APPROVED

MINUTES OF THE MEETING OF THE NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM BOARD AT THE OFFICES OF THE NEW JERSEY DEPARTMENT OF INSURANCE TRENTON, NEW JERSEY July 12, 1995

Members present: Maureen Lopes, Chair; Dana Benbow, Vice Chair (Prudential); Nancy Fiorentino (DOH); Stephen Fischl, M.D.; Charlotte Furman (Home Life); Sanford Herman (Guardian); Charles Oliver (BCBSNJ); Leon Moskowitz (DOI); Amy Mansue (HIP of New Jersey); David Turner (Aetna); Dutch Vanderhoof; Melanie Willoughby.

Others present: Kevin O'Leary, Executive Director; Wardell Sanders, SEH Program Assistant Director; Ellen DeRosa, IHC Program Assistant Director; DAG Maria Smyth (DOL).

I. Call to Order

M. Lopes called the meeting to order at approximately 9:50 a.m. and announced that notice of the meeting had been published in three newspapers and posted at the Department of Insurance and the Office of the Secretary of State in accordance with the Open Public Meetings Act. A quorum was present.

II. Public Comment Session

No public comments were offered.

III. Minutes

- * C. Furman made a motion to approve the draft minutes of the June 21, 1995 meeting. D. Vanderhoof seconded the motion and the motion was approved by voice vote with A. Mansue, C. Oliver, and M. Willoughby abstaining.
- C. Oliver asked that the record reflect that the Blue Cross and Blue Shield of New Jersey Board representatives were provided with a redacted draft copy of the executive session minutes of the June 21, 1995 meeting. He further stated that Blue Cross objected to receiving a redacted version of those minutes.

IV. Legislative report

M. Lopes noted that Board members were provided with copies of A-3123, a bill sponsored by Assemblyman Garrett effecting the SEH Program, as well as a summary of the changes proposed by the bill. She further noted that the bill had not been formally

introduced, but would be introduced in the near future. She asked Board members to review the bill, and be prepared to discuss it at the next Board meeting.

V. Policy Forms Issues; Rider Filings

M. Lopes raised an issue first raised by Blue Cross at the last meeting concerning the standard form's references to "family coverage." She asked whether the Board should permit variable language in the forms so that the forms would not include references to "family coverage" when an employer offers employee coverage only. C. Oliver noted that the present forms create ambiguity when used with employee only coverage. Ellen DeRosa noted that the current definition of "covered person" was limited to persons to whom coverage was offered, and that the certificates issued to employees permit carriers to include an indication of what type of coverage is being offered. She suggested that ambiguities could be covered by reminding carriers by bulletin that certificates should include an indication of the coverage being offered. D. Benbow noted that prior to reform, carriers would typically use two contracts, one for employee coverage and another for family coverage. C. Oliver said that any time a consumer is provided with an ambiguous document, the chance of consumer confusion becomes significant, and puts the carrier at risk. After some discussion, the Board agreed to include variable language in the plans so that carriers could choose to use employee only forms or family coverage forms. The Board asked Ms. DeRosa to make the appropriate changes to the forms.

[S. Fischl arrived.]

The Assistant Director reported that the Policy Forms Committee had reviewed various optional benefit rider filings. The first rider filing considered was from Blue Cross which, similar to a previously filed and approved rider from Blue Cross, would lower the Coinsured Charge Limit for POS Plans C and D, but which would be designed for employee only coverage. Based on the Board's previous discussion of employee coverage, M. Lopes asked C. Oliver if he would like the Board to still consider the rider. C. Oliver withdrew the rider from consideration.

* D. Benbow made a motion to accept the recommendation of the Policy Forms Committee with respect to filing 1 from New York Life, as set forth in exhibit 1, to find the filing incomplete and not in substantial compliance. C. Furman seconded the motion, and the motion was approved unanimously by voice vote.

[L. Moskowitz arrived.]

