NEW JERSEY

INDIVIDUAL HEALTH COVERAGE PROGRAM BOARD

20 West State Street, 10th floor
CN 325
Trenton, NJ 08625

MAY 9, 1995

Directors Present: D. Benbow (Prudential); M. L. B. Kaplan (Blue Cross and Blue Shield of New Jersey); L. Moskowitz (Department of Insurance); R. Rondum; R. Smart (Mutual of Omaha); G. Young (USHealthcare)

Others Present: K. O'Leary, Executive Director; DAG Maria Smyth (DOL); Ellen DeRosa, IHC Program Assistant Director

I. Call to Order

D. Benbow called the meeting to order at 9:38 a.m. and announced that notice of the meeting had been published in three New Jersey newspapers and posted at the Department of Insurance and the Office of the Secretary of State in accordance with the Open Public Meetings Act. K. O'Leary took roll call and determined that a quorum was present.

II. Review of Minutes

R. Rondum said that it was her understanding that a Federally Qualified HMO could use modified community rating using factors such as age and sex. That being the case, she wanted to be assured that HIP had used true community rating and not modified community rating in connection with the conversion business HIP requested permission to consider in the satisfaction of its 1993 minimum enrollment share. D. Benbow stated that HIP had used true community rating.

G. Young offered a motion to adopt the minutes of the April 11, 1995 Board Meeting. M. L. B. Kaplan seconded the motion. The Board voted unanimously in favor of adopting the minutes.

III. Report of the Chairman

D. Benbow said there was nothing to report at that time. Discussion of the auditing firm was to occur during the Executive Session.

IV. Report of the Executive Director

K. O'Leary announced that the election for two carrier seats was to take place during the Board meeting. He said that the Assistant Director had reviewed the Absentee ballots which had been accepted until 4:00 p.m. on May 8, 1995, and disallowed those which were submitted by non-member carriers as well as those which were duplicates. He asked the Assistant Director to report on the election results.

The Assistant Director asked if any carrier present at the meeting wished to submit a ballot. None were submitted.

Blue Cross and Blue Shield of New Jersey was elected as the Health Service Corporation and Mutual of Omaha was elected as the foreign insurer.

Votes for the foreign insurer seat were cast as follows:

- Mutual of Omaha: 30
- Time Insurance Company: 8
- Washington National: 5
- Oxford Health Insurance: 1

(Note: An additional absentee ballot which had apparently been faxed to an incorrect number was received following the election. Since the time on the fax indicated it had been sent prior to the deadline for the absentee ballots, it should be noted that Washington National received 6 votes.)

K. O'Leary noted that both of the newly elected seats were for 3 year terms.

K. O'Leary next discussed the preliminary assessments. He said that the Assistant Director had followed up with carriers that had submitted questionable non-member certifications or Exhibit Ks. As a result, the list of carriers named on the preliminary assessment spreadsheet should be fairly close to accurate. He reported that the spreadsheet had been mailed to member carriers on May 4, 1995. Any carrier that wished to request an exemption from the 1995 reimbursable loss assessment would have until June 1, 1995 to submit that request. He stated that the spreadsheet that had been released to carriers had subsequently been modified, and that a modified version was contained in the packets provided to Board members. The original calculations had allocated over 35% of the losses to BCBSNJ. Thus, the excess losses had to be re-distributed among the other carriers subject to assessment . K. O' Leary briefly explained the purposes for several of the columns on the spreadsheet. He noted that, per regulation, the minimum enrollment share for 1995 was not discounted, as it had been in the past. For 1995, carriers would have to enroll a number of non-group persons equal to 100% of their minimum market share in order to qualify for a full exemption.

D. Benbow asked whether the 1994 non-group persons total should be inclusive of all persons, or only those which a carrier could use to calculate the number of non-group persons for the purpose of the exemption. K. O'Leary said that the regulations indicated that the 1994 total of non-group persons was supposed to include all non-group persons. L. Moskowitz inquired as to whether TAC had reviewed the assessments. K. O'Leary said the committee had not. D. Benbow asked the Assistant Director to provide TAC with copies of Exhibit K for all carriers that had reported non-group persons as well as copies of the documentation and certification of minimum enrollment share from those carriers that had requested an exemption. He said TAC would review. If the 1994 non-group total was incorrect, the Executive Director would be able to release revised 1995 minimum enrollment share numbers in time for carriers to decide whether to request an exemption, as due June 1, 1995. L. Moskowitz asked if the Board would have to act in the event of a modification. D. Benbow said no Board action would be required since no final bills were scheduled to be released until after completion of the audit.

Next, K. O'Leary asked the Board to consider the Expense Report. He noted that the documentation the Board had asked him to secure from McQueeny, Davis, Kohm & Partners had been provided.

R. Rondum offered a motion that the McQueeny, Davis, Kohm & Partners item of expense, along with all other expenses included on the expense report, be approved for payment. M. L. B. Kaplan seconded the motion. The Board voted unanimously in favor of approving the payment of the expenses included on the Expense Report.

K. O'Leary stated that the packet provided to Board members included a draft copy of Bulletin 95-0__, dealing with student coverages. He said that the thrust of the Bulletin was to advise carriers that are in the student coverage market that they could not continue to violate IHC statutes and regulations. He said that Gail Simon had advised him that the Commissioner would review and approve policies issued directly to colleges and universities as discretionary groups. L. Moskowitz observed that it was too late to develop rigid standards for the 1995 - 1996 school year, as schools had to release enrollment materials during the spring of 1995. He said the solution presented in the Bulletin would give carriers a window in which to operate during the 1995 - 1996 school year.

M. L. B. Kaplan asked what kind of benefits were provided in the plans. D. Benbow said the Bulletin did not speak to the benefits, but rather to the manner of issue. L. Moskowitz said that carriers would sell whatever benefits were normally sold, but that the forms were required to be filed. He pointed out that law in New Jersey required that student coverage be available. G. Young said that if carrier did not file and continued to sell, it would likely be doing so through a Trust. D. Benbow said enforcement action would be taken against such carriers. M. L. B. Kaplan speculated that there would be disruption in the market when carriers realized they could not use Trusts, and must file with the Department. He noted that some Trusts were controlled by agents.

M. Smyth said her office would be suggesting changes, and wanted to coordinate the Bulletin with other advice. If the Board wanted to discuss the nature of the other advice, she said she could do so during Executive Session. D. Benbow said that the draft Bulletin was fairly lose to what the Board intended. Therefore, no Board action was required, other than to state that the Bulletin was to be sent. K. O'Leary said that if he received no substantive changes, he would send a copy to the Board for information only. R. Rondum expressed concern that the advice from the Attorney General's Office might require substantive changes. D. Benbow said the Bulletin should be released unless something that necessitated delay emerged from the Attorney General's Office.

Tom Smith noted that three carriers had responded to Joint Advisory Bulletin 95-01. He said enforcement was the responsibility of the Department. K. O'Leary stated that those companies, and others, would only be able to continue to market student plans if they filed with the Commissioner. L. Moskowitz added that if a carrier was currently writing using an unapproved form, that carrier would be required to file the form in order to continue writing student plans.

K. O'Leary next reported that he had received a letter from the NAIC. A committee had been working on an individual coverage model bill and he had been invited to speak at a committee conference in June. L. Moskowitz said K. O'Leary could not

represent the Commissioner. D. Benbow commented that the NAIC had approached K. O'Leary and the Board, not the Commissioner. The Board would want any model that would emerge to be consistent with New Jersey law.

R. Rondum expressed concern with "brain drain." The Board had hired K. O'Leary to work for the Board and not to advise other entities. She wanted him to stay close to the New Jersey program. K. O'Leary clarified that the NAIC meeting would take place over a Saturday and Sunday, thus not taking time that would have been spent on Board matters.

R. Smart said she had had involvement with NAIC committees and that the committee working on the individual model bill was confused regarding the New Jersey program. She said the Board could not be uninvolved. L. Moskowitz said that persons beyond K. O'Leary may need to be involved as well. R. Smart cautioned that the New Jersey program was still in early stages, and the Board could not assert that New Jersey had found *the* way to address the individual market. K. O'Leary said he would be an advocate as regards the New Jersey approach. D. Benbow said other states have tried to address the individual market and have not even come close to what New Jersey has accomplished. L. Moskowitz agreed that New Jersey was in a unique position.

G. Young offered a motion that the IHC Board pay the expenses associated with the Executive Director traveling to St. Louis to meet with the NAIC committee. M. L. B. Kaplan seconded he motion. The Board voted unanimously in favor of payment of the St. Louis trip expenses for K. O'Leary.

