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
July 21, 1999

Members present: Gary Cupo; Darrel Farkus (Oxford); Linda Ilkowitz (Guardian); Charlotte Furman (Anthem Health & Life); Larry Glover (Chair) (arrived at 9:50 a.m.); Jane Majcher (DOBI); Bryan Markowitz (arrived at 10:00 a.m.); Mary McClure (The Prudential); Michael Torrese (Horizon BCBSNJ); Dutch Vanderhoof; Eric Wilmer (Celtic); Bonnie Wiseman (DOHSS).

Others present: Ellen DeRosa, Deputy Executive Director; DAG Jennifer Fradel (DOL); DAG Josh Lichtblau (DOL); Wardell Sanders, Executive Director.

I. Call to Order

W. Sanders called the meeting to order at 9:45 a.m. He 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.

He stated that three new persons had recently been appointed to serve on the SEH Board. He introduced and welcomed Gary Cupo, a newly appointed Board member. W. Sanders noted that the other two new Board members were invited to the Board meeting, but were unable to attend.

DAG J. Lichtblau introduced DAG Jennifer Fradel. He announced that she will replace him as counsel for the SEH Board beginning with the September 1999 Board meeting.

Public Comments

W. Sanders asked if any member of the audience wished to offer comments concerning the items stated on the agenda. Harry Witsen asked about the status of the Board's investigation into the United Business Workers of America (UBWA) plan. D. Farkus read a copy of a letter that Oxford sent to Oxford members who had purchased coverage through the UBWA. The letter indicated that Oxford terminated its relationship with Local 452 due to concerns about how the plan had been marketed, and that coverage would cease as of July 31, 1999.

III. Minutes

June 16, 1999

J. Majcher offered a motion to approve the minutes of the Open Session of the June 16, 1999 Board meeting, as amended. D. Vanderhoof seconded the motion. The Board voted in favor of the motion, with G. Cupo abstaining.

IV. Staff Report

Expense Report (see attached)

M. McClure offered a motion to approve the payment of the expenses specified on the July 21, 1999 expense report. L. Ilkowitz seconded the motion. The Board voted unanimously in favor of approving the motion.

Survey on Cost Reduction Suggestions

E. DeRosa reported that she had requested responses to the survey concerning cost reduction suggestions that were made by the Marketing Committee by July 7, 1999 in order that the responses could have been compiled prior to the July Board meeting. She said she had not yet received responses from a number of carriers on the Board. She asked Board members to please remind the actuarial staff to whom they directed the survey to please try to respond soon. She said that she hoped she would have all the responses shortly and would compile them for the Marketing Committee to consider prior to the September Board meeting.

Executive Order 92

W. Sanders noted that the Board materials include a copy of a letter from Acting Commissioner Christine Grant of the Department of Health and Senior Services acknowledging the Board's support for the Task Force on Mandated Health Benefits to be created as a result of the Executive Order and the Board's willingness to provide assistance.

Legislative Update

- S.1719: W. Sanders said this bill, which would amend the SEH law to provide participation credit for employees who waive coverage due to coverage under Medicare or coverage under another group health benefits plan, had been reported out of the Senate Health Committee. He noted that participation credit is currently provided only for employees who waive coverage due to coverage under another plan offered by the same employer, or who have coverage under a spouse's group plan.
- A.3371: W. Sanders said that this bill establishes the KidCare Equity and Partnership Programs that the Board had discussed during prior meetings. He said he believed this bill had also been reported out of Committee.

RFP for Auditing Services

W. Sanders asked the Board if any member had any questions or concerns with the text of the draft RFP that was included in the Board materials. He noted that the IHC Board, after review by the Legal and Operations Committees, voted to approve a similar proposal. No Board member expressed any concerns with the text. W. Sanders stated that the RFP was being reviewed by the Attorney General's office. Subject to that review, he asked the Board to vote to approve the RFP.

C. Furman offered a motion to approve the RFP for auditing services, subject to the review and approval of the Attorney General's office. J. Majcher seconded the motion. The Board voted unanimously in favor of the motion.