* C. Furman made a motion to accept the recommendation of the Policy Forms Committee with respect to filing 2 from New York Life, as set forth in exhibit 1, to find the filing complete and in substantial compliance. M. Willoughby seconded the motion, and the motion was approved unanimously by voice vote. C. Oliver, noting that the Board's discussion regarding employee only coverage would not make the Blue Cross rider filing unnecessary, asked the Board to reconsider the filing. The Assistant Director noted that while the attached recommendations from the Policy Forms Committee did not include a recommendation with respect to the Blue Cross filing, the Committee had determined that the filing was otherwise complete and in substantial compliance.

* D. Benbow made a motion to find the optional benefit rider filing described in exhibit 1 complete and in substantial compliance. M. Willoughby seconded the motion, and the motion was approved by voice vote with C. Oliver and L. Moskowitz abstaining.

VI. Report of the Department of Insurance

L. Moskowitz reported that, pursuant to their statutory responsibilities, the Departments of Insurance and Health held a joint hearing on the issue of community rating in the small employer market on June 29, 1995. He noted that individuals presented testimony both for and against community rating in the small employer market. He reported that the Departments had developed four questions to be presented to all hearing participants, which questions were designed to provide greater detail on the issue of community rating. He noted that the Departments would develop a report to present to the Legislative leadership and to the Governor's office. He also noted that the Garrett bill, discussed earlier at the Board meeting, addressed the community rating provision of the statute, freezing the current 3 to 1 ban. He indicated that the review of the Garrett bill should be made in light of the report developed by the Departments.

VII. Policy Form Changes

M. Lopes said that the proposed policy forms changes had been sent to Board members and that carrier members were to report to the Department of Insurance on the cost impact of each proposed change. Bob Vehec of the Department of Insurance reported that the Department had received only one response, which did not provide a response in terms of a range, and that therefore it would be inappropriate to provide the information to the Board. M. Lopes then posed the question to the Board whether the total cost impact of the changes would be prohibitive, and whether specific changes should be considered individually. S. Herman reported that the change to provide for family aggregate for deductibles and coinsurance was the most expensive element of the proposed changes and would be in the 1% to 2% range, the addition of fertility services to indemnity plans without preapproval would be approximately 1.2%, and that the other additions would be minimal. C. Furman reported that the family deductible and coinsurance change would be approximately 1.2%. C. Oliver reported that the family deductible change would be less than 1%, the bone marrow transplant provision would be approximately 1.5%. M. Lopes suggested that the pieces together would result in a total impact on price of about 5%. A. Mansue noted that the maternity benefit and the bone marrow transplant change were the result of legislative requirements and therefore would have to be part of the package, and the fact that these changes are required should be

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made clear to small employers. C. Furman noted that the addition of fertility services, while not required by statute for indemnity carriers, was driven by a desire to have the benefits of the HMO plan mirror those of the indemnity plans.

A. Mansue said that she did not have a sense of what small employers would consider as an acceptable level of increased cost. C. Oliver noted that he was not sure that a 5% increase would be acceptable. S. Herman noted that the Board should recognize that cost may increase independent of any policy form changes. D. Vanderhoof said that the trend toward increased cost may not be as great for small employers, as many move into managed care plans. S. Fischl referred to a recent New York Times article which he said indicated that provider costs were decreasing. D. Turner indicated that Aetna had not seen a general trend of decreasing provider costs. A. Mansue said that the issue for the Board was whether a 5% increase was acceptable or not, and whether the Board should remove certain changes to bring down the cost impact of the changes. After a brief discussion of the cost impact of the proposed changes, D. Benbow said that detailed discussions about pricing must be avoided to avoid antitrust concerns. M. Lopes noted that the proposed changes were in response to what the Board perceived as market demands, and noted that she did not expect the Board to make significant changes to the policy forms in the future. After some discussion, M. Lopes indicated that proposed changes could appear in the form of a standard rider, as part of the standard policy forms. or the changes could be left to the carriers to offer via optional benefit rider. S. Herman noted that the cost of coverage is one of the most significant things considered by a small employer, and that if changes were not to address catastrophic coverage, the Board should consider not adding the benefits. C. Oliver and D. Vanderhoof agreed that small employers consider cost as a key factor in deciding whether to purchase a plan. L. Moskowitz noted that the standard forms already address matters that are not catastrophic coverage. A. Mansue noted that the Board had spent approximately six months reviewing the policy forms and considering what changes consumers would like to see to the standard forms. She further noted that the proposed changes consisted of six clarifications, eight additions, and that the remainder of the additions were required by law. C. Furman noted that the only three additions which were not typically covered by indemnity plans were nutritional counseling, nicotine dependence treatment, and vision coverage for children.

