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
May 17, 2000

Members participating: Gary Cupo; Timothy English (Guardian); Darrel Farkus (Oxford); Larry Glover (arrived at 9:45 a.m.); Claudine Harper (NYLCare) (arrived at 9:45 a.m.); John Kilgallin (CIGNA); Jane Majcher (DOBI); Bryan Markowitz (arrived at 9:50 a.m.); Kevin Monaco (arrived at 9:50 a.m.); Vaughn Reale; Robert Shalango (United Healthcare); Tony Taliaferro (AmeriHealth); Mike Torrese (Horizon BCBSNJ); Dutch Vanderhoof (arrived at 9:50 a.m.) Bonnie Wiseman (DOHSS).

Others present: Ellen DeRosa, Deputy Executive Director; DAG Prince Kessie (DOL); Wardell Sanders, Executive Director.

I. Call to Order

W. Sanders called the meeting to order at 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 member of the audience wished to offer comments concerning the items stated on the agenda. No comments were offered.

III. Minutes

April 19, 2000
B. Wiseman offered a motion to approve the minutes of the Open Session of the April 19, 2000 Board meeting. T. Taliaferro seconded the motion. The Board voted in favor of the motion, with T. English, J. Kilgallin and V. Reale abstaining.

IV. Staff Report

Expense Report (see attached)
T. Taliaferro offered a motion to approve the payment of the expenses specified on the May 17, 2000 expense report. M. Torrese seconded the motion. The Board voted unanimously in favor of approving the motion.

Legislative Update

W. Sanders referred the Board to his May 10, 2000 memorandum regarding A. 1606. He summarized the key features of the bill, which include: allowing IHC and SEH carriers to offer one or more of the standard plans as an Exclusive Provider Organization plan; permitting carriers in the individual market to rate based on age, gender, and geography, with initial rate bands of 1.5:1, and changing to 2:1 as of January 1, 2000; and amending the SEH loss ratio calculation to include certain expenses as claims.

W. Sanders said that a copy of his DRAFT testimony that was prepared in anticipation of a Senate Legislative Oversight Committee hearing that was to be held on May 11, 2000, was included in Board materials. W. Sanders said the hearing, which was to consider the affordability of coverage and consider whether the Board developed the standard plans in a manner consistent with the legislative intent, was cancelled. B. Markowitz explained that some persons in the legislature believe the standard plans should have been crafted to contain distinct coverages.

Decreasing Riders
W. Sanders said that a list identifying riders of decreasing value that have been approved by the Department of Banking and Insurance was included in Board materials.

Outreach
W. Sanders said he had been invited to speak at a meeting of the National Academy for State Health Policy to be held August 7, 2000 in Minneapolis. He said he was asked to speak about the IHC Program, but that the contacts that are made at such a meeting would be useful for both the IHC and SEH markets. In the event the meeting sponsor would not pay for expenses, W. Sanders asked if the SEH Board would be willing to jointly share the cost with the IHC Board.

B. Markowitz offered a motion to cover half the costs for W. Sanders to attend the August 7, 2000 meeting of the National Academy of State Health Policy. L. Glover seconded the motion. The Board voted unanimously in favor of the motion.

State Continuation Form
W. Sanders said that a Board member indicated that it would be helpful for the Board to create a standard form that employees could complete to elect state continuation. He said a sample form that is used by a SEH carrier was included in the Board packets. He noted that the federal government had not developed a specific form for persons to use when electing COBRA. He also noted that staff does not receive requests from employees for such a form.

D. Farkus said Oxford would not be interested in receiving a form such as the sample form that was provided. He said Oxford uses an Add/Change form to process continuations.

B. Markowitz said the members of NJBIA are primarily interested to know what they must do. He suggested that a checklist might be helpful. V. Reale said his office receives calls such as “Am I subject to continuation?”

E. DeRosa said the vast majority of continuation-related calls she receives are from persons whose former employers have refused to offer the opportunity for continuation. She said that the employers sometimes cooperate after receiving a copy of the Continuation Bulletin, but that a number are simply not interested in offering continuation.