Public Service Announcements (PSAs)
W. Sanders said he had heard from a number of people who heard the PSAs on the SEH and IHC Programs that the Commissioner recorded. He said he had gotten calls from some people who learned about the Programs as a result of the announcements.

V. Report of the Policy Forms Committee

Optional Benefit Rider Filings

Nippon

E. DeRosa explained that Nippon had filed a Selective Contracting Arrangement (SCA) submission with the Department that had not yet been approved. The rider Nippon filed would amend a PPO plan that Nippon would market once the SCA filing has been approved. E. DeRosa said the Committee recommended that the filing be found incomplete and not in substantial compliance for the following reasons: the filing did not include the required certification, no rate filing had been made, the filing did not include copies of the pages being amended, the rider did not identify the name of the carrier and did not include an identifying form number. In addition, she said the committee was confused with some of the text in the rider and believed it should be clarified. E. DeRosa said she would work with the carrier if the carrier wanted to try to correct the filing.

J. Majcher offered a motion that the Board find the Nippon rider filing incomplete and not in substantial compliance. D. Vanderhoof seconded the motion. The Board voted unanimously in favor of the motion.

Prudential

E. DeRosa said that while the Committee reviewed a filing from Prudential, the company withdrew the filing. No Board action was therefore required.

University Health Plans (UHP)
E. DeRosa said the riders filed by UHP would extend the maximum age for dependents who are full-time students to 25 from age 23 as in the standard plans. She said there was a minor problem with the certification language but that the carrier corrected the language.

D. Vanderhoof offered a motion that the Board find the University Health Plans rider filing, as amended, complete and in substantial compliance. M. Torrese seconded the motion. The Board voted unanimously in favor of the motion.

Policy Forms Interpretation Issues

E. DeRosa explained that as a result of the Advisory Bulletin on coverage for intensive outpatient services, she had received an inquiry from a carrier seeking additional guidance. She reported that the Policy Forms Committee discussed the inquiry but recognized that technical guidance would be helpful. The Committee requested information from people with claims expertise. E. DeRosa said the information that resulted from the inquiry suggested that the Board should research further before responding to the inquiry.

D. Farkus said he believed the Board should seek clinical guidance. C. Furman suggested that the Department of Health and Senior Services or the Department of Banking and Insurance might be able to provide some guidance.

The Board agreed that if a standard definition concerning intensive outpatient services already exists, that it would want to consider that definition before providing any more guidance than was already provided in the Bulletin. In the meantime, the Board agreed that carriers should be guided by the Advisory Bulletin, as released.

E. DeRosa said the Committee also considered requests from indemnity carriers to define certain terms used in the standard plans in the Home Health Care provision. She said the language in the plans includes the terms *part-time*, *intermittent*, *full-time* and *short term*, but that the plans do not define these terms. She explained that the Committee members suggested various definitions, but that no consistent definition could be provided. E. DeRosa said the Committee considered a Department regulation that the Board might want to consider in order to establish some limits concerning *part-time*, and *intermittent* care. She reported that the Committee believes the Home Health Care provisions in both the non-HMO and HMO plans needs to be reviewed and that the Committee would meet during August in order to be prepared to make a recommendation concerning a revised home health care benefit when the Board meets in September.

L. Ilkowitz suggested that it might be helpful to contact home health care providers to find out if the agencies use a standard definition for these terms. B. Wiseman offered to identify a contact person or agency that staff could call.

L. Glover noted that it would be important for the Board to thoroughly research intensive outpatient services coverage and home health care coverage before sending further communications to carriers to provide guidance on the questions that were raised.

DAG J. Lichtblau reminded the Board that it had determined that the home health care coverage under the HMO plan was unlimited, subject to medical necessity. In making any changes to the home health care coverage under the standard plans, he said the Board should be conscious of the potential for disparity unless the Board acts to apply the same requirements to all plans.