K. O'Leary asked for comments regarding a poster he had designed for use in Doctor offices. He said he intentionally wanted it to look like a government announcement and did not want it to appear too slick. R. Rondum asked that the patient be gender neutral, and turned 180 degrees. L. Moskowitz commented that the second paragraph implied that employers could get help with costs. Tom Smith suggested that the text refer specifically to individual coverage to avoid possible misunderstanding. D. Benbow said any other comments should be given to K. O'Leary. Also, the poster would have to be discussed with the SEH Board and with the Access Program.

K. O'Leary said he had accepted an invitation from the chair of the Massachusetts House Insurance Committee, and had spoken to the committee on May 4, 1995. Everyone involved with the committee asked him questions. On May 5, 1995, he had participated on a panel arranged by the Harvard School of Public Health.

K. O'Leary asked that the Board adopt N.J.A.C. 11:20-3.1 regarding the permissible differential for plans which utilize a selective contracting arrangement.. He said no comments had been received. D. Benbow asked if there were a motion to adopt. L. Moskowitz said the Department's bulletin concerning POS would soon be released. He said the Board's regulation might require modification. L. Moskowitz offered a motion to adopt the regulation. There being no Board member willing to second the motion, D. Benbow closed the discussion.

V. Report of the Forms Committee

R. Smart said the committee had received several additional certifications (Exhibit Q). There were still some carriers that appeared on the rates pages that accompany the Buyer's Guides that have not submitted the certifications. D. Benbow suggested that TAC should withdraw any determination of rate filing completeness for those carriers that failed to submit the certifications. He asked which carriers failed to provide certifications. R. Smart identified: Centennial; Greater Atlantic; National Casualty; National Health; Sanus; and Travelers.

M. L. B. Kaplan offered a motion that the Board direct the Executive Director to tell carriers that did not file certifications to either file the certifications forthwith, or cease and dessist selling forthwith. L. Moskowitz seconded the motion. The Board voted unanimously in favor of the Board directing the Executive Director to take such action.

R. Smart noted that there was a new carrier - Continental Casualty. Its certification indicated a PPO plan, using Private Health Care Systems. Principal Mutual had added a PPO. D. Benbow said TAC needed to look for corresponding rates.

D. Benbow asked that the rate activity spreadsheet be expanded to include data concerning the certification.

R. Smart had met with the Assistant Director to discuss policy forms changes suggested by the SEH Board. She said she would indicate on the issues list how the SEH Board had addressed the issues. D. Benbow said that changes for the IHC plans would be discussed at the June meeting, or perhaps during a special Board meeting called specifically to discuss policy forms.

R. Rondum asked that the Attorney General's Office provide the statutory basis for prohibiting an expansion of the definition of dependent child to include grandchildren.

BREAK: 11:00 - 11:15

VI. Report of the TAC

D. Benbow suggested that there should be a bulletin sent to carriers requiring carriers to characterize rate action as increasing or decreasing by xx%. D. Benbow commented that TMG filed a rate increase of 100%. R. Rondum said that if a one year rate guarantee were required, such increases could not occur for one year.

D. Benbow offered a motion that the Board accept TAC recommendations regarding rate filings, as shown on the TAC report. M. L. B. Kaplan seconded the motion. The Board voted unanimously in favor of accepting TAC recommendations.

D. Benbow said that the refund plans TAC had reviewed required technical corrections.

VII. Report of the Legal Committee

M. L. B. Kaplan said the committee had nothing to report.

VIII. Report of the Marketing Committee

K. O'Leary said that discussion on the RFP for a Public Relations firm would be delayed until the June meeting.

R. Smart commented that changes to the Buyer's Guide, consistent with the 1995 modification to the forms, had not been made. She asked about the status of an insert to the Guide reflecting the changes. (E. Shrem was not present to offer a status report.)

K. O'Leary said that first quarter enrollment reports were due in mid-May. D. Benbow said that Access Program enrollment would be reflected in future IHC enrollment reports. (No Access Program policies were issued during the first quarter.)

M. L. B. Kaplan offered a motion that the Board enter Executive Session to discuss legal matters. G. Young seconded the motion. The Board voted unanimously in favor of beginning executive session.

Executive Session began at 11:30 a.m., and continued until 12:50.

D. Benbow offered a motion that the Board award 2 audit contracts to Deloitte & Touche (D&T). The first contract would be for the program audit of program years 1993 - 1994 at a rate of $85 / hour, and for program year 1995 at a rate of $89 / hour, to a 3 year maximum of $26,000, inclusive of out-of pocket expenses. The second contract would be for the 1993 and 1994 reimbursable loss audit at a rate of $98 / hour, to a maximum of $115,000 for the 2 year period. Out of pocket expenses would be in addition to the hourly rate. For 1995, the guaranteed rate would be $102 / hour. The contract would include an appropriate termination provision. R. Smart seconded the motion. The Board voted unanimously in favor of awarding the contracts to D&T, under the stated terms.

C. Nicholas said she had sent out several releases.

M. L. B. Kaplan offered a motion to adjourn the meeting. L. Moskowitz seconded the motion. The Board voted unanimously in favor of adjourning the meeting. The meeting ended at 1:00 p.m..

May 26, 1995

Directors Present: D. Benbow (Prudential); S. Kelly (Blue Cross and Blue Shield of New Jersey); C. Mc Devitt and L. Moskowitz (Department of Insurance); R. Rondum; E. Shrem, R. Smart (Mutual of Omaha); C. Wowkanech (Chair), G. Young (USHealthcare) *NOTE*: L. Moskowitz and C. Wowkanech participated via telephone conference.

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

I. Call to Order

D. Benbow called the meeting to order at 9:37 a.m. and announced that notice of the meeting had been published in three New Jersey newspapers and posted at the Department of Insurance and the Office of the Secretary of State in accordance with the Open Public Meetings Act. K. O'Leary took roll call and determined that a quorum was present.

D. Benbow advised that the focus of the meeting would be as follows: Executive Session; Approval of Expenses; and Policy Forms. The meeting would end no later than 12:30 p.m..

R. Smart offered a motion to begin Executive Session. C. Wowkanech seconded the motion. The Board voted unanimously in favor of beginning Executive Session.

Executive Session - 9:45 a.m. - 10:30 a.m.

Break: - 10:30 a.m.- 10:40 a.m

Note: C. Wowkanech terminated participation via the telephone conference before the open session resumed.

Report of the Executive Director

K. O'Leary discussed the Expense Report that was included in the packets provided to Board members.

E. Shrem offered a motion to approve the payment of the expenses included on the report. G. Young seconded the motion. The Board voted unanimously in favor of approving the payment of the expenses included on the Expense Report.

Policy Forms Committee

R. Smart distributed packets to Board members containing 3 sections. One section outlined issues which were still under consideration by the Forms Committee. A second section discussed Forms Committee recommended changes to the policy forms. The final section presented issues for Board discussion. She explained that in order to meet the desired mid-June filing deadline with Office of Administrative Law (OAL), the Board would have to act quickly to make decisions regarding proposed language.

D. Benbow suggested that the Board begin by discussing the section of items identified as requiring Board discussion. He reminded the Board that the Board was only reviewing text at that time, and that voting to propose text would occur at the June 13, 1995 meeting.

L. O'Leary stated that the Board should respond, in general, to all the comments received as a result of the Public Comment Session. Maria Smyth suggested that the Board could merely acknowledge that the Board had received comments on stated issues, and that no changes were being proposed at this time.

Note: The order of discussion generally followed the order outlined in the Policy Form Committee handouts to Board members. Numeration listed in the minutes is consistent with that contained in the handouts.

I. Medical Treatment Outside the U.S.

R. Smart clarified that the issue was whether the IHC forms should allow overage for persons while traveling outside the U.S. and / or persons who are temporarily outside the U.S. on a business assignment. G. Young noted the difficulties HMOs have with respect to coverage outside the service area of the HMO.

The Board determined that coverage should be provided to persons while they travel outside the U. S. No text changes should be made to allow coverage for persons temporarily outside the U. S. on a business assignment.

