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 November 19, 1997

Members present: Jane Majcher, *Vice Chair* (DOBI); Amy Mansue (HIP of New Jersey); Justin Fiedler (BCBSNJ); Charlotte Furman (Anthem Health and Life); Eileen Gallagher (NYLCare); Linda Ilkowitz (Guardian); 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*; Pearl Lechner, *Program Accountant*; DAG Josh Lichtblau (DOL).

I. Call to Order

J. Majcher called the meeting to order at approximately 9:40 a.m. W. Sanders 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

W. Sanders asked if any person attending the meeting wished to offer any comments. No comments were offered.

III. DOHSS Presentation on the HMO Performance Report

W. Sanders reported the Department of Health and Senior Services ("DOHSS") had published an HMO Performance Report Card, which provides information on the quality of the key HMOs in New Jersey. He noted that the purpose of the report was to give consumers the information they need to make informed choices regarding their health coverage, and to motivate HMOs to improve performance. Single copies may be obtained from the DOHSS by dialing (888)393-2062 or sending a fax to (609)633-0807.

Natan Shapiro and Frances Prestiani, representatives from DOHSS, provided the Board with a summary of the Performance Report Card, stating how the information was gathered. They noted that the publication of the Report was linked to reporting requirements in the HMO regulations. They indicated that the DOHSS would be

publishing these reports on regular basis and that the reports would include all network based plans in the future.

The Board commented that the Report Card was a very helpful consumer education piece. Some members commented on the format which they indicated should be considered by the Board in its review of its Buyer's Guide. W. Sanders indicated that the Board should discuss issues regarding the distribution of the Performance Report to consumers of small employer health benefits coverage. He indicated that the Board could, for example, advise consumers how to obtain the Report Card in its Buyer's Guide, and could include a link on its web site to the DOHSS' web site.

IV. Minutes

** L. Moskowitz made a motion to approve the draft minutes of the October 22, 1997 Board meeting, as amended. D. Vanderhoof seconded the motion, and the motion was approved by voice vote with A. Mansue and J. Fiedler abstaining.*

V. Report of the Policy Forms Committee

E. DeRosa reported that the Committee met on November 10th and 13th to discuss optional benefit riders and other matters. She described the riders submitted and noted the Committee's recommendations.

A. CIGNA

Rider 1: Amends the HMO POS plan to provide prescription drug coverage subject to a card option with a $5/10 copay and a mail option with a $0/5 copay.
Recommendation: Complete and in substantial compliance.

** A. Mansue made a motion to accept the recommendation of the Policy Forms Committee. J. Fiedler seconded the motion, and the motion was approved unanimously by voice vote.*

Rider 2: Amends the HMO POS plan to waive the hospital confinement copay.
Recommendation: Complete and in substantial compliance

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

B. HIP

Rider 1: Amends the HMO POS plan to provide a $5/10 in-plan prescription drug benefit.
Recommendation: Complete and in substantial compliance.

Rider 2: Amends the HMO POS plan to provide a $7/14 in-plan prescription drug benefit.
Recommendation: Complete and in substantial compliance.

Rider 3: Amends the HMO POS plan to provide open access to specified in-plan preventive care services.
Recommendation: Complete and in substantial compliance.

Rider 4: Amends the HMO POS plan to provide open access to specified in-plan dental fillings services, subject to the physician visit copay.
Recommendation: Complete and in substantial compliance.

Rider 5: Amends the HMO POS plan to provide open access to 20 in-plan chiropractic services, subject to the physician visit copay.
Recommendation: Complete and in substantial compliance.

Rider 6: Amends the HMO POS plan to provide $400 reimbursement for hearing aids once every 36 months.
Recommendation: Complete and in substantial compliance.

Rider 7: Amends the HMO POS plan to provide $50 reimbursement for corrective lenses and contact lenses once every 24 months.
Recommendation: Complete and in substantial compliance.

