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 18, 1998

Members present: Karen Dickinson (HIP of New Jersey); Charlotte Furman (Anthem Health & Life); Joan Fusco (Horizon BCBSNJ); Larry Glover, Chair (arrived at 9:50 a.m.); Linda Ilkowitz (Guardian); Mary McClure (The Prudential); Dutch Vanderhoof (arrived at 9:55 a.m.); Bob Vehec (DOBI); Eric Wilmer (Celtic); Bonnie Wiseman (DOHSS).

Others present: Ellen DeRosa, Deputy Executive Director; DAG Josh Lichtblau (DOL); Joanne Petto, Assistant Director; Wardell Sanders, Executive Director.

Managed Care Plan Performance Report

W. Sanders introduced Frances Prestianni of the Department of Health and Senior Services (DOHSS). F. Prestianni reported that the DOHSS released the second annual Performance Report of Managed Care Plans in early November 1998. She provided copies for Board members and others attending the meeting. F. Prestianni discussed the following:

- Why the DOHSS produced the Report;
- Criteria for the selection of HMOs that are included in the Report.
- Sources of data;
- Major Changes made to the Report in 1998 as compared to 1997;
- Objectives of the Report;
- Structure of the Report; and
- How to use the Report.

F. Prestianni noted that the information contained in the Report supplies only one piece of the puzzle. The Report suggests issues a consumer may want to consider when selecting a health plan. She said the Report was available through a toll free number and could be accessed on the world wide web. W. Sanders added that the DOBI web site links to the DOHSS web site. F. Prestianni said that that people at the DOHSS were looking into creating a link from the Report site to the DOBI site.

Several Board members expressed some concerns with the Report, including what it means for a carrier to be rated above or below the mean, and the inclusion in the Report of data from HMO carriers but no other entities that offer “managed care” plans. Several Board members questioned the appropriateness of staff distributing the Reports when giving presentations to agents and brokers. W. Sanders invited Board members to provide written comments to him concerning the distribution of the Report. He said he would share the concerns with the Marketing Committee.

I. Call to Order

L. Glover called the meeting to order at approximately 10:30 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

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

III. Minutes

October 21, 1998
D. Vanderhoof offered a motion to approve the open session minutes of the October 21, 1998 Board meeting, as amended. L. Ilkowitz seconded the motion. The Board voted in favor of the motion, with two abstentions (C. Furman, K. Dickinson).

IV. Report of Staff

Expense Report (see attached)
C. Furman offered a motion to approve the payment of the expenses specified on the November 18, 1998 expense report. M. McClure seconded the motion. The Board voted unanimously in favor of approving the motion.

Legislative Activity
W. Sanders referred to the summary of 1998 legislative activity that was included in Board materials.

Mental Health Parity (A. 660): W. Sanders reported that the Assembly Banking and Insurance Committee heard A. 660 on November 9, 1998. He said this Bill would require full parity of coverage for care and treatment of a mental or nervous condition. He noted the Bill would apply to plans issued in the individual, small employer and large group markets. W. Sanders explained that staff received a number of calls during the weeks prior to the hearing from persons seeking information concerning the coverage provided under the individual and small employer plans for the care and treatment of mental or nervous conditions. He noted that Assemblywoman Vandervalk, sponsor of A. 660, had been among the persons seeking information.

W. Sanders reported that he provided testimony at the hearing regarding the scope of coverage for the treatment of mental or nervous conditions provided under the standard plans. He said he also noted the potential for anti-selection, particularly in the individual market. He said the Committee asked him if the Board had done a study concerning the cost impact the Bill might have on the small employer market and that he replied that the

Board had not conducted a study. He reported that the bill was reported out of Committee.

Heritage Foundation Meeting: L. Ilkowitz reported that she attended a meeting in Washington. DC, sponsored by the Heritage Foundation, which she described as a "think tank." She said the speakers reported that there are over 43 million persons uninsured and that 80% of those persons are employees and their dependents who have no access to employer based coverage. She said the Foundation believed the tax code could be used to increase the number of persons insured by providing a tax incentive to persons who buy individual coverage. She noted that "health marts" are also features in the plan suggested by the Foundation. She commented that the proposal does not include a mandatory coverage provision.

Prompt Payor Bill (A. 2121): W. Sanders noted that a comment letter on this Bill, written by Don Bryan, was included in Board materials.

Regulatory Activity
W. Sanders explained that the Prevailing HealthCare Charges System (PHCS) is the fee profile IHC and SEH carriers are required to use to determine a reasonable and customary charge in cases where there is no negotiated fee schedule. He said the PHCS data was published and available from the Health Insurance Association of America (HIAA) and that the SEH regulations identify HIAA as the source for the data. He said HIAA recently sold PHCS data to Ingenix, Inc. He said the regulations would require modification to identify Ingenix, Inc. as the new data source.

HIP
W. Sanders stated that a News Release concerning HIP was included in Board materials. He said the release discussed a temporary restraining order that allows the DOBI and DOHSS to ensure that the HIP Health Centers remain open and that services will continue, without interruption, to HIP members. W. Sanders reported that the hearing that had been scheduled to place HIP in rehabilitation had been delayed. He explained that HIP is not permitted to write new business in any market, but that new employees and dependents could be added to existing groups. W. Sanders noted that the State set up a toll free number to respond to consumer inquiries. He said staff received a fair number of calls from HIP customers.