- * D. Benbow made a motion to propose the revisions as amendments to the standard policy forms, rather than as a rider option. A. Mansue seconded the motion, and the motion was approved with C. Oliver and S. Herman voting against the motion. The motion passed.
- M. Lopes indicated that the Board would next consider the proposed change to the family deductible and coinsurance cap independent of the other changes.
- * C. Furman made a motion to amend the standard policy forms to permit carriers to offer one of the following options: a family deductible and coinsurance provision with the family deductible and coinsurance cap computed on an aggregate

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basis with the cap set at three times the individual amount, or alternatively, a family deductible and coinsurance provision with the cap computed on an individual basis, with the cap at two times the individual cap (which option is in the current form); and the carrier must offer only one of these options to all small employers. L. Moskowitz seconded the motion, and the motion was approved unanimously by voice vote.

* A. Mansue made a motion to approve the other changes to the policy forms listed in Exhibit 2, and that the rule proposal contain an explanation of those items which were required by statute. S. Herman seconded the motion, and the motion was approved by voice vote with C. Oliver abstaining.

The Board noted that the proposed changes would have an overall impact on the rates of approximately 3.5%. Peter Thexton asked whether the changes to the forms, if adopted, would be effective on January 1, 1996. The Board agreed that the changes would be effective upon issue or renewal on or after January 1, 1996.

* L. Moskowitz made a motion to propose revisions to the HMO contract which correspond to the revisions to the indemnity plans and listed in Exhibit 3. A. Mansue seconded the motion, and the motion was approved by voice vote with C. Oliver abstaining.

VIII. Additional Policy Form Matters

M. Lopes noted that Prudential had recently raised the issue that the rider for prescription drugs did not clearly address the same drugs which are not offered in "doses" such as topical creams. She referred to a memorandum distributed to the Board which provided alternative language to address such prescription drugs. C. Furman said that she had reviewed the proposed language and found that its specificity raised other concerns. M. Lopes said that the Board would have to consider the issue at a later time.

M. Lopes referred to a draft IHC Bulletin 95-06, which would provide guidance to carriers for addressing changes to the policy forms required by statute prior to the anticipated effective date for the more comprehensive changes to the policy forms. The Board agreed that the bulletin should be a joint bulletin, with different sections in the bulletin for compliance under the IHC and SEH Programs respectively. The Board indicated that carriers in the small employer market could submit optional benefit riders as a means of complying with the new laws. A. Mansue said that she would provide guidance to staff in drafting language to address the 48 hour maternity care provision with respect to HMO contracts.

IX. Definition of "Coverage"

The Assistant Director presented the Board with draft language to modify N.J.A.C. 11:21-3.2(d), which would provide carriers with guidance on what constitutes "coverage" for purposes of optional benefit riders of increasing actuarial value. C.

Furman asked how the draft language would address changes to statutory definitions and preexisting conditions provisions. Since the preexisting condition provision is part of the Covered Charges with Special Limitations section, the draft rule proposal would permit changes to that provision. The Board agreed that changes to the definition section of the forms could be made in conjunction with changes which otherwise constitute changes to "coverage," but that no modification was necessary to the draft rule amendments.

* D. Benbow made a motion to propose the draft amendment to N.J.A.C. 11:21-3.2(d). C. Furman seconded the motion, and the motion was approved unanimously by voice vote.