Rider 8: Amends the HMO POS plan to provide $35 reimbursement for corrective lenses and contact lenses once every 24 months.
Recommendation: Complete and in substantial compliance.

Rider 9: Amends the HMO POS plan to waive the hospital confinement copay.
Recommendation: Complete and in substantial compliance.

L. Moskowitz expressed some concern about HIP riders 3, 4, and 5 above. A. Mansue noted that these riders to amend their POS product were consistent with HIP's offerings of HMO plans. E. DeRosa confirmed that HIP had secured approval of a limited open access HMO product in the large group market.

** J. Fiedler made a motion to accept the recommendation of the Policy Forms Committee. L. Ilkowitz seconded the motion, and the motion was approved by voice vote with A. Mansue and L. Moskowitz abstaining.*

C. **New York Life**

Replacement pages for Riders 1 - 8 which were found to be complete and in substantial compliance during the October 22, 1997 Board meeting. These riders allowed direct access to network providers; added specified copayment limits; and replaced the coinsured charge limit with a specified out of pocket maximum. The

replacement pages address the selection of a PCP. The riders as originally submitted stated that the covered person must select a PCP. The replacement text states that the covered person is encouraged to select a PCP.
Recommendation: Complete and in substantial compliance.

** L. Ilkowitz made a motion to accept the recommendation of the Policy Forms Committee. D. Vanderhoof seconded the motion, and the motion was approved by voice vote with E. Gallagher abstaining.*

D. University Health Plans

Rider 1: Amends the HMO plan to provide a vision care benefit where the examination is subject to the physician visit copay.
Recommendation: Subject to receipt of corrected forms and certification, complete and in substantial compliance.

Rider 2: Amends the HMO POS plan to provide a vision care benefit where the examination is subject to the physician visit copay. Non-network coverage is also provided, subject to the deductible and coinsurance.
Recommendation: Subject to receipt of corrected forms and certification, complete and in substantial compliance.

Rider 3: Amends the HMO POS plan to reduce the coinsured charge limit to $5,000.
Recommendation: Subject to receipt of corrected certification, complete and in substantial compliance.

Rider 4: Amends the HMO plan to apply the same physician visit copay to the initial maternity visit as for all other physician visits.
Recommendation: Subject to receipt of corrected certification, complete and in substantial compliance.

Rider 5: Amends the HMO POS plan to apply the same physician visit copay to the initial maternity visit as for all other physician visits.
Recommendation: Subject to receipt of corrected certification, complete and in substantial compliance.

Rider 6: Amends the HMO plan to waive the hospital confinement copayment.
Recommendation: Subject to receipt of corrected certification, complete and in substantial compliance.

Rider 7: Amends the HMO POS plan to waive the in-network hospital confinement copay.
Recommendation: Subject to receipt of corrected certification, complete and in substantial compliance.

Rider 8: Amends the HMO plan to provide a $5/10 prescription drug copay.
Recommendation: Rider withdrawn by carrier.

** E. Gallagher made a motion to accept the recommendation of the Policy Forms Committee. C. Furman seconded the motion, and the motion was approved unanimously by voice vote.*

E. DeRosa reported that the Committee also reviewed an alternative utilization review filing from Blue Cross and Blue Shield of New Jersey. She reminded the Board that such filings required the Board's prior approval.

A. Blue Cross and Blue Shield of New Jersey

Amends the previously approved alternate utilization review text to apply the utilization review provisions to all facility admissions, not just hospital admissions. Thus, admission in an extended care or rehabilitation facility, and hospice care which is other than home hospice care would be subject to the utilization review provisions. The penalty for non-compliance is 50%. Since the standard plans state that extended care or rehabilitation facility, and hospice care are subject to carrier pre-approval which results in no benefit if pre-approval is not secured, the application of the utilization review provisions is more favorable to the consumer. The revised text also greatly reduces the list of surgical services which require pre-authorization.
Recommendation: Approve the alternate text.