II. Dose Intensive Chemotherapy, Autologous Bone Marrow Transplant and Peripheral Blood Stem Cell Transplants

R. Smart explained that there was a new law that required carriers to *offer* coverage for Dose Intensive Chemotherapy, Autologous Bone Marrow Transplant and Peripheral Blood Stem Cell Transplants. The current text in the standard policy forms would not satisfy the requirements of the law if an applicant elected to purchase coverage for the services outlined in the law. She noted that under the IHC program, there were 5 standard riders available to the Board. One rider could be designated for such mandatory offers. Since the IHC forms cannot be amended by optional riders, as can the SEH forms, use of one of the standard riders would be the only avenue the IHC Program Board could use if the Board wished to treat the offer of coverage truly as an offer. Alternatively, the Board could elect to include the coverage as a mandatory benefit in the standard plans.

D. Benbow suggested that carriers would be at a disadvantage if they had to offer coverage as a rider in the individual market. L. Moskowitz stated that the solution would be to make the benefit mandatory.

The Board was inclined to include the benefit as a mandatory benefit, but asked carrier members to investigate the consequences with their companies. The Board further agreed to initiate discussions with the legislature regarding the impact of "offers" on the standard IHC plans.

III. Oral Contraceptives

R. Smart asked whether it was the Board's intention to cover charges for drugs other than those which were medically necessary to treat an accidental illness or injury. She advised that the SEH Board had agreed to amend the SEH standard policy forms to specifically include coverage for oral contraceptives. She commented that such action was consistent with a recorded joint Board decision to cover charges for oral contraceptives. She asked whether there were other "preventive" drugs or services that should also be covered. If yes, the modification to the text would be broader than simply specifying coverage for oral contraceptives.

The Board asked the Policy Form Committee to draft language that would specify coverage for oral contraceptives. No other preventive drugs or services were to be added.

IV. Pre-Existing Conditions Exclusion (PEC)

R. Smart explained that the current forms failed to specify that PEC credit applied if there were to be up to a 30 day lapse in coverage. She also explained that the Buyer's Guide discussed a credit for time served when a person changes carriers or coverage.

K. O'Leary discussed the credit as it applied to a person who had been diagnosed or treated by a physician for a condition under a prior plan. Such clause was intended to protect persons who were first diagnosed while covered under a prior plan. As regards such prior plan, the condition would not have been considered a PEC since it did not occur within 6 months prior to the effective date. Since the condition would not have been a pre-existing condition under the terms of the prior plan, the legislature believed it should not be considered a PEC under a succeeding plan.

R. Smart commented that there was some confusion as regards benefit changes in the standard plans and that staff had reported to her that some carriers believed the PEC provision operated on a benefit to benefit basis. Thus, when the plans were amended to cover TMJ, for example, a person who suffered from the condition was being subjected to a PEC since the prior coverage had not included coverage foe TMJ.

The Board agreed that the provision should be clarified to discuss the permissible 30 day lapse in coverage and the credit mechanism. The Board asked that the PEC provision be revised to clarify that it operates on a coverage to coverage basis, not a benefit to benefit basis.

2. Therapy Services

The Board agreed with the Policy Committee's recommendation that the Alternative Treatment provision be made a mandatory provision as opposed to a variable provision, thus allowing all carriers the opportunity to provide in excess of the 30 visits per year specified for certain therapies.

11. Benefit Period

The Board suggested that before any change would be made to use a benefit period year as opposed to a calendar year for purposes of deductible accumulation, coinsurance period, and any duration of services, that indemnity carriers should be questioned as to whether their systems could handle both a benefit period year and a calendar year, and what their thoughts were on a uniform system.

Other Issues

Maria Smyth asked about the status of a change in the IHC law to comply with **OBRA '93.** K. O'Leary said he believed that a bill had not yet been introduced.

D. Benbow remarked that the IHC and SEH Boards should defer any action with respect to **PPO and POS** policy forms issues pending release of rules from the Department of Insurance.

D. Benbow said that if any Board member has any comments with respect to the policy forms changes such comments should be provided in writing to R. Smart.

Maria Smyth agreed to review the election record for the Board positions of Chair and Vice Chair.

G. Young offered a motion to adjourn the meeting. S. Kelly seconded the motion. The Board voted unanimously in favor of adjourning the meeting. The meeting adjourned at 11:50 a.m. .

JUNE 13, 1995

Directors Present: D. Benbow (Prudential); M.L.B. Kaplan (Blue Cross and Blue Shield of New Jersey); L. Moskowitz (Department of Insurance); R. Rondum; E. Shrem; R. Smart (Mutual of Omaha), C. Wowkanech (Chair)

Others Present: DAG Maria Smyth (DOL); Ellen DeRosa IHC Program Assistant Director

I. Call to Order

C. Wowkanech called the meeting to order at 9:45 a.m. and announced that notice of the meeting had been published in three New Jersey newspapers and posted at the Department of Insurance and the Office of the Secretary of State in accordance with the Open Public Meetings Act. E. DeRosa took roll call and determined that a quorum was present.

II. Review of Minutes

May 9, 1995

R. Rondum clarified that her request to M. Smyth was whether there was a statutory basis for prohibiting the expansion the definition of "child" to include grandchildren.

D. Benbow suggested that the rate guarantee comment attributed to R. Rondum during the TAC report should be expanded to clarify that her concern was with the absence of a one year rate guarantee.

R. Smart asked that her comment regarding the NAIC committee be clarified to specify confusion as regards the NJ program.

D. Benbow asked that the motion regarding the selection of D&T be corrected to state that out - of - pocket expenses would be in addition to the hourly rate.

L. Moskowitz offered a motion that the Board approve the minutes of the May 9, 1995 Board Meeting, as amended. R. Smart seconded the motion. The Board voted unanimously in favor of adopting the minutes, as amended.

May 26, 1995

D. Benbow asked that his comment regarding the offer of coverage for dose intensive chemotherapy in the individual market be clarified to note that the concern existed if the coverage were to be offered as a rider.

L. Moskowitz offered a motion that the Board approve the minutes of the May 26, 1995 meeting, as amended. R. Rondum seconded the motion. The Board voted unanimously in favor of adopting the minutes, as amended.

III. Report of the Chairman

C. Wowkanech noted that a press conference had been scheduled for 2:00 p.m.. Given the nature of the issues to be discussed during Executive Session, he stated that the order of the agenda would be revised to move the Executive Session to the next agenda item to ensure that the Board had sufficient time to discuss all the issues that had to be addressed during Executive Session.

M.L.B. Kaplan offered a motion to begin Executive Session. R. Smart seconded the motion. The Board voted unanimously in favor of beginning Executive Session.

Executive Session: - 9:55 - 11:45

Break: - 11:45 - 12:00. Before the meeting resumed, R. Rondum initiated recognition of the fact that C. Wowkanech was celebrating his Birthday.

In order to take Board action with respect to a discussion that had occurred during Executive Session, D. Benbow offered a motion that the Board rule in favor of HIP Health Plan and allow HIP to include open enrolled, community rated conversion lives to be included in HIP's calculation of non-group persons for 1993. R. Rondum seconded the motion. The Board voted as follows: 4 in favor (E. Shrem, D. Benbow, C. Wowkanech, R. Rondum); 1 opposed (R. Smart); 2 abstained (M.L.B. Kaplan, L. Moskowitz) The motion carried by majority vote.
(M. Smyth offered to take care of necessary paperwork with HIP.)

IV. Report of the TAC Committee

D. Benbow reported that TAC recommended that the Board deem 3 rate filings complete, and approve 2 refund plans, as noted on the 06-13-95 Report of TAC, copy attached.

D. Benbow offered a motion that the Board accept the recommendations of TAC. M.L.B. Kaplan seconded the motion. The Board voted unanimously in favor of accepting the recommendations of TAC.

D. Benbow reported that only 4 refund plans had been approved to date. The goal would be to take action to secure appropriate plans from the remaining 8 carriers that must make refunds such that the Board would be in a position to approve the remaining plans no later than the scheduled July Board meeting. If any carrier would be unresponsive, TAC would present the circumstances to the Board for further action.

V. Report of the Assistant Director

E. DeRosa noted that the Board packets included a compilation sheet reflecting first quarter 1995 enrollment statistics. Only one carrier had failed to provide a report of first quarter data. She asked the Board to review the written report of the Executive Director, and the Expense Report.

D. Benbow offered a motion to approve the payment of the expenses included on the Expense Report dated May 26, 1995. E. Shrem seconded the motion. The Board voted unanimously in favor of payment of the expenses included on the expense report.

VI. Report of the Forms Committee

R. Smart provided an updated listing identifying carriers that have provided the required Certification of Compliance (Exhibit Q).

R. Smart began the discussion of forms issues by noting that many of the outstanding IHC issues were also outstanding issues for the SEH Board.

The packet of materials had been previously distributed to Board members to allow for prior review.