X. Department of Insurance Regulations

L. Moskowitz reported that the Department had recently proposed a rule regarding the loss ratio requirements of the SEH Act. He noted that the proposal would be distributed with a bulletin to carriers instructing them to file by August 1, 1995 pursuant to the proposal. The Assistant Director reported that the Department had published a rule proposal regarding the SEH premium comparison survey. The Board asked for an update on the survey at its next meeting.

XI. HMO Blue Exhibit BB, Part 1 Filing

The Executive Director reported that the Board had received an Exhibit BB, Part 1 filing from HMO Blue. He indicated that the filing raised the following issues:

- 1) In response to section 2(b), HMO Blue certified that Plans A, B, C, D and E comply with the SEH Board's small employer health benefits plans forms. The cover letter accompanying the Exhibit BB dated 5/15/95 indicated that HMO Blue was offering "the HMO standard plan services and supplies as the in-network benefit and the fee-for-service Plan D benefits as the out-of-network benefit." The plan, as described in the cover letter, would not comply with the standard forms created by the Board. In addition, the cover letter did not indicate that HMO Blue was selling Plans A, B, C, or E.
- 2) In response to section 2(c), HMO Blue did not certify that its HMO plan complied with the standard HMO form.
- 3) In response to section 3(a)(2), HMO Blue indicated that it was offering a Plan D in conjunction with a selective contracting arrangement. The Executive Director noted that the DOI list of carriers with approved selective contracting arrangements did not include HMO Blue.
- 4) In response to section 3(b)(1), HMO Blue indicated that it was offering \$10 and \$20 copayment options for "In-Network" services. The standard HMO contracts, however, did not distinguish between "In-Network" and "Out-Network."
- 5) In response to section 3(b)(2), HMO Blue indicated that it is offering the inplan prescription drug coverage with 50% Co-Insurance. This option, while consistent with the standard HMO options, was inconsistent with indemnity plan POS options.
- 6) In response to section 3(d)(8), HMO Blue indicated that it had received approval of alternative utilization review provisions. While the Board has approved an

alternative utilization review filing from BCBSNJ, the Board's records did not contain information regarding a similar approval for HMO Blue.

- 7) With respect to HMO Blue's Certificate of Coverage for Plan D POS provided to the Board, the Executive Director noted that if offered by an indemnity carrier, the Certificate would present no issues except that it incorrectly used a Co-Insurance Cap provision rather than a Coinsured Charge Limit provision, and appeared to include alternative utilization language not approved for that carrier. However, the May 15, 1995 letter from Debbie Cieslik to Ward Sanders, was not consistent with the copy of HMO Blue's Certificate of Coverage. As noted above, the letter indicated that the POS plan offered by HMO Blue was "the HMO standard plan services and supplies as the innetwork benefit and the fee-for-service Plan D benefits as the out-of-network benefit." The standard POS text developed by the Board did not provide for full HMO look alike services and supplies.
- 8) The Executive Director referred to a copy of an excerpt from an HMO Blue rate filing. He said that the excerpt illustrated that the In-Network benefits of HMO Blue's POS product mirror all standard HMO benefits except with respect to the prescription drug coverage. He noted that the standard HMO forms permitted the use of a 50% Co-Insurance or \$15 copay, whereas HMO Blue's POS rate filing used a deductible and 80% Co-Insurance, and the Exhibit BB, as discussed above, indicated the use of a 50% Co-Insurance.

M. Lopes said that the Board should be consistent with respect to the ability of carriers to raise issues with respect to filings before the Board. She indicated that a Board meeting was not the proper forum to permit a carrier to debate the Board's reasoning, but that if there were factual information useful to the Board's decision, that factual information could be provided. C. Oliver responded to the Executive Director's presentation by stating that HMO Blue's Exhibit BB, Part 1 was a second Exhibit BB filing, and intended for HMO Blue's PPO products only. With respect to section 3(a)(2), he responded that HMO Blue had filed a replacement page on July 11, correcting this response. With respect to section 3(b), he indicated that the issue of whether an HMO could offer out-of-network benefits would have to be resolved in a hearing. With respect to section 3(b)2, C. Oliver indicated that in-plan prescription drug coverage could be offered under an HMO/POS product. With respect to section 3(d)(8), he noted that utilization review features applied to out-of-network benefits, and that Blue Cross and Blue Shield had received approval of an alternate utilization review features. Lastly, he noted that the SEH Board had not yet developed appropriate forms for HMOs to use in offering POS products.

The Executive Director then addressed the appropriate procedure for acting on the Exhibit BB filing. He noted that the Board's initial action would give rise to the right to a hearing.

* A. Mansue made a motion to not accept HMO Blue's Exhibit BB, Part 1 filing and to notify HMO Blue that it had a right to a hearing on the matter. D. Benbow

seconded the motion, and the motion was approved by voice vote with C. Oliver abstaining.

C. Oliver asked what HMOs who wish to offer POS products should do in the absence of regulations. Channel McDevitt of the Department responded that carriers should use the proposed rules which would be appearing shortly in the *New Jersey Register*.

C. Furman noted that the changes agreed to by the Board did not include changes to pages of the PPO provisions of the policy forms. The Board agreed that those changes would appear in a later adoption. M. Lopes indicated that the Policy Forms Committee would be meeting before the next meeting to discuss POS and PPO policy forms.

XII. Medical Savings Accounts

A. Mansue provided the Board with a rough draft of a report regarding Medical Savings Accounts. She noted that the SEH Act requires the Board to provide a report regarding MSAs to the Legislature. She asked Board members to review the draft and provide comments to her, and asked Board members to provide any reports or information regarding MSAs. She noted that while 13 states had passed laws regarding MSAs, none of those states require policies to be community rated. C. Furman noted that there is a report on MSAs published by the Academy of Actuaries that may be useful. C. Furman also noted that there may be federal legislation regarding MSAs in the near future. A. Mansue indicated that the report to the Legislature should be provided as soon as possible. D. Benbow noted that without federal tax amendments, MSAs would not provide an attractive options for employers.

XIII. Report of the Assistant Director

The Assistant Director referred to a spreadsheet provided to the Board that reflected revised enrollment reporting for the 1st Quarter of 1995. He said that the spreadsheet included a revised report from The Guardian which had underreported dependent coverage of approximately 2000 persons with respect to new issues. approximately 1000 persons in renewals, and approximately 15,000 persons in plans in force at the end of the 1st Quarter. He indicated that Guardian had reported "dependent units" rather than dependents, and that Guardian's confusion was the result of the yearly enrollment reporting regulation which requested "dependent units" rather than dependents. The Assistant Director asked the Board if it had meant to require reporting of dependent units, and the Board responded that it did not. He also noted that many carriers had indicated that they were estimating dependent coverage because their systems did not capture real numbers of dependent coverage, and asked if the Board should develop a formula for estimating such coverage so that carriers provided consistent estimates. The Board agreed, and D. Benbow noted that the IHC Board had developed such a formula. The Assistant Director said that he would prepare a rule proposal to reflect this discussion.

The Assistant Director referred to a draft rule proposal which would amend N.J.A.C. 11:21-7.6, the participation regulation. The change would provide credit for coverage under any health benefits plan provided by the employee's small employer. He indicated that the change was requested at the last Board meeting. C. Furman said that she thought the issue presented to the Board at the last meeting was whether to expand credit from "any HMO plan" to "any managed care plan." The Assistant Director responded that while that was the issue presented to the Board, the Board had decided to expand credit to all plans. L. Moskowitz expressed a concern that the draft proposal should be clarified to indicate that no credit would be given for self-funded plans. The Assistant Director responded that Subsection 7 of the SEH rules defined "health benefits plans" which definition referred to standard and nonstandard small employer plans, but that he could make clear in the summary of the rule proposal that credit may not be given for self-funded plans.

* C. Furman made a motion to propose the draft amendments to N.J.A.C. 11:21-7.6 to provide credit for coverage under "any health benefits plan." L. Moskowitz seconded the motion, and the motion was approved unanimously by voice vote.

XIV. Report of the Executive Director

The Executive Director reported he had sent interim assessment bills to carriers. He noted that, pursuant to a consent agreement with the Department of Insurance, Independence Blue Cross had agreed to pay assessments to the IHC and SEH Programs. He indicated that appropriate adjustments would be made for carriers during the final assessment.

The Executive Director distributed an expense report. He noted that the only large item was the cost for reproducing copies of the Buyers' Guide. The Assistant Director noted that carriers were still receiving free copies of the Guide, pursuant to an earlier decision by the Board, in amounts permitted by the Board.

* L. Moskowitz made a motion to approve the expense report, attached hereto as exhibit 4. C. Furman seconded the motion, and the motion was approved unanimously by voice vote. [Met 2/3rds supermajority requirement.]

The Executive Director reported that he had met with representatives of Deloitte & Touch concerning the audit of the SEH Program. He noted he had received responses to a bid for a bookkeeper to put the books in order for the audit, and he would like authorization for up to \$5000 to hire the bookkeeper who is also providing similar services to the IHC Program.

* A. Mansue made a motion to approve spending up to \$5000 for the hiring of the same bookkeeper hired by the IHC Board. D. Benbow seconded the motion, and the

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motion was approved unanimously by voice vote. [Met 2/3rds supermajority requirement.]

The Executive Director referred to a letter sent from a representative of CIGNA which commended the work of the SEH Board's staff. With respect to outreach efforts, he reported that he had recently appeared on a radio show entitled "New Jersey Today" and had spoken to a branch of the New Jersey Health Underwriters Association. He also indicated that he had accepted an invitation to participate in a forum in Portland, Oregon to be paid by forum's organizers. He also distributed copies of a response to a Letter to the Editor in a recent edition of *The Trentonian*. Lastly, he reported that the IHC Program had held a press conference on July 11, 1995, and he distributed copies of some of the press resulting from the press conference.

The Executive Director referred to a memorandum regarding enforcement procedures. He noted that the memorandum was meant to address all enforcement matters facing the Board. The memorandum noted that the threshold issue in enforcement issues was jurisdiction: if the matters dealt with licensure, it should be referred to the Department for action; if the matter dealt with a violation of the SEH Act or rules, the Board should investigate the matter and seek voluntary compliance, and then refer it to the Department for appropriate action. He indicated that these procedures were outlined in a previous memorandum of understanding between the Board and the Department. In the context of HMOs offering POS products, the issue of licensure and the Board's statute and regulations were involved. The Executive Director recommended that issues of licensure be referred immediately to the Department, and that the Board's staff should, where appropriate, follow-up with HMOs with respect to their responses to SEH Bulletin 95-03, to determine what violations of the SEH Act and rules, including policy forms, had occurred. He noted that the Attorney General's Office could be asked to provide the Board with a list of appropriate actions.

A. Mansue noted that the Board needed to take swift action with respect to HMOs offering POS actions. She expressed a concern that the actions outlined above would not address past actions by HMOs. She noted that significant issues of competition have been raised since some HMOs have been told that they could not provide out-of-network benefits, while other HMOs seem to have been selling POS products in the small employer market. The Executive Director noted that the Department could look at past actions by carriers with respect to matters referred to it by the Board.

* A. Mansue made a motion to adopt the enforcement procedures outlined by the Executive Director above. M. Willoughby seconded the motion, and the motion was approved unanimously by voice vote.

XV. Responses to SEH Bulletin 95-03

The Assistant Director referred the board to a handout which included a spreadsheet showing the responses to SEH Bulletin 95-03 from HMOs and copies of

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those responses. He noted that ten HMOs had provided responses prior to the SEH Board meeting.

XVI. Executive Session

M. Lopes said to the audience that the Board would be entering executive session for the purpose of discussion enforcement actions and that the Board would not be discussing any matters after executive session.

* M. Lopes made a motion to enter executive session for the purpose of discussing enforcement actions. D. Vanderhoof seconded the motion, and the motion was approved unanimously by voice vote.

XVII. Close of Meeting