** L. Ilkowitz made a motion to accept the recommendation of the Policy Forms Committee. C. Furman seconded the motion, and the motion was approved by voice vote with Justin Fiedler abstaining.*

W. Sanders commented that the Board, Policy Forms Committee, and staff had developed a practice of assisting carriers that had filed optional benefit riders to correct filings that were unclear, confusing, or which did not provide the information required by the Board's regulations. He indicated that some carriers had come to expect the Board to act on filings or amended filings on very short notice despite the fact that the Board has 45 days from the date of the last amendment to the filing to review the filings. He expressed concern that this process had created expectations that were in some cases unreasonable, and resulted in considerable time commitments from the Committee and staff. The Board agreed that it should issue a bulletin to carriers providing them with the Board's meeting schedule and Policy Forms Committee meeting schedule so that carriers did not develop unreasonable expectations.

E. DeRosa reported that staff had received a letter from Blue Cross and Blue Shield of New Jersey which stated that in three ways it intended to relax some aspects of how it administered its standard health benefits plans. E. DeRosa reported that she had reviewed the letter and did not find any concerns by two of the measures proposed by

Blue Cross and Blue Shield since they could be accomplished within the permissible variable text of the forms. She reported that one of the measures which provided that benefits would be provided for certain emergency services regardless of whether the insured contacted the carrier within the time frames set forth in the contract. E. DeRosa's concern was that this process may create false expectations, resulting in a covered person believing that no emergency services would require the insured to contact the carrier within the time frames set forth in the contract. A. Mansue indicated that this practice was probably common, was essential for claims services, and did not pose a great harm to consumers. She commented that the HMO regulations require such treatment of emergency care services. E. DeRosa noted that neither the SEH nor the IHC forms were subject to the HMO regulations. If the Board believed that one or more of the requirements of the HMO regulations should be incorporated into the standard plans, she asked that it be accomplished through modifications to the standard plans as opposed to allowing one or more carriers to administratively address certain features of the HMO regulations. After some discussion, the Board agreed that the Policy Forms Committee should review the HMO regulations to determine with which portions the Board should consider voluntarily complying.

D. Vanderhoof raised a rating issue which resulted in some small employers in gaming the rating requirements of the law by obtaining a plan and dropping it shortly thereafter to obtain lower rates. The Board agreed that D. Vanderhoof should provide some background information to the DOBI, as it is responsible for rating issues in the small group market.

VI. Report of Marketing Firm

Kris Mattson from Wenzel & Company reported that her office had begun to work on new designs for the Buyer's Guide and Premium Comparison Survey. She distributed models of some potential layout designs. She indicated that the Marketing Committee would be meeting on Tuesday, November 25, 1997 to discuss the new layout design and to discuss changes to the text.

She reported that she was tracking the results of the mailing to the State Chambers of Commerce. W. Sanders reported that he had received many calls resulting from an article published in the Somerset Chamber publication, and from two other Chambers asking him to speak at their monthly meetings.

W. Sanders reported that the Premium Comparison Survey filings were due on November 17, 1997. He reported that the Public Affairs office of the DOBI was forwarding the reports to him for handling.

VII. Report of the Finance and Operations Committee

W. Sanders reported that the Committee met via telephone conference at 10:00 a.m. on November 18, 1997. The first issue discussed was whether, based on the results

of a survey conducted, the Board should consider a modification to its participation regulation to limit an employer's ability to purchase any number of plans or riders. He reported that the Committee noted that the application of the Board's participation regulation, which permits an employer to purchase multiple plans or riders, had the potential to result in increased administrative burdens and selection issues. He noted that the survey showed, however, that less than half of the carriers responding found that the current participation regulation posed a significant administrative or selection problem. The Committee also noted the difficulty of a change in regulation or in an interpretation of the regulation which would restrict what some employers have come to expect with respect to the ability to purchase multiple plans. He indicated that the Committee recommended that the Board not consider a modification to its participation regulation at this time, but continue to monitor the effects of the Board's participation requirements and reconsider the issue in another year. L. Moskowitz noted that the results of the survey seemed to suggest that a significant number of carriers did have administrative or selection problems warranting a consideration of some action by the Board. After some discussion, the Board decided to accept the Committee's recommendation to not modify the regulation at this time, but to continue to monitor the issue.