R. Smart first directed the Board's attention to the "Recommendations for changes submitted for review on 5/26/95."

M.L.B. Kaplan commented that item 7 should be reconsidered in light of the fact that the standard IHC policy forms no longer contain a coordination of benefits type provision. He was concerned that the termination provisions of the individual policy allowed a covered person to retain the individual policy in the event he or she became eligible for a group plan that was not the same or similar. As a result, a covered person could be insured under 2 plans.

The Board agreed to consider the issue during the "open issues" portion of the discussion. The new open issue, however, would not replace the recommendation made in item 7, as such recommendation was an appropriate text clarification.

M.L.B. Kaplan expressed concern with item D. 2. of the additional recommendations section. The text of the suggested grievance procedure section referenced the regulation governing the submissions of commercial carriers. He noted that BCBSNJ was not subject to such regulation.

The policy committee agreed to suggest more inclusive language.

M.L.B. Kaplan commented that while a recommendation concerning item D. 3. was being deferred at this time, he would not be in favor of allowing an option for a $5,000 or a $10,000 coinsured charge limit

D. Benbow expressed concern with item A. 2. of the additional recommendations stating that inclusion of coverage for behavioral therapy as part of nicotine dependence treatment may be too expansive. He noted that protocols for smoking cessation were not as well defined as for other preventive benefits. He was concerned that a covered person might utilize a substantial amount of the allowed $300 preventive benefit for a service which may not be as efficacious s some other services. L. Moskowitz commented that imposing limits on appropriate procedures

was not desirable, but did add that the Department of Health was reviewing the language for the nicotine dependence treatment service.

M.L.B. Kaplan offered a motion that the Board accept the recommendations for changes submitted for review on 5/26/95, and additional recommendations dated 6/13/95. E. Shrem seconded the motion. The Board voted unanimously in favor of accepting the recommendations.

R. Smart stated that the policy form committee would begin to make formal changes to the forms in preparation for the proposal filing.

The Board next reviewed the open issues.

The IHC Board agreed to defer discussion of the *foot care* issue pending the SEH Board review of Medicare guidelines which had recently been provided to the SEH policy form committee.

The IHC Board agreed to defer discussion of the *fertility* issue pending the SEH Board review of the requirements which applied to a federally qualified HMO.

The IHC Board agreed to defer discussion of the *physical therapy / therapeutic manipulation* issue pending SEH Board review and analysis of reported claims practices of carriers on the Board.

M.L.B. Kaplan expressed concern with the proposed modification to the *utilization review* text. He suggested that the forms included an appeals procedure which could be used. R. Rondum said the new text was necessary to deal with situations in which the physician and patient adhered to all requirements associated with pre-review, but the review organization denied the request for admission or surgery. If the patient nevertheless decided to proceed with the hospitalization or surgery, the standard plans would impose a 50% reduction in benefits. R. Rondum objected to the application of any penalty in those instances where the admission or surgery was subsequently proven to have been medically necessary and appropriate, but the review organization initially withheld authorization. D. Benbow suggested that if a carrier recognized after the fact that a judgment error had been made that carrier would, as a matter of good business practice, voluntarily waive any penalty.

The Board decided that the forms should clearly state that no penalty would apply if a person initially sought authorization, was denied authorization, but nevertheless proceeded with treatment, and it was later proven that treatment was medically necessary and appropriate.

M.L.B. Kaplan expressed concern with allowing an unlimited number of *self-referrals* to OB/GYN providers.

M.L.B. Kaplan commented that inclusion of benefits for *dose intensive chemotherapy* in the standard forms was inappropriate since the law required that the benefit be offered, and was not mandated benefit coverage.

The Board agreed to schedule an additional meeting to discuss and vote on the open issues. The meeting was scheduled for Thursday, June 22, 1995, at 9:30 a.m.. D. Benbow said that TAC was having a meeting on Tuesday and would therefore have additional matters for Board consideration during the additional meeting.

M.L.B. Kaplan offered a motion to adjourn the meeting at 1:30 p.m.. R. Smart seconded the motion. The Board voted unanimously in favor of adjourning the meeting.

JUNE 22, 1995

Directors Present: D. Benbow (Prudential); M.L.B. Kaplan (Blue Cross and Blue Shield of New Jersey); L. Moskowitz (Department of Insurance); R. Rondum; E. Shrem; R. Smart (Mutual of Omaha); G. Young (USHealthcare)

Others Present: K. O'Leary, Executive Director; DAG M. Smyth (DOL), E. DeRosa, IHC Program Assistant Director

I. Call to Order

D. Benbow called the meeting to order at 9:40 a.m. and announced that notice of the meeting had been published in three New Jersey newspapers and posted at the Department of Insurance and the Office of the Secretary of State in accordance with the Open Public Meetings Act. K. O'Leary took roll call and determined that a quorum was present.

K. O'Leary explained that C. Wowkanech would not be present at the meeting since three pieces of legislation of interest to the AFL-CIO were to be voted on the day of the meeting.

D. Benbow stated that the Board would defer review of the minutes of the June 13, 1995 Board meeting until the next meeting. The essential agenda items would be the reports of the TAC and the Policy Forms committee.

II. Report of the Executive Director

K. O'Leary reported that he had an initial meeting with the auditors on June 21, 1995. He provided them with a brief overview of the program, with emphasis on the source of funds and the disbursement of the funds. The auditor recommended that the Board employ a bookkeeper to work on setting up financial statements.

M.L.B. Kaplan offered a motion that the Board authorize the Executive Director to employ a bookkeeper who would be paid an hourly wage, but not to exceed $5,000 for all services rendered. G. Young seconded the motion. The Board voted unanimously in favor of authorizing the employment of a bookkeeper.

K. O'Leary clarified that required public bidding procedures had been followed and that the Board could award a contract to a public relations firm.

III. Report of the TAC

M.L.B. Kaplan asked why the TAC reports reflected the votes of TAC members. D. Benbow explained that the votes were shown in order to report the minority opinion as well as the majority opinion.

D. Benbow offered a motion that the Board accept the recommendation of the TAC and deem the rate filings made by Sanus Health Plan and Principal Financial Group complete. R. Smart seconded the motion. The Board voted unanimously in favor of deeming the rate filings complete.

D. Benbow offered a motion that the Board accept the recommendation of the TAC and accept the refund plans submitted by HIP Health Plan, Metropolitan Life Insurance Company and Principal Financial Group. M.L.B. Kaplan seconded the motion. The Board voted unanimously in favor of accepting the refund plans.

D. Benbow stated that the Board had received requests for exemption from the 1995 reimbursable loss assessment from a number of carriers. He explained that the approval of any of the requests would be conditional, as carriers would have to demonstrate enrollment of the minimum number of non-group persons during 1995 in order to qualify for the exemption. He further explained that by requesting an exemption a carrier was barred from requesting reimbursement for any reimbursable losses that may be incurred during 1995.

D. Benbow said that the requests of two entities should be denied since they were not licensed carriers at the time the requests were made. (AmeriHealth and Metra Health)

He said that the requests of two carriers could be accepted if revised certification language were provided. (MET Life and Principal Financial Group)

The requests of twelve carriers could be accepted. See the attached TAC report for a complete list of these carriers.

D. Benbow offered a motion that the Board accept the recommendation of the TAC and accept the requests for exemption from 14 carriers, as noted on the attached TAC Report. G. Young seconded the motion. The Board voted unanimously in favor of accepting the exemption request recommendations of TAC.

D. Benbow said some carriers had not filed requests for exemption. Those carriers would therefore be eligible to file for reimbursement of any reimbursable losses, and would also be subject to the reimbursable loss assessment and redistribution of loss assessment.

The following carriers, in the market as of June 1, 1995, the date by which the request for exemption was due, did not file to request an exemption:

BCBSNJ
Bankers Life & Casualty
Centennial Life
Continental Casualty
Greater Atlantic
Manhattan National Life
Mega Life & Health
National Casualty
National Health
Oxford
PFL Life
Time
Trustmark

[L. Moskowitz arrived at 10:05 a.m..]

IV. Report of the Policy Forms Committee

E. Shrem asked when changes to forms were to be effective. R. Smart said that the goal was January 1, 1996.

D. Benbow discussed the time table the SEH Board had adopted at the SEH Board meeting the previous day. He noted the SEH Board had asked carrier members to quantify the changes in terms of a percentage increase to existing rates, and report the information to the Department of Insurance. The SEH Board planned to file with the Office of Administrative Law (OAL) by July 24, 1995. The proposal would appear in the August 21, 1995 NJ Register. There was to be a joint hearing with the SEH and IHC Boards on September 12, 1995. The deadline for public comment would be September 20, 1995. The SEH Board would move its September meeting to September 27, and adopt the changes at that meeting. Adopted text would be submitted to OAL by October 6, 1995 and published in the NJ Register on November 6, 1995.