Operations Issue
W. Sanders reported that the firm the SEH Board had hired to assist in the preparation of the financial books for the program had begun work on Friday, November 6, 1998.

1996 Loss Ratio Analysis
W. Sanders reported that Neil Vance, actuary for the DOBI, prepared an analysis of the 1996 loss ratio data for the SEH carriers. A copy of the analysis, showing a total refund of $18.9 million, was included in Board materials. W. Sanders noted that N. Vance commented that most of the refunds were due to coverage under non-standard plans.

Outreach
W. Sanders reported that he had written a letter to the editor in response to a report BNA published in August 1998 on a Heritage Foundation report. Although the BNA Reporter did not publish his letter, he said they promised to do a full story on the New Jersey reforms. He noted that the Board materials include an article that is generally favorable to the New Jersey reforms.

W. Sanders noted that Irene Card, a reporter who writes for some of the smaller newspapers in New Jersey, wrote an article about the New Jersey reforms.

W. Sanders said he was interviewed in connection with an article on HIPAA for *Employee Benefit News*, a national magazine. He said it appeared the reporter had misunderstood some of his comments, particularly with respect to employers reducing contribution levels. He said a copy of the article was included in Board materials.

E. DeRosa reported that she spoke at a seminar sponsored by the New Jersey Business and Industry Association on October 28, 1998. She said her topic was buying health insurance.

Other
E. DeRosa reminded the Board that she had asked for comments on Advisory 98-SEH-09 no later than November 18, 1998.

J. Petto reported that 3rd quarter enrollment carriers from all IHC carriers had been received. She said she hoped to have the 3rd quarter IHC enrollment reports completed by the beginning of the week of November 23rd. She said she was awaiting enrollment data from at least one SEH carrier.

V. Report of the Legal Committee

Employee Leasing Companies
W. Sanders reported that the Committee considered two approaches to address employee leasing companies.
Maryland Approach: By statute, Maryland modified the definition of an employer and a health benefits plan such that an employer is the employer, regardless of the involvement of a leasing company.
Control Test Approach: Using common law principles, the carrier would determine whether the employer or the leasing company is the employer.

He said the Legal Committee recognized that the application of the Maryland approach would require statutory changes. The committee believed the control test approach was supportable based on current law. The Committee deferred to the Board on the policy issue concerning employee leasing companies.

W. Sanders said he called officials in both Maryland and Colorado to secure information on the regulation of employee leasing companies. He said he was also interested to learn

how they police the laws they have enacted. He said he had not received return calls from either state.

J. Fusco commented that it would be important to establish a test that would be easy to apply. DAG J. Lichtblau noted that the carrier could look at the contract between the professional employee organization and the employer. He suggested there would need to be joint regulation by the DOBI and the Board since the application for coverage would likely be made as a large group plan. W. Sanders said he would speak with the DOBI concerning a joint position.

VI. Report of the Policy Forms Committee

E. DeRosa explained that while the Committee did not receive any riders to review, the Committee considered several issues that had been raised.

Viagra

E. DeRosa said the Committee considered comments from carriers concerning the Advisory Bulletin which advised carriers that medically necessary and appropriate treatment with Viagra would be covered under the standard plans. The Committee recognized that the initial enthusiasm for this prescription drug seems to have subsided. The Committee recommended that no exclusion be added to the forms, as had been suggested by some carriers, to exclude coverage for the treatment of sexual dysfunction.

Diagnostic Services

E. DeRosa said the Committee considered an inquiry for an HMO carrier concerning whether the diagnostic services copayment must be collected for a diagnostic service such as routine blood work. She said the Committee believed a carrier could administratively waive the collection of the copayment for services such as routine blood work and that it was not necessary to modify the standard plans to show that a copay would not be collected for routine blood work.

Domestic Violence

E. DeRosa said the Committee considered whether to amend the standard plans to specifically state that the pre-existing conditions exclusion could not be used as a basis to deny coverage for the treatment of an injury sustained as a result of domestic violence. She said the Committee believed it was not necessary to amend the forms.

The Board recommended that a Bulletin be released to remind carriers that the law requires coverage for the treatment of injuries which are sustained, while insured, as a result of domestic violence.

New Plan Designs

E. DeRosa said the Committee considered the new Plan A/50, a 50%/50% plan, that has been made available in the IHC market. E. DeRosa described Plan A/50, and the $2500 deductible option available with Plans A/50 thorough C, as well as the $30 HMO copay option. DAG J. Lichtblau said he looked into whether the SEH law allowed the Board to

eliminate Plan A, as the IHC Board had done. He reported that the statute was written differently and that the SEH Board did not seem to have similar latitude to modify Plan A. The Board expressed an interest in the $2500 deductible option and the $30 copayment for HMO plan. E. DeRosa explained that the availability of a $30 HMO copay would extend to PPO and POS plans which must use copay options available to an HMO. She volunteered to summarize the plan possibilities and fax the summaries to Board members so the actuaries and marketing people could provide some feedback.

VII. Executive Session

C. Furman offered a motion to begin Executive Session. D. Vanderhoof seconded the motion. The Board voted unanimously in favor of beginning Executive Session.

[Executive session: 12:00 - 12:05 p.m.]

VIII. Close of Meeting

D. Vanderhoof offered a motion to adjourn the Board meeting. L. Ilkowitz seconded the motion. The Board voted unanimously in favor of adjourning the meeting. The meeting adjourned at 12:05 p.m.

Attachment: Expense Report