VIII. Report of the Interim Executive Director

W. Sanders presented the Board with an expense report attached hereto as Exhibit 1. He noted that the two Division of Law expenses for the National Association of Preferred Providers, et al ("NAPP") litigation would need to be discussed during executive session and should be considered separately.

** A. Mansue made a motion to approve the expense report, except for the Division of Law expenses for the NAPP litigation. C. Furman seconded the motion, and the motion was approved unanimously by voice vote.*

W. Sanders reported that the SEH assessment was mailed via certified mail to carriers. He indicated that he would provide the Board with payment information at the next meeting.

W. Sanders provided the Board with an updated of legislative matters. He reported that five bills of interest were introduced on November 6, 1997. The first bill was A-3253 (Felice). The bill would modify the IHC Act by changing the initial "two-year calculation period" to a period beginning on 1/1/98, rather than beginning on 1/1/97. The second bill was A-3188 (Gusciora). The bill would allow consumers to sue their health insurance carrier for medical malpractice. The third will was A-2905 (Cordemus). The bill statement to this bill states that it requires HMOs and small employer plans that cover "routine foot care" to permit podiatric physicians to provide such services. He indicated that it appeared to be a provider bill rather than a mandated benefit bill. He indicated, however, that since it is activated only where the plan covers routine foot care, and that the SEH plans do not cover routine foot care, the bill appeared to have no impact on the market at the present time. He indicated that he provided comments on the bill to

the DOBI expressing the staff's concerns. He reported that the bill was reported out of Committee. The fourth bill was A-3250 (Felice). The bill would amend the Health Wellness Promotion Act to change its provisions from a guarantee offer to mandated benefit law. The fifth bill was A-3198 (DiGaitano and Doria). The bill amends the SEH Act to exempt a small employer carrier that gave notice to withdraw from January 1, 1997 to June 30, 1997 from the 5-year ban on re-entry into the market. He noted that he believed that three carriers had filed to withdraw during the period described in the bill.

W. Sanders reported that the Board packets contained a Market Conduct Study of a carrier's business in the individual and small employer markets, the first completed Market Conduct Study of these markets. He noted that the study does not require any action by the IHC or SEH Boards. Nevertheless, he indicated that it may provide some insight into general compliance in the market. His suggestion was for Board members to provide him with any comments, suggestions or concerns that they have so that the Board can begin to undertake steps to address those concerns. L. Moskowitz noted that problems with a carriers claims payments may have an impact on the loss assessment in the individual market. W. Sanders indicated that he would raise this issue with the IHC Board. E. DeRosa noted that the audit conducted by Deloitte and Touche considered an analysis of claim payments.

W. Sanders reported that he provided K. Mattson's markup of typographical errors on the SEH Board's web page to the DOBI and that the corrections were made. He noted that the packets also included a memorandum regarding the measurement of activity on the DOBI's web pages; he indicated that he would pass along future reports to the Board. W. Sanders also reported that he had discussed the possibility of creating links to the SEH Board's web information to some other web sites with a representative of the DOBI. He indicated that there was precedent for creating links to and from the web sites from State agencies with private entities. The Board asked W. Sanders if he had explored e-mail addresses for staff. He said that he was still investigating installation of e-mail. He noted that the staff's computers were not linked to DOBI's mainframe.

W. Sanders reported on 2nd Quarter 1997 enrollment statistics. He noted that the reports show the shift over time to standard health benefits plans from nonstandard plans which, at the end of the 2nd quarter, represented about 80 percent of the plans in force.