B. Markowitz suggested that it would be helpful for a sub-group to discuss the type of information that should be added to a revised Continuation Bulletin. B. Markowitz, G. Cupo and K. Monaco volunteered to participate in such a sub-group.

V. NJBIA 1999 Health Benefits Survey Report

B. Markowitz said the survey results were released during an April 19, 2000 press conference. He said NJBIA surveyed members that have 2 or more employees. He noted that the *average* increase in the cost of coverage experienced by those responding to the survey was 6.6%. He also noted that in the past employers would change plans to help control employer cost. He said a more recent trend seems to be for employers to ask employees to pay a greater percentage of the cost of coverage. He spoke about some of the charts in the survey.

D. Vanderhoof questioned the information set forth in Chart 2. He noted that the heading refers to "Percentage of All Employers Providing Coverage." D. Vanderhoof said he would be surprised if in 1999 only 74% of employers provided dependent coverage, as the chart indicates. He said he believed the chart addresses not what percentage *provide coverage*, but rather, what percentage *pay a portion of the cost toward coverage.* B. Markowitz explained that for the purposes of the survey, *paying a portion* of the cost of coverage was considered to be *providing* for coverage. If an employer were paying nothing toward the cost of dependent coverage, then the employer would be considered as not providing coverage. D. Vanderhoof disagreed and suggested that for future years, the heading of the chart should be clarified.

VI. Report of Legal Committee

W. Sanders said the Committee discussed two issues.

Draft Professional Employer Organization (PEO) Bulletin

The Committee considered the text of a draft bulletin on PEOs. The Bulletin discusses identification of what entity is the employer, with *control* over the employees, as the critical issue to determine if a PEO may offer health insurance to employees. If the PEO is not the employer because it does not exercise sufficient control over the employees, then the entity that is the employer may purchase coverage, not the PEO.

W. Sanders explained that he sent the Bulletin to Governor's Counsel for review.

D. Vanderhoof noted that the draft Bulletin was silent with respect to inforce plans that have been issued to PEOs.

Application of P.L. 1999, c. 395 and P.L. 1999, c. 341
The Committee considered whether these two laws, neither of which specifically amends the SEH law, applies to the SEH program. The Committee concluded that since HMO carriers must comply with both laws as a condition of the Certificate of Authority, that the laws clearly apply to HMO plans issued in the SEH market. As a matter of policy, the Board has attempted to preserve a level playing field. The Committee believed that to be consistent with that practice, all plans, whether issued by an HMO or by a non-HMO should be required to comply with the laws. The Board agreed.

VII. Report of the Marketing and Finance and Operations Committees

W. Sanders said that since the Marketing Committee and the Finance and Operations Committee considered identical issues regarding changes to the SEH Program, that he combined the minutes.

Expansion of State Continuation
The Committees considered whether dependents who cease to be eligible as dependents should be entitled to elect to continue coverage, and whether the 12-month continuation period should be expanded to 18 months for employees and 36 months for dependents, like under COBRA.

The Finance and Operations Committee agreed that these changes would improve access to coverage, but noted there would be a cost impact, based on the assumption that persons who continue coverage tend to be persons with higher health risks. The Committee wanted to know what other states have done with continuation.

The Marketing Committee believed both changes would be beneficial, but wanted to know the cost impact.

L. Glover commented that the expanded continuation would address “life changes” such as divorce or college. D. Farkus noted that the increased cost for some health risks might be better spread to the SEH market than the IHC market.

Rating Changes
Both the Finance and Operations Committee and the Marketing Committee opposed permitting carriers to underwrite employer groups with fewer than 20 employees; permitting carriers to charge an administrative charge with each bill; limiting the percentage of rate increases; and standardizing the age/sex rating methodology.

Protections against Adverse Selection
Both the Finance and Operations Committee and the Marketing Committee agreed that allowing employers to select multiple plan options has presented some problems in the market. The Marketing Committee suggested that open enrollment periods, or

modifications to the participation requirement may be appropriate. The Committee would like to know how other states have addressed multiple plans.

The Finance and Operations Committee did not reach agreement concerning whether there should be a dependent participation requirement. The Marketing Committee opposed permitting a dependent participation requirement.