D. Benbow asked if the IHC Board believed it needed to ask for actuarial evaluation. G. Young asked what the intent of the evaluation would be. D. Benbow explained it would provide some data as to the cost range for the changes. He suggested that it would be useful to have some idea as to cost impact of the changes before having a hearing on the changes.

R. Smart said that K. O'Leary had shared the SEH schedule with her. She was concerned with delaying publication until November 6, 1995 as it would allow little time for carriers to modify their issue systems to reflect the changes. She said that the majority of the changes the Board had agreed to were language clarifications which would not impact the rates.

D. Benbow said the Board should ask a group of actuaries to evaluate the cost impact.

R. Rondum expressed concern that any actuarial impact might counterbalance public concerns which had been addressed by the changes. She also expressed concern about delaying the process and putting carriers in a position to not be able to be ready by January 1, 1996.

D. Benbow suggested that the Board could mail out material when the Board adopted the changes after the end of the comment session, and carriers would thus be able to begin work toward policy form modifications prior to the November publication date.

R. Smart noted that the Board was required, by law, to review the policy forms each year. The Board could send a schedule to carriers along with the proposal text, thus alerting carriers to the time table the Board planned to use. The IHC Board could participate in the September 12, 1995 hearing, receive comments by September 20, 1995, and schedule an additional meeting for the afternoon of September 27, 1995 for the purpose of adopting the changes. The Board could mail the adopted forms text to Carriers and industry associations such as the HIAA by early October. The NJ Register publication date would follow on November 6, 1995.

D. Benbow asked that carrier members have their actuaries review the changes and provide a range of impact as a percentage of premium to Bob Vehec (DOI) by next Friday (June 30, 1995).

R. Smart then asked the Board to address the Open Issues identified on the POLICY FORMS REVIEW OPEN ISSUES list dated 6/22/95.

Routine Footcare

E. DeRosa discussed the approach taken by the SEH Board. She said the SEH Board had reviewed the draft text which had been patterned after Medicare Guidelines and decided to modify the text to exclude coverage for routine footcare in connection with treatment of neurological conditions

After some Board discussion, G. Young offered a motion that the IHC Board adopt the same routine footcare language the SEH Board intended to adopt. M.L.B. Kaplan seconded the motion. R. Rondum objected to the modification to the text since the text would not be consistent with Federal Medicare Guidelines. A voice vote followed. 5 in favor (G. Young, M.L.B. Kaplan, R. Smart, L. Moskowitz, D. Benbow); 1 opposed (R. Rondum); 1 abstained (E. Shrem) The motion carried by majority vote.

Infertility

R. Smart commented that the text specified in the memo written by Jim Donnellan would allow coverage for artificial insemination and certain prescription drugs. It was her understanding that such language had been approved in connection with a Federally Qualified HMO product.

G. Young expressed concern that the current standard plans exclude surrogate motherhood but the proposed text would not. He stated that his company was a Federally Qualified HMO and that USHealthcare drew the line at exams which diagnosed the problem as infertility, and his company did not cover drugs. He preferred to stay closer to current NJ standard plan text.

D. Benbow stated that some HMOs offering the standard plan may not be using the plan as a Federally Qualified plan.

L. Moskowitz stated that he wanted the IHC approach to infertility to parallel the SEH Board approach. [Note: The SEH Board planned to use the approach outlined in J. Donnellan's memo, and make the benefit subject to carrier approval when offered by an indemnity carrier.]

G. Young asked if indemnity carriers would have to provide the same benefit as HMOs. M.L.B. Kaplan suggested that there was no need to make the plans consistent since different delivery systems were involved.

The Board agreed that the benefit should be included in indemnity plans, but subject to carrier pre-approval. G. Young agreed to review the USHealthcare approach and report to the Board. E. DeRosa agreed to investigate the specific nature of the objection one HMO had received upon filing the standard HMO with HCFA for use as a Federally Qualified plan. Final decision deferred until next meeting.

Dose Intensive Chemotherapy, Autologous Bone Marrow Transplant and Peripheral Blood Stem Cell Transplants

D. Benbow shared the approach the SEH Board had discussed. A carrier could either elect to include the optional benefit in all standard plans, or a carrier could elect to make the benefit available as a rider in connection with all standard plans.

M.L.B. Kaplan noted that the Board should not act to mandate a benefit that the legislature had required to be made available as an offer. R. Rondum suggested that if carriers could offer the benefit in different ways that the plans would no longer be standard plans. L. Moskowitz said that the Board must act in a manner consistent with the law. The law did not require that all plans include the benefit.

D. Benbow offered a motion that the Board allow carriers to elect to either include the benefit in all standard plans, or offer the benefit as a rider in connection with all standard plans. G. Young seconded the motion. A voice vote followed. 6 in favor (G. Young, M.L.B. Kaplan, R. Smart, E. Shrem, L. Moskowitz, D. Benbow); 0 opposed; 1 abstained (R. Rondum) The motion carried by majority vote.

R. Smart said she would work on language to be included in the standard plans or a rider.

M. Smyth agreed to verify the effective date of the optional benefit. D. Benbow said that the Board should issue a Bulletin to carriers to address the period between the effective date of the law and the date the standard plans would be revised to specifically address the handling of the benefit (January 1, 1996).

Utilization Review

L. Moskowitz offered a motion that the Board accept the revised language proposed by the Policy Form Committee. G. Young seconded the motion. The Board voted unanimously in favor of approving the revised Utilization Review language.

M.L.B. Kaplan offered a motion that the Board begin Executive Session. R. Smart seconded the motion. The Board voted unanimously in favor of

beginning Executive Session. [*Note: Only Board members participated in the Executive Session.]*

Executive Session: 11:40 a.m. -11:58 a.m.

It was reported to E. DeRosa, for the purpose of the minutes, that D. Benbow had offered a motion to end the Executive Session and resume open session, and M.L.B. Kaplan had seconded the motion. The Board had voted unanimously in favor of closing the Executive Session and resuming open session.

[D. Benbow and L. Moskowitz left the meeting before the open session resumed at 12:00. C. McDevitt replaced L. Moskowitz as the representative of the Commissioner. G. Young served as chair.]

Therapeutic Manipulation

E. DeRosa reported that the SEH Board decided to make no change to the current text. She noted that the existing definition of Therapeutic Manipulation included services which may be considered to be physical therapy.

Carrier members of the Board agreed to review the issue further and report to R. Smart.

Grievance Procedure

M.L.B. Kaplan offered a motion to approve the revised text of the Grievance Procedure. E. Shrem seconded the motion. The Board voted unanimously in favor of approving the revised Grievance Procedure text.

Same or Similar / Eligibility for Coverage

R. Smart and Sandi Kelly agreed to review the issue further and work on draft language.

Other Issues

M. Smyth reported that a bill concerning 48 hour maternity care coverage was likely to be signed on Monday (6/26) The bill would require policy form text changes. Also, the Board should review coverage for children's eye examinations since such coverage was required to be provided by Federally Qualified HMOs.

The Board agreed to schedule an additional meeting to discuss and vote on all outstanding issues. The meeting was scheduled for Friday, June 30, 1995, at 9:30 a.m.. Board members may elect to participate via conference call.

V. Other Business

G. Young asked the Board to review the Expense Report.

M.L.B. Kaplan offered a motion to authorize the Executive Director to pay the expenses included on the expense report. C. McDevitt seconded the

motion. The Board voted unanimously in favor of authorizing the payment of the expenses included on the expense report.

There being no further business to discuss, M.L.B. Kaplan offered a motion to adjourn the meeting at 12:33 p.m.. R. Smart seconded the motion. The Board voted unanimously in favor of adjourning the meeting.

June 30, 1995

Directors Present: D. Benbow (Prudential); M.L.B. Kaplan (Blue Cross and Blue Shield of New Jersey); L. Moskowitz (Department of Insurance); R. Smart (Mutual of Omaha); L. Yourman

Note: The above named directors, except D. Benbow, participated via teleconference.

