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
October 20, 1999

Members present: Gary Cupo; Darrel Farkus (Oxford); Larry Glover (Chair); Linda Ilkowitz (Guardian); Charlotte Furman (AH&L); Jane Majcher (DOBI); Mary McClure (NYLCare); Michael Torrese (Horizon BCBSNJ); Dutch Vanderhoof (arrived @ 10:05); Eric Wilmer (Celtic); Bonnie Wiseman (DOHSS).

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

I. Call to Order

L. Glover called the meeting to order at 9:55 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.

W. Sanders noted that M. McClure was the representative for NYLCare.

II. Public Comments

L. Glover asked if any member of the audience wished to offer comments concerning the items stated on the agenda. No comments were offered.

III. Minutes

September 15, 1999
J. Majcher offered a motion to approve the minutes of the Open Session of the September 15, 1999 Board meeting, as amended. M. Torrese seconded the motion. The Board voted in favor of the motion, with L. Glover abstaining.

IV. Staff Report

Expense Report (see attached)
C. Furman offered a motion to approve the payment of the expenses specified on the October 20, 1999 expense report. L. Ilkowitz seconded the motion. The Board voted unanimously in favor of approving the motion.

Outreach
W. Sanders reported that he spoke at a HCFA conference in San Francisco in late August. He said he spoke about the data collection efforts in New Jersey as well as the individual market assessment mechanism. Deb Garnick, one of the researchers who worked on the Harvard-Brandeis study of the IHC Program, also spoke about health reforms in New Jersey. W. Sanders said presenters at the conference gave updates on federal regulations and bulletins. He noted that a copy of one of the Bulletins was included in Board materials. He said the HIPAA related issues included how group size should be counted, what happens when a group size increases or decreases, and application of a pre-existing conditions exclusion. He reported that regulations would be promulgated in segments with topics including: associations; extension of benefits; active work requirements; eligibility and rates. W. Sanders said the implementation and enforcement issues faced by States were discussed, along with data collection efforts. He said that Technical Advisory Groups would be formed that would provide informal input to HCFA. He said he has materials from the Conference and would make them available to any Board member who would like to review them.

W. Sanders said he would develop an outline of the issues the SEH Board will need to address with respect to HIPAA compliance and forward the outline to the SEH Legal Committee for consideration.

Legislative Update
W. Sanders said that a summary of legislative activity was included in Board materials. He noted that the Federal Access and Patient Protection legislation passed the House. He briefly discussed some of the features of the Access to Insurance Bill and the Norwood Dingel Patient Protection Bill.

W. Sanders commented that on the State level, S.222, a bill amending the Health Wellness Promotion Act, is on a second reading and among other things, specifically exempts the IHC and SEH Programs from the requirements of the law.

1998 Current Population Report on Health Insurance Coverage
W. Sanders said the U.S. Census Bureau released a 1998 Report on health insurance coverage. The Report shows that the percentage of New Jersey residents without health coverage decreased from 16.5% to 16.4%.

Garden State Hospitalization Plan
W. Sanders reported that Garden State Hospitalization Plan was placed under direct control of the Department on September 27, 1999. The Life and Health Guaranty Association has been activated to cover outstanding claims.

Professional Employer Organizations (PEOs)
M. Torrese asked about the status of discussions on Professional Employer Organizations. W. Sanders said that the Department is still studying the issue.

Policy Forms Adoption
W. Sanders said that the policy form adoption was filed with the Office of Administrative Law. Notice was sent to the interested parties list and all carriers were sent a Bulletin that includes the text carriers must use if they elect to comply with the forms changes by using the Compliance and Variability Rider.

1998 Assessment Collection
W. Sanders reported that payments have been made by a majority of the member carriers.

Riders of Decreasing Value
W. Sanders noted that a list of riders of decreasing value that have been approved by the Department was included in the Board materials.

V. Report of the Policy Forms Committee

Optional Benefit Riders
E. DeRosa reported that Anthem Health and Life of New York submitted an optional benefit rider filing. She noted that while the forms in the filing were identical to optional benefit riders submitted by AH&L, the two companies are not affiliated. C. Furman briefly discussed the relationship between these two companies. E. DeRosa explained that the riders in the filing amend PPO and POS plans. She said she contacted the carrier to find out if it had an approved Selective Contracting Arrangement (SCA). The carrier did not, but hoped to rely on the SCA approval for AH&L. E. DeRosa said the Department notified Anthem Health and Life of New York that it must submit an SCA application on its own. Thus, the riders are designed to amend plans that the carrier cannot offer since it does not have an approved SCA. E. DeRosa also noted that the language in the riders does not reflect the text that the Board adopted in September 1999 and would need to be updated to be consistent with current standard language. She said that riders are filed with the Board on an informational basis. Unless the Board takes action to find the filing incomplete, the carrier could deem the filing complete and use the riders. She suggested that the Board should find the filing incomplete.
D. Farkus offered a motion to find the optional benefit rider filing submitted by Anthem Health and Life of New York as incomplete. D. Vanderhoof seconded the motion. The Board voted in favor of the motion, with C. Furman abstaining.