VI. Report of the Legal Committee

W. Sanders reported that the Committee considered several issues.

Home Health Care

W. Sanders reported that the Committee considered an inquiry the Board received from counsel for a carrier in which the Board was asked about the consequences to a member's coverage if a carrier determines that home health care is not the most cost-effective setting. He said the Committee believed the language in the standard plan was clear and that the plan does not require the carrier to provide coverage for home health care if there is a more cost effective setting in which to provide medically necessary and appropriate care. In response to whether the carrier could provide coverage up to the cost for the most cost-effective care, W. Sanders said the Committee noted that carriers may always provide coverage that is greater than the coverage required by the plan.

Mental Health Parity for Biologically-based Mental Illness (S.86)

W. Sanders reported that the Committee considered whether visitation limits were permitted under S.86 and whether outpatient coverage for the treatment of a biologically-based mental illness may be made subject to pre-approval or pre-certification. He said the Committee unanimously agreed that visitation limits were not permitted under the law. He reported that the Committee did not reach a consensus concerning pre-approval or pre-certification. He said the Committee discussed whether pre-certification or pre-approval would be considered a "benefit limit," since the imposition of a benefit limit which is not applicable to other illnesses would be prohibited under the law. He reported that one member thought pre-approval or pre-certification was a benefit limit and one member thought pre-approval or pre-certification would not be a benefit limit, and three members believed it could be argued either way. W. Sanders said that the Committee also considered whether, assuming pre-approval or pre-certification is a benefit limit, such a limit would be permitted for outpatient mental health services for a biologically-based mental illness. He reported that again, the Committee did not reach a consensus. He said two members believed the limit would not be permitted, one believed it would be permitted, and two believed it could be argued either way.

L. Ilkowitz asked E. DeRosa to explain pre-approval and pre-certification and the associated consequences so all Board members would be clear as to the type of provision Horizon suggested should be included in the standard plans. E. DeRosa explained that pre-certification is the process that carriers apply to inpatient hospitalizations and surgical procedures, without regard to the nature of the illness or injury. E. DeRosa said the penalty provision included for failure to secure pre-certification was variable such that a carrier could apply a flat dollar penalty or a percentage penalty, where the percentage could range from 1% to 100%. E. DeRosa said pre-approval was a process the Board applied to a specific list of services such as home health care, hospice care, and durable medical equipment. She noted that failure to secure pre-approval would result in a 100% reduction in benefits.

M. McClure explained that pre-approval or pre-authorization would allow a carrier to determine medical necessity prior to receipt of services or supplies rather than expect the covered person to wait until after charges have been incurred to find out a service or supply is not covered because it was not medically necessary. M. Torrese said pre-approval or pre-authorization are cost-containing measures. E. DeRosa said that from her experience speaking with the numerous consumers and agents who call Board staff, it appears that pre-approval and pre-certification act to limit access to benefits by virtue of the delay while the covered person waits to learn if the service will be approved or certified. She further asked how determining medical necessity before rather than after the service could save cost. She reasoned that if a service is medically necessary it will be covered and if it is not, whether that is determined before or after, did not seem it should have an effect on cost to the carrier.

M. McClure expressed discomfort with stating that pre-approval or pre-certification would be a benefit limit. L. Ilkowitz commented that she could argue either way in a discussion as to whether pre-approval and pre-certification should be viewed as benefit limits.

DAG J. Lichtblau stated that Assistant Commissioner Gale Simon made it clear during the Legal Committee meeting that the Department would not approve the standard indemnity-based plans if they were to include a provision for pre-approval or pre-certification in connection with outpatient treatment of a biologically–based mental illness. L. Ilkowitz said she believed using pre-approval or pre-certification would violate the spirit of the law.

L. Glover took a poll of Board members concerning whether they thought the forms should include a provision for pre-approval or pre-certification in connection with outpatient treatment of a biologically–based mental illness.