Others Present: K. O'Leary, Executive Director; DAG M. Smyth (DOL); E. DeRosa IHC Program Assistant Director

I. Call to Order

D. Benbow called the meeting to order at 9:50 a.m. and announced that notice of the meeting had been published in three New Jersey newspapers and posted at the Department of Insurance and the Office of the Secretary of State in accordance with the Open Public Meetings Act. E. DeRosa took roll call and determined that a quorum was present.

II. Report of the Policy Forms Committee

R. Smart stated that the materials mailed to Board members on June 23, 1995 and faxed to Board members on June 29, 1995 would be considered during the meeting.

Therapeutic Manipulation / Physical Therapy

R. Smart explained that some of the services listed in the definition of therapeutic manipulation could be provided as part of physical therapy. She reported that she had been advised that the SEH Board had reviewed the issue and determined that no change to policy language was necessary.

She stated that the distinction in services was really a claims issue, and that the coding of the provider would indicate whether the service was considered to be therapeutic manipulation or physical therapy. For any codes shared by both types of services, the carrier could look to the provider. That is, if a physical therapist performed the service, the carrier would consider the service to be physical therapy. L. Moskowitz observed that looking to the provider to determine the nature of the benefit would be contrary to prior practices which were entirely benefit driven. Jim Donnellan commented that the intent was to allow up to 30 visits per year for therapeutic manipulation **and** up to 30 visits per year for physical therapy. R. Smart recommended that the IHC Board make no change to policy language at this time, but should continue to monitor the issue for possible modification in the future. L. Moskowitz suggested that the Board should consider providing carriers with some guidance as to how to distinguish between a therapeutic manipulation claim vs. a physical therapy claim.

L. Moskowitz offered a motion that the Board make no change in policy language regarding therapeutic manipulation / physical therapy. R. Smart seconded the motion. By roll call vote, 5 in favor, 0 opposed, the Board voted to make no change to the policy language regarding therapeutic manipulation / physical therapy.

Vision Coverage for Children's Eye Exams

R. Smart explained that this issue arose as a result of a review of the requirements for an HMO. She noted that the standard HMO form provides coverage for eye exams during a routine physical, and that the standard indemnity plans include a preventive care benefit which could be used for routine physicals. A well child visit would generally include vision screening. She recommended that the IHC Board make no change in policy language.

R. Smart offered a motion that the Board make no change in policy language regarding vision screening. M.L.B. Kaplan seconded the motion. By roll call vote, 5 in favor, 0 opposed, the Board voted to make no change to the policy language regarding vision screening.

Group Coverage / Duplication

R. Smart said that the proposed language was consistent with the regulations. That is, if a person was eligible for coverage under a group plan, he or she may not purchase an individual policy. Since the rules to explain "same or similar" were too complex to completely address in the policy forms, the proposed language would simply mention that a person *may* be eligible to purchase an individual policy during the open enrollment period. L. Moskowitz asked Channel McDevitt if the proposed language was consistent with the manner in which the Health Access Program decided to address duplicate coverage. She indicated it appeared to be consistent.

*L. Moskowitz offered a motion that the Board approve the proposed language regarding group coverage. R. Smart seconded the motion. A roll call vote followed. 4 in favor (D. Benbow, M.L.B. Kaplan, L. Moskowitz, R. Smart); 1 abstained (L. Yourman) Since 5 votes would be required to recommend a modification to the policy form language, the issue was tabled. (**NOTE - OPEN ISSUE TO BE DISCUSSED AT NEXT BOARD MEETING.)***

48 Hour Maternity

R. Smart reported that the Governor had signed the bill (A. 2224) on June 28, 1995. The bill had an immediate effective date and applied to new policies issued, and existing policies renewed, on or after that date. She noted that while the revised forms would address the coverage as of January 1, 1996, carriers would be required to provide such coverage immediately.

R. Smart asked the Board to review the proposed language. She explained that the standard plans defined medically necessary and appropriate in terms of what the carrier deemed to be medically necessary and appropriate. The bill gave the attending physician the right to determine medical necessity, and also allowed the mother to request in-patient care.

D. Benbow suggested that the Board should release a Bulletin to advise carriers that the bill had an immediate effective date and that the fact that the standard plans would not include language until January 1, 1996 would not mean that carriers could not comply with the law.

The Board directed the Executive Director and staff to work with the Department of Insurance and Attorney General's office to develop a Bulletin which would be sent to carriers participating in the marketing of IHC standard plans. The Bulletin should include the language that the Board intended to propose, and advise carriers that such language was subject to review during the comment period prior to adoption.

L. Moskowitz offered a motion that the Board include the drafted policy language regarding 48 hour maternity. M.L.B. Kaplan seconded the motion. By roll call vote, 5 in favor, 0 opposed, the Board voted to include the 48 hour maternity policy language.

Direct Access to OB/GYN (issue applies only to PPO and POS plan language)

R. Smart explained that the current language allowed a female insured person to self refer to her OB/GYN only once per year. She noted that the SEH Board intended to expand such direct access. M.L.B. Kaplan opposed expansion. R. Smart agreed with him.

*D. Benbow noted that neither position concerning this issue would attract the 5 votes necessary to take action regarding a policy form change, and tabled the issue. (**NOTE - OPEN ISSUE TO BE DISCUSSED AT NEXT BOARD MEETING.)***
D. Benbow asked Jim Donnellan to prepare a white paper, addressed to both the IHC Board and the SEH Board, explaining the self - referral issue.

Infertility

R. Smart explained that this issue arose as a result of HMO Federal Qualification requirements. L. Moskowitz reported that he had had a discussion on another matter with a person from HCFA earlier in the week. He had taken the opportunity to inquire about HCFA requirements for infertility services. L. Moskowitz expected to receive some written materials soon.

*The Board decided to defer any discussion of the issue until the materials were received and reviewed. (**NOTE - OPEN ISSUE TO BE DISCUSSED AT NEXT BOARD MEETING.)***

Autologous Bone Marrow Transplant

R. Smart said the draft language was consistent with the requirements of the law. The note in the text was intended to advise carriers of the methods carriers may elect to make the benefit available. She said that carriers electing to use the rider approach would be directed to include the specified language on a newly created mandated benefit offer rider. (The IHC Board has 5 available standard riders and would use one of the riders as a mandated benefit offer rider. This mandated offer, as well as any future such mandated benefit offers would be included on this rider.)

L. Moskowitz commented that there would have to be a premium rate filing. D. Benbow noted that he had already made note of the fact that the rate filing regulations would require modification.

M.L.B. Kaplan asked if a separate Pre-Existing Conditions (PEC) exclusion could be included if the benefit were offered by rider. After some discussion, the Board asked M. Smyth to review whether the Board could impose a PEC exclusion on the rider benefits. ***(NOTE - OPEN ISSUE TO BE DISCUSSED AT NEXT BOARD MEETING.)***

Conclusion: D. Benbow listed the issues to be discussed during the July 18, 1995 Board Meeting. (Group Coverage; OB/GYN; Infertility; ABMT) He asked if deferring decisions until that meeting would jeopardize meeting the desired proposal publication date. R. Smart said she thought the desired publication date would not be jeopardized since she could work on the issues that had already be voted upon.

Bob Vehec reported that he had not yet received any cost information.

III. Report of the TAC

D. Benbow said that the TAC report provided during the prior meting had inadvertently omitted a discussion of the exemption request from First Option Health Plan. He noted that First Option Health Plan was a licensed HMO and had filed an Exhibit K, and thus satisfied the criteria to receive a conditional exemption. He said that the letter to notify First Option health Plan should make it clear that the Board was granting a conditional exemption, but that First Option's ability to enter the individual market. as a state qualified HMO was a separate, unrelated issue.

D. Benbow offered a motion that the Board grand a conditional exemption from 1995 reimbursable loss assessments to First Option health Plan. M.L.B. Kaplan seconded the motion. The Board voted unanimously in favor of granting a conditional exemption to First Option Health Plan.

IV. Close of Meeting

M.L.B. Kaplan offered a motion to adjourn the meeting. L. Moskowitz seconded the motion. The Board voted unanimously in favor of adjourning the meeting. The meeting concluded at 11:00 a.m..

July 18, 1995

ANNUAL MEETING

Directors Present: P. Carmody (Mutual of Omaha); M.L.B. Kaplan (Blue Cross and Blue Shield of New Jersey); Jan LeRoux (Prudential); L. Moskowitz (Department of Insurance); E. Shrem; G. Young (USHealthcare); L. Yourman; C. Wowkanech (Chair)

Others Present: K. O'Leary, Executive Director; DAG M. Smyth (DOL); E. DeRosa, IHC Program Assistant Director

I. Call to Order

C. Wowkanech called the meeting to order at 9:39 a.m.. K. O'Leary announced that notice of the meeting had been published in three new Jersey newspapers and

posted at the Department of Insurance and the Office of the Secretary of State in accordance with the Open Public Meetings Act. K. O'Leary took roll call and determined that a quorum was present.