Distribution and Payment
The Department of Banking and Insurance's position is that carriers may issue plans electronically and may take electronic applications, although contesting an application without an actual signature may be difficult. Both Committees favored allowing electronic distribution and applications.

The Department of Banking and Insurance's position is that carriers may receive payment by credit card. D. Vanderhoof expressed concern that an employer might receive frequent flyer credit for payment by credit card, using employee contributions.

Participation Credit for Waivers
Both the Finance and Operations Committee and the Marketing Committee support providing participation credit for persons who waive coverage due to coverage under a student plan, a parent's plan, retiree plan, other employer plan or Medicare. The Marketing Committee would like to see credit extended for coverage under CHAMPUS or similar federal plans.

Loss Ratio
The Finance and Operations Committee did not reach agreement on whether expenses attributable to the operations of the carrier's medical director, utilization management and disease management should be considered as claims for loss ratio calculation purposes. The Marketing Committee favored allowing such expenses as claims.

Pre-Existing Conditions Limitations
The Committees considered whether the pre-existing conditions limitation provision should apply to all groups with 2-50 employees rather than just to groups with 2-5 employees as current law provides. The Finance and Operations Committee believed there might not be a significant cost savings and that any such change should apply prospectively so employers would have sufficient notice of the change. However, the Committee did not reach an agreement on whether to pursue the change. The Marketing Committee believed the change to expand the application of the pre-existing conditions limitation should be pursued.

Eligibility
Neither Committee considered whether the definition of an eligible employee should be modified to require 30 hours per week.

Plan Design
Both Committees recognized that A. 1606 includes a provision that would allow the EPO plan design.

Both committees favored higher copay options.

Both Committees favored introducing a 3-tier pharmacy rider that allows an open formulary.

Both Committees favored eliminating Plan A.

Survey
Both committees opposed conducting a survey of employers.

Mandated Benefits
Both Committees expressed concern with the effect of mandated benefits on cost.

Withdrawn Carriers
The Finance and Operations Committee disagreed that it is necessary to study why carriers have withdrawn from the SEH market. The Marketing Committee, and G. Cupo in particular, was interested in knowing which carriers have withdrawn.

[Break: 11:30 – 11:45]

VIII. Report of the Policy Forms Committee

E. DeRosa said the Committee reviewed an optional benefit rider filing from PHS Health Plans. She said the Committee noted some concerns with the filing, but that if the carrier could correct the filing, the Committee would recommend that it be found complete. She said she contacted the carrier and explained the concerns, but that the person who needed to make corrections had been out sick and had not made the necessary changes. As a result, the filing remained incomplete and not in substantial compliance.

D. Vanderhoof offered a motion to find the PHS Health Plans rider filing incomplete and not in substantial compliance. J. Majcher seconded the motion. The Board voted in favor of the motion, with T. English abstaining.

E. DeRosa said the Committee considered standard rider text that employs a 3-tier copay and allows an open formulary. She said the Committee would be researching what copay ranges would be appropriate. In addition, she said the Department had raised an issue concerning providing a benefit for use of a non-participating pharmacy that would comply with the 30% differential rule.

E. DeRosa said she understood the interest in having higher copays and a 3-tier pharmacy rider as quickly as possible. She suggested that separating the forms proposal might lead

to confusion in the market. Further, she said there were outstanding issues surrounding a 3-tier pharmacy rider that would delay proposal of such text. She noted that carriers may file riders of decreasing value in the meantime. D. Farkus suggested that if the Board were to propose the higher copay options as *options* there might not be confusion since only carriers that want to offer the higher options would be required to make forms changes.

M. Torrese offered a motion that the Board use the expedited rule proposal process to propose a $30 copayment, as optional with the HMO, POS and PPO plans, and a $2500 deductible as optional for use with indemnity plans B-D and the PPO and POS plans. T. Taliaferro seconded the motion. The Board voted unanimously in favor of the motion.

IX. Close of Meeting

D. Vanderhoof offered a motion to adjourn the Board meeting. J. Majcher seconded the motion. The Board voted unanimously in favor of the motion.

[The meeting adjourned at 12:10 p.m.]

Attachment: Expense Report