M. Torrese	Yes
G. Cupo	Abstain
M. McClure	Yes
B. Markowitz	No
B. Wiseman	No
D. Farkus	No
D. Vanderhoof	No
J. Majcher	No
E. Wilmer	Yes
C. Furman	No
L. Ilkowitz	No
L. Glover	Abstain

B. Markowitz offered a motion that the provision the Board proposes to comply with S.86 NOT include a provision whereby a carrier could require pre-approval or pre-authorization in order to access outpatient care for the treatment of a biologically-based mental illness. D. Vanderhoof seconded the motion. The Board voted in favor of the motion, with two abstentions, G. Cupo and E. Wilmer.

[Break: 11:10 – 11:30]

Application of Health Wellness Promotion Act

E. DeRosa said the Committee considered a question raised by Horizon as to whether the Health Wellness Promotion Act ("Act") applies to the SEH plans. She explained that the law uses the phrase "except as otherwise provided…" and that Horizon believed that such language meant the SEH plans do not have to comply with this mandated offer law. E. DeRosa said the Board received advice from the Attorney General's Office before the standard plans were adopted and that the advice stated the law applies. The "except as otherwise provided" phrase should be understood as saying that if the SEH Act specifically said the Health Wellness Promotion Act did not apply to SEH plans, then it would not apply. Otherwise, the Act applies. E. DeRosa said staff located a letter the Board sent to the sponsors of the Act in which the Board notified the sponsors that the Board intended to craft standard plans that would provide a wellness benefit structured differently than the benefits set forth in the law, but that the Board believed the benefit it created would be more beneficial to consumers. E. DeRosa said there was no evidence in the Board's files to suggest the Board received a reply to the letter.

E. DeRosa explained that the approach the Board used in the plans does not appear to strictly comply with the Act in two ways. First, the Act lists specific services for which coverage is to be provided. She explained that with the current $300 benefit, it would be possible for a covered person to exhaust the $300 benefit without getting any of the services the Act lists. She explained that any wellness services beyond the first $300 are not covered under the standard plans. Secondly, she explained that while the $300 benefit is first dollar coverage (no deductible, no coinsurance) if a covered person were to have already satisfied the deductible and coinsurance under a plan, the total dollar amount for females age 45 and older under the Act exceeds the $300 benefit the standard plans provide. She said the memo she included in Board materials outlined several approaches the Board could use to comply with the law.

E. DeRosa reminded the Board that the Act is a mandated offer law, which means the coverage must be *offered* to every employer and not necessarily included in every plan. Thus, the Board could use one of the standard riders to provide the coverage. If an employer wants the coverage, the rider would be attached to the plan and would provide coverage in addition to the $300 preventive care benefit. She noted that the use of a rider would require that the employer application be revised to add a question to ask if the employer wants to add the wellness rider. She cautioned, however, that the use of a rider could be administratively burdensome for carriers.

E. DeRosa said the standard plans could be amended to add the coverage required by the Act, in addition to the $300 preventive care benefit. C. Furman suggested that another option would be to replace the $300 benefit with coverage as required by the Act. The deductible and coinsurance could be waived to make use of the coverage more attractive. D. Vanderhoof said the $300 benefit is a positive feature in the plans and should not be removed.

After some discussion concerning the potential cost associated with the various options and the perception the market may have for any of the options, the Board decided that it needed additional time to consider the possible options. The Board asked that the Marketing Committee meet to evaluate the possible options and then make a recommendation to the Board. In addition, the Board would like the cost of the various options to be evaluated.

C. Furman offered a motion that the Board propose forms changes to comply with the Mental Health Parity Law P.L. 1999, c. 106 and the law requiring coverage for dental anesthesia for certain severely disabled covered persons, P.L. 1999, c. 49, and to correct the forms concerning coverage for dental prosthetics. D. Vanderhoof seconded the motion. The Board voted unanimously in favor of the motion.

VII. Executive Session Minutes

D. Vanderhoof offered a motion to approve the minutes of the Executive Session of June 16, 1999, as amended. M. McClure seconded the motion. The Board voted in favor of the motion, with two abstentions, B. Markowitz and G. Cupo.

VIII. Close of Meeting

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

Attachment: Expense Report