to draft changes to the Buyer's Guide first and forward it to the Marketing Committee. He indicated that he hoped that a revised Buyer's Guide could be published early in 1998.

W. Sanders reported that a research team from Harvard and Brandeis that had received a grant from the Robert Wood Johnson Foundation to do a study of the reforms in New Jersey's individual health coverage market would be providing a report to the IHC Board at the IHC Board's November 12, 1997 meeting. D. Vanderhoof indicated that it was reported that the study was to be published in August of 1997. W. Sanders reminded the Board that the IHC Board had not paid for the study nor was it in control of the study.

W. Sanders reported that the Board packets included a DOBI bulletin to small employer carriers on the premium comparison survey, which includes some modifications to the reporting format. He noted that the bulletin extends this year's filing deadline from November 1, 1997 to November 17, 1997.

W. Sanders reported that the Board packets included an excerpt from the DOBI's 1996 annual report addressing the IHC and SEH Programs.

W. Sanders reported that the packets included an editorial from the Trenton Times referring to hearing at which state regulators testified to Congress that carriers were subverting the intent of the federal law by charging high risk groups very high rates, and by linking broker commissions to the health risks of the applicants. He reported that there was no recognition in the editorial that these practices were prohibited in New Jersey, that these loopholes did not exist. W. Sanders referred to a letter to the editor which he submitted noting that New Jersey already had protections in place to prohibit the kind of activities reported to Congress.

With respect to outreach, W. Sanders reported that he spoke to the South Jersey Health Underwriters on September 23, 1997, to the Commissioner's Life/Health Underwriters Advisory Board on September 30, 1997, and to the Health Affairs Committee of the New Jersey Business and Industry Association on October 1, 1997. He also reported that he filmed a segment for a half hour cable show called "Financial Matters" which would air on November 11 at 8:30 am on CTN Cable TV stations in New Jersey. He noted that the host of the show asked him to return to film another segment in March 1998.

VIII. Executive Session

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

[B. Markowitz left the meeting.]

IX. Close of Meeting

** L. Moskowitz made a motion to adjourn the meeting. C. Furman seconded the motion. The Board voted unanimously in favor of adjourning the meeting.*