With respect to outreach, he reported that had reduced the number of speeches given due to the volume of issues facing staff. He indicated that staff would better be able to fulfill outreach opportunities when the open staff position is filled. He did note that the New Jersey Business News' November 10-16th edition included a focus section on health care, with two articles based on information that he supplied to the paper.

W. Sanders reported that Chubb Colonial Life filed with DOBI to withdraw from the small employer market. The carrier indicated that it was withdrawing from small employer markets in New Jersey as well as a number of other states.

W. Sanders reminded Board members to provide him with comments to DOBI's Draft Standards for Formularies as soon as possible.

W. Sanders reported that the draft bulletin describing the impact of P.L.1997, c.146 and the Health Care Quality Act had been reviewed and approved by both the IHC and SEH Legal Committees. He indicated that the bulletin would be mailed later in the week.

W. Sanders reported that Guardian Life entered the individual market on November 1, 1997 with PPO plans as well as traditional plans.

IX. Report of the Legal Committee

W. Sanders reported that the Committee met via telephone conference at 2:00 p.m. on November 11, 1997. The first issue discussed was what is meant by the term "political subdivision" as it is used in the amended definition of "small employer?" He noted that the amended definition of "small employer" found in P.L.1997, c.146 conformed the SEH Act with HIPAA, including within the definition of a "small employer" political subdivisions. He noted that G. Simon of DOBI noted that the State Health Benefits Plan should more appropriately consider any impact of the amendments to the SEH Act on the State Health Benefits Program. He reported that the Committee concluded that political subdivisions may qualify as small employers, and that DAG Lichtblau agreed to investigate what entities might be included within the meaning of "political subdivisions." W. Sanders also noted that DOBI had alerted a representative of the State Health Benefits Plan and its Deputy Attorney General of the potential impact of HIPAA and P.L.1997, c.146 on the State Health Benefits Plan.

W. Sanders reported that the second issued discussed was what is meant by the term "paid" in the regulatory definition of an "eligible employee." He noted that as part of a large set of regulatory amendments in 1996, the Board amended the regulatory definition of "eligible employee" to indicate that the employee must be a paid employee. The purpose of the amendment was to protect the guaranteed issue, small employer market from abuse. Further, the Board issued a bulletin indicating that carriers could require that a small employer provide tax records as a method to prove that a person was an eligible employee. At the October 1997 Board meeting, the Board inquired as to whether a person with imputed income would qualify as an eligible employee, and asked the broader question: what constitutes a paid employee? W. Sanders reported that the Committee noted that to define "paid" beyond financial compensation to incorporate imputed income and other circumstances where there is no monetary compensation would be nearly impossible. The Committee further noted that the introduction of a requirement that an eligible employee be "paid," in retrospect, may have been unnecessarily restrictive. W. Sanders reported that the Committee recommended that the Board remove the regulatory requirement that an employee must be a paid employee in order to be eligible as part of the Board's upcoming changes to its regulations to comply with HIPAA, and further that carriers could continue to make reasonable inquiries

(including the collection of tax information) to determine whether an employee is an eligible employee. After the regulatory changes, carriers may find that certain unpaid employees would qualify as eligible employees. L. Moskowitz expressed concern about the removal of a requirement that an employee be paid. The Board agreed that the Committee should reconsider the issue and make a recommendation on a method to provide some measure of assurance that an employee is truly working for an entity.

The third issue discussed by the Committee was whether there was a legal impediment for a carrier to electronically enroll an employee. He noted that the Committee agreed that it was important to distinguish electronic enrollment from the execution of the employer application. He reported that the Committee concluded that there would be no legal impediment with a carrier instituting an electronic enrollment procedure. The carrier, however, would operate without a signed enrollment card at its own risk, and the Board was not endorsing the text of the electronic enrollment. L. Moskowitz expressed some concern about the lack of control or oversight over the process. After some discussion, the Board accepted the Committee's recommendation.

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.*

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.*