II. Review of Minutes (Open Session)

June 13, 1995

M.L.B. Kaplan offered a motion to approve the minutes of the June 13, 1995 Board meeting. G. Young seconded the motion. The Board voted in favor of approving the minutes, with appropriate abstentions.

June 22, 1995

P. Carmody voiced R. Smart's suggested a modification to the Policy Forms Committee report concerning an actuarial study and any resultant delay to the proposal process.

G. Young offered a motion to approve the minutes of the June 22, 1995 Board meeting, as amended E. Shrem seconded the motion. The Board voted in favor of approving the amended minutes, with appropriate abstentions.

June 30, 1995

J. Laroux suggested that the statement made by J. Donnellan should be clarified to state that up to 30 therapeutic manipulation visits were allowed.

M.L.B. Kaplan offered a motion to approve the minutes of the June 30, 1995 Board meeting, as amended. G. Young seconded the motion. The Board voted in favor of approving the amended minutes, with appropriate abstentions.

III. Report of the Chair

C. Wowkanech welcomed L. Yourman to the Board on behalf of himself and the rest of the members of the IHC Board. He commented that she would be an asset to the Board and would provide further balance to the perspective of Board members.

C. Wowkanech reported that the July 11, 1995 press conference announcing enrollment statistics for the first quarter of 1995 had been well attended by the press. He stated that the numbers for the first quarter were excellent.

L. Moskowitz said that Health Access numbers for the prior week indicated over 1000 new lives. He asked if the IHC Program enrollment report for future quarters would include Health Access Program enrollees. Since the enrollment data reported by carriers would not distinguish between a Health Access person and a self-pay person, K. O'Leary said that the data would have to be coordinated such that the report would specify IHC Program enrollment both including and excluding Health Access Program enrollment

C. Wowkanech said that Assemblyman Garrett intended to introduce new legislation in September or October. In his opinion, the legislation, which would modify the SEH

Program would also be harmful to the IHC Program. He said that a number of Carriers would be signing a letter of opposition to be sent to the Governor and legislative leadership. E. Shrem offered to contact members of the broker community to request similar action.

IV. Annual Meeting Business

Election of Board Officers

Chair

J. Laroux nominated C. Wowkanech to serve as Chair of the IHC Program Board. P. Carmody seconded the nomination. The Board voted unanimously in favor of electing *C. Wowkanech* as Chair of the IHC Program Board.

Vice Chair

E. Shrem nominated Prudential to serve as Vice Chair of the IHC Program Board. C. Wowkanech seconded the motion. The Board voted unanimously in favor of electing *Prudential* as Vice Chair of the IHC Program Board.

Secretary

G. Young nominated Blue Cross and Blue Shield of New Jersey to serve as Secretary to the IHC Program Board. C. Wowkanech seconded the motion. The Board voted unanimously in favor of electing *Blue Cross and Blue Shield of New Jersey* as Secretary of the IHC Program Board.

Schedule of Board Meetings

C. Wowkanech offered a motion to approve the proposed schedule of meetings (copy attached to the minutes). M.L.B. Kaplan seconded the motion. The Board voted unanimously in favor of approving the schedule of meetings, as proposed.

Committees

Note: Attached to these minutes are copies of membership lists for each committee, as nominated, and elected below. DAG M. Smyth would serve as a non-voting participant of all committees.

Legal

K. O'Leary briefly outlined the responsibilities of the Legal Committee.

M.L.B. Kaplan nominated BCBSNJ (Chair), Mutual of Omaha (Vice Chair), Prudential, USHealthcare, and Aetna to serve on the Legal Committee. G. Young seconded the nomination. The Board voted unanimously in favor of constituting the Legal Committee, as stated.

Policy Forms Committee

K. O'Leary briefly outlined the responsibilities of the Policy Forms Committee.

L. Moskowitz nominated Mutual of Omaha (Chair), R. Rondum (Vice Chair), Prudential, BCBSNJ, and Time Insurance Company to serve on the Policy Forms Committee. C. Wowkanech seconded the nomination. The Board voted unanimously in favor of constituting the Policy Forms Committee, as stated.

Technical Advisory Committee
K. O'Leary briefly outlined the responsibilities of the Technical Advisory Committee.

L. Moskowitz suggested that the TAC should have a public member. After some discussion, the Board concluded that the presence of the Department of Insurance, as a voting member, would represent the interests of the public and that the expertise offered by the Department was needed.

M.L.B. Kaplan nominated Prudential (Chair), BCBSNJ (Vice Chair), USHealthcare, Department of Insurance, HIP Health Plan, and Aetna to serve on the Technical Advisory Committee. L. Moskowitz seconded the motion. The Board voted unanimously in favor of constituting the Technical Advisory Committee, as stated.

Marketing Committee
K. O'Leary briefly outlined the responsibilities of the Marketing Committee.

M.L.B. Kaplan nominated E. Shrem (Chair), BCBSNJ (Vice Chair), Prudential, USHealthcare, and HIP Health Plan to serve on the Marketing Committee. E. Shrem seconded the nomination. The board voted unanimously in favor of constituting the Marketing Committee, as stated.

Operations Committee
K. O'Leary briefly outlined the responsibilities of the Operations Committee.

C. Wowkanech nominated C. Wowkanech (Chair), Prudential (Vice Chair), Department of Insurance, and L. Yourman to serve on the Operations Committee. M.L.B. Kaplan seconded the nomination. The Board voted unanimously in favor of constituting the Operations Committee, as stated.

Complaint Committee
K. O'Leary briefly outlined the responsibilities of the Complaint Committee. He noted that this Committee was contemplated by the Plan of Operations, but had not previously been constituted.

L. Moskowitz nominated L. Yourman (Chair), R. Rondum (Vice Chair), Department of Insurance, and USHealthcare to serve on the Complaint Committee. C. Wowkanech seconded the motion. The Board voted unanimously in favor of constituting the Complaint Committee, as stated.

The Board agreed that another Carrier, which did not hold a seat on the IHC Board, should be invited to participate in his Committee.

M. Smyth noted that the Board has been operating under a Temporary Plan of Operations. and suggested that the Operations Committee should look into developing a permanent Plan of Operations. M. Smyth also commented that the Board has not yet developed a Code of Ethics, and offered to assist with the development of a Code of Ethics.

K. O'Leary reminded the Chairs of each committee that it was their responsibility to hold meetings, and move the work along. The Board staff would be available to provide support, as required.

Budget

K. O'Leary asked the Board to review the budget included in the packets. E. Shrem asked that the allowance for "other promotional materials" for marketing be increased from $25,000 to $89,000. E. Shrem said that during the Marketing Committee report she would detail the proposed plans of the Marketing Committee which would require the additional funds. C. Wowkanech suggested that the ratification of the Budget be postponed until after E. Shrem had an opportunity to discuss the plans of the Marketing Committee.

[Break - 10:50 a.m. - 11:15 a.m.]

V. Report of the Marketing Committee

E. Shrem distributed information summarizing the plans of the Marketing Committee. L. Yourman suggested that the Board should look into using the Internet as a means to disseminate information.

L. Moskowitz said he viewed IHC as one part of a three part program. He questioned whether marketing efforts would best be done as an IHC stand-alone effort, or would it be best to work in conjunction with the other two Boards. He suggested that member carriers might be concerned with spending the amount of money proposed by the Marketing Committee, and would prefer to see Marketing as well coordinated and integrated.

C. Wowkanech said he was pleased with the outline of projects, and noted it was very aggressive.

M.L.B. Kaplan said he would like to see what the numbers would be like if Marketing efforts were to be coordinated. E. Shrem asked when the SEH Board would hire a marketing consultant. K. O'Leary said it would likely be in August.

C. Nicholas said there might be difficulty with getting any funding assistance from Health Access since its funding came through the Department of Health. She expected, however, that the Health Access Program would not object to being mentioned in any IHC Program materials.

M.L.B. Kaplan offered a motion that the Board ratify the budget, as proposed, subject to re-opening with respect to the $25,000 marketing allowance, as necessary. G. Young seconded the motion. The Board voted unanimously in favor of ratifying the budget, as proposed.

[C. Wowkanech left the meeting at 11:45 a.m.. G. Young assumed the role of Chair.]

VI. Report of TAC

S. Kelly distributed a copy of a TAC report. (Copy attached to minutes)

K. O'Leary asked for clarification of the TAC meeting discussion concerning National Casualty. While the Company was not selling new business, he questioned whether the Company should be asked to withdraw from the market. L. Moskowitz said that,

if the Company were not selling new business, it was misleading to include the Company on rate sheets. The Board concluded that the Company should be contacted to request a written statement concerning the offering of new business before the Company would be removed from the rate sheets.

M.L.B. Kaplan suggested that if any Company would fail to respond to a request for additional information that the Company's rate filing should be deemed incomplete. K. O'Leary noted that once a filing had been deemed incomplete, the Company must stop selling. E. Shrem asked what would happen if an application were sent in to a Company whose rate filing had been deemed incomplete. Would the person be covered? The Board agreed that there would be reasonable time allowed for the Company to release notice of cessation of new business to the sales force.

L. Moskowitz offered a motion that the Board accept the recommendations of the Technical Advisory Committee. P. Carmody seconded the motion. The Board voted unanimously in favor of accepting the recommendations of the Technical Advisory Committee.

VI. Report of the Forms Committee

S. Bazer provided materials to the Board for consideration. The Board decided to vote on each issue, separately.

1. Group Coverage - Duplication of Coverage

M.L.B. Kaplan offered a motion to accept the language, as drafted. G. Young seconded the motion. The Board voted unanimously in favor of accepting the drafted language concerning group coverage - duplication of coverage.

2. OB/GYN Visits (Indemnity Plan - POS Issue)

E. Shrem said a female should be able to self-refer more than once per year. M.L.B. Kaplan suggested that unlimited self-referral would increase the cost of the plan.

L. Moskowitz offered a motion that variable language be permitted such that a Carrier could either limit self-referral to once per year, as currently stated in the plan, or could allow for unlimited self-referral for non-surgical gynecological care and routine pregnancy care. P. Carmody seconded the motion. The Board voted in favor of allowing the use of variable language, with one vote opposed (M.L.B. Kaplan).

3. Infertility Services benefit

G. Young offered some background information concerning why this issue had been raised. L. Moskowitz said he had had a discussion with HCFA and that he was advised that specifics as to what infertility services would be covered were not required to be included in a Federally Qualified HMO plan.

G. Young asked if the indemnity plans should include coverage for infertility services, as do the HMO forms. M.L.B. Kaplan suggested that the Board should remember that premiums for an individual plan are not tax deductible as group premiums may be.

L. Moskowitz suggested that the Board make no change as regards infertility services. the Board concurred.

4. ABMT

At the request of the Board, the legal advice of the Attorney General's Office concerning the question regarding whether a carrier may apply a separate pre-existing condition to the ABMT benefit was delivered in Public Session. M. Smyth reported that she had completed her review and that the weight of authorities led to the conclusion that no separate pre-existing condition exclusion should be applied. She noted that an argument in support of a separate pre-existing conditions exclusion could be made, but that this position was not the stronger legal course. G. Simon said that the Department would not allow a separate pre-existing condition exclusion in filings submitted by carriers for the large group market.

L. Moskowitz offered a motion that the Board accept the draft language concerning coverage for ABMT. E. Shrem seconded the motion. The Board voted in favor of accepting the language, with one vote in opposition (M.L.B. Kaplan).

5. Nutrition Counseling

L. Yourman asked if food supplements recommended as a result of the nutrition counseling would also be covered. The Board agreed that this proposed covered charge, of itself, would not require coverage for food supplements, but that the supplements may already be covered as a prescription item.

E. Shrem offered a motion that the Board accept the draft language concerning coverage for nutrition counseling. L. Yourman seconded the motion. The Board voted in favor of accepting the language, with votes cast as follows: 5 in favor (L. Yourman, E. Shrem, L. Moskowitz, J. Laroux, P. Carmody) and 2 opposed (M.L.B. Kaplan, G. Young)

6. Application

S. Bazer explained that the current text regarding the effective date of coverage would not apply to applications taken during the open enrollment period. Coverage applied for during the open enrollment period would not take effect until the following January 1.

E. Shrem offered a motion that the Policy Forms Committee draft language to address the January 1 effective date for persons applying during the open enrollment period. M.L.B. Kaplan seconded the motion. The Board voted unanimously in favor of accepting such a change in the application language and requested the Committee draft appropriate language.

7. Plan A

M. Smyth said a question was raised concerning the application of 48 - hour maternity care and ABMT benefits to Plan A, which had been brought to her attention by a Board member and Board staff. M. Smyth advised that she had briefly reviewed the issue and was prepared to give the Board some guidance. The Board elected to receive the preliminary advice and discuss the issue during Open Session. M. Smyth

summarized that Plan A was a Basic or "bare bones" plan, pursuant to law, and said that the IHC law had exempted the plan from specific benefit mandates. The IHC Act also gave the Board the right to modify the Basic plan.

48-hour maternity

The 48 - hour maternity care bill stated that a plan which provided maternity coverage was subject to the law. Plan A provides maternity coverage, as directed in N.J.S.A. 17B:26-2 and the corresponding laws applying to HMOs and Health Service Corporations. Accordingly, the 48 -hour maternity care bill should apply to Plan A. M.L.B. Kaplan said that the 48-hour maternity law should apply to Plan A.

G. Young noted that the Board had previously voted to include 48-hour maternity in all plans, and Plan A was part of that decision. Therefore, it was not necessary to take another vote to include the benefit in Plan A.

ABMT

M. Smyth reviewed the language of the ABMT bill which provides that coverage must be offered in addition to benefits provided in the IHC reglations. It appeared that the Board had some flexibility in determining whether ABMT was intended to be offered in Plan A. M.L.B. Kaplan suggested that Carriers be given the opportunity to make separate elections as to the manner in which ABMT benefits would be offered in: 1) Plan A; and 2) Plans B-E and HMO.

M.L.B. Kaplan offered a motion to amend the prior action concerning the manner in which a Carrier would offer coverage for ABMT. He moved that a Carrier be permitted to make separate elections with respect to 1) Plan A, and 2) Plans B-E and HMO. For all Plans subject to the election, the carrier would either elect to include the benefit in all plans, or offer the benefit by rider in all plans. L. Moskowitz seconded the motion. The Board voted unanimously in favor of accepting the motion to allow separate elections.

[M. Smyth asked that the minutes reflect that she agreed with M.L.B. Kaplan .]

VII. Report of the Executive Director

L. Moskowitz offered a motion to approve the payment of the expenses shown on the Expense report. P. Carmody seconded the motion. The Board voted unanimously in favor of approving the payment of the expenses shown on the Expense report.

K. O'Leary said he had received four bids for the bookkeeper position, two from bookkeepers and two from accountants. He hired a bookkeeper who is working with D&T to set up the books.

K. O' Leary reported the following outreach:

06-26	NJN Radio
06-27	NJ AHU
08-08	Portland Oregon (Expenses paid by organization)
07-15	NAIC Conference Call

He reported that he wrote a response letter to the editor which should soon appear in The Trentonian.

M.L.B. Kaplan offered a motion that the Board begin Executive Session. E. Shrem seconded the motion. The Board voted unanimously in favor of beginning Executive Session.

[Executive Session - 1:38 p.m. - 2:07 p.m.]

E. Shrem offered a motion that the Board approve the selection of The Marcus Group as marketing consultant for the IHC Board, with appropriate provisions for termination in the contract. G. Young seconded the motion. The Board voted unanimously in favor of accepting The Marcus Group as marketing consultant for the IHC Board.

VIII. Close of Meeting

At 2:10 p.m. M.L.B. Kaplan offered a motion to adjourn the meeting. E. Shrem seconded the motion. The Board voted unanimously in favor of adjourning the meeting.

August 22, 1995

Directors Present: M.L.B. Kaplan (Blue Cross and Blue Shield of New Jersey); Jan LeRoux (Prudential); L. Moskowitz (Department of Insurance); R. Rondum, E. Shrem; R. Smart (Mutual of Omaha), G. Young (USHealthcare); L. Yourman

Others Present: K. O'Leary, Executive Director; DAG M. Smyth (DOL); E. DeRosa, IHC Program Assistant Director

I. Call to Order

G. Young called the meeting to order at 9:45 a.m.. K. O'Leary announced that notice of the meeting had been published in three New Jersey newspapers and posted at the Department of Insurance and the Office of the Secretary of State in accordance with the Open Public Meetings Act. K. O'