Home Health Care and Private Duty Nursing
E. DeRosa reported that the Committee discussed the information provided by the Home Health Assembly concerning definitions of terms used in a home health benefit such as "part-time," "full-time" and "intermittent." She said the Committee also discussed information submitted by carrier members of the Committee concerning administration of the benefits. The members of the Committee who participated in the meeting agreed that simply defining terms would not be sufficient. Rather, E. DeRosa said they believed that in addition to defining terms, the forms should specify limits, either based on number of days or hours or dollar amounts. She said the Committee believed it would be helpful to gather information from other carriers to find out what benefit limits, if any, are included in their large group plans. The Committee did not believe the coverage in the small employer plans should be significantly more generous than coverage provided under

large group plans. The Board did not believe that a survey of carriers regarding home health coverage and private duty nursing coverage was warranted at this time. As two Committee members were unable to participate in the meeting, the Committee will further discuss the coverage during the November Committee meeting. E. DeRosa also noted that the Department representative on the Committee suggested that the Board consider whether HIPAA allows the Board to modify a plan that must be guaranteed renewable. E. DeRosa said that the renewability issue would be considered by the Legal Committee.

[Break: 11:05 a.m. – 11:23 a.m.]

VI. Report of the Legal Committee

Notice of termination

W. Sanders said the Committee considered a number of group plan termination situations and the premium payment liability for each.

Prospective Notice: If the employer provides written notice that coverage should end as of a future date, the carrier must honor the request and terminate coverage as of the requested date. The employer is liable for the payment of premium until the termination date.

Retroactive notice: If the employer provides written notice that coverage should have ended as of a prior date, the carrier cannot be required to retroactively terminate the coverage. The employer may be held liable for premium payment through the date the notice is received. A carrier *may* elect to retroactively terminate coverage if the employer can demonstrate that new coverage was secured and was effective as of the date the employer requested as a termination date.

Current Notice: If the employer provides written notice that coverage should end immediately, the employer may be held liable for the payment of premium until the date the notice is received.

No Notice: If the employer does not pay the premium due, coverage stays in force during the grace period. The employer may be held liable for the payment of the premium for the time coverage was in force during the grace period.

D. Vanderhoof expressed concern that there would be double coverage during the overlap period if the former carrier would not agree to retroactively terminate coverage upon receipt of proof that a replacement plan was secured. He suggested that an employer might decide to purchase double coverage in order to secure additional coverage for those services that have limited coverage. E. DeRosa explained that the guidance the Legal Committee provided was not new or unique to the SEH Program. She explained that carriers have assumed risk. Until they receive notice that the plan is being terminated, they continue to have responsibility for the risk. Whether the employees used the old plan or whether the old plan was replaced with another plan does not have an affect on the risk the carrier assumed. Premium is required for the risk that has been assumed. She further explained that if a carrier continues coverage in force beyond the requested termination date or beyond the end of the grace period, the carrier cannot require premium payment for such additional periods.

G. Cupo suggested that if carriers could be required to give renewal notices at least 60 days prior to the renewal date it would give the employers more time to consider the renewal and apply for replacement coverage, if necessary. He said that if the applications for the replacement coverage could be submitted earlier, the new carrier would have time to send the approval letters before the requested effective date. M. Torrese said that employers tend to act at the last minute. He said that having the notice earlier would not necessarily mean that the employers would apply more promptly. E. DeRosa noted that some states require 60-day notice for renewals but those notice requirements are generally state-specific and do not tend to be market-specific.

D. Vanderhoof suggested that the Board should survey carriers to find out how they handle termination requests. L. Ilkowitz suggested that a better approach would be to issue a Bulletin and state that this is how termination works.

J. Majcher offered a motion to accept the recommendation of the Legal Committee concerning when coverage ends and the liability for premium payment. L. Ilkowitz seconded the motion. The Board voted in favor of the motion, with D. Vanderhoof opposed.

The Board took a poll on whether to conduct a survey or release a Bulletin. All Board members, except D. Vanderhoof, favored a Bulletin. D. Vanderhoof favored a survey.

G. Cupo asked that the Board consider the 60-day notice requirement. The Board agreed to consider extending the notice requirement from 30 days to 60 days when it reviews the standard plans in 2000.

Commission Survey

W. Sanders said that one carrier provided morbidity data. That data, which was provided by a carrier that has a significant block of business, shows that there is a very strong correlation between group size and morbidity, with smaller size groups having higher morbidity. Paying lower commissions to agents for the sale of smaller group cases could therefore be a means to avoid sales to the smaller groups whose experience is likely to be worse than the experience of larger groups. W. Sanders suggested that the most effective way to prohibit paying lower commissions for smaller groups would be to amend the regulations. He said there was nothing in the Unfair Trade Practices Act or the NAIC Model regulation on small group reform to address commissions.

D. Vanderhoof said he would be concerned that unless there is a prohibition, carriers will implement two levels of commissions, and the other carriers will be forced to follow suit or risk attracting all the smaller size group business.

The Board voted as to whether commission levels based on group size should be prohibited and whether the Board should amend the regulation to state that commissions cannot vary based on group size. The Board took a straw poll on the issue. Nine members said that commissions based on group size should be prohibited and that the Board should propose a regulation to so state. J. Majcher abstained. D. Farkus said that

if the commission payment could come from the 75% portion of the loss ratio calculation, he would agree it should be regulated. However, if it continues to come from the 25% portion of the loss ratio calculation, he did not believe it should be regulated.

L. Glover suggested that it would be important to seek guidance from the Commissioner on the commission issue.

VII. Close of Meeting

J. Majcher offered a motion to adjourn the Board meeting. C. Furman seconded the motion. The Board voted unanimously in favor of adjourning the meeting. [The meeting adjourned at 12:55 p.m.]

Attachment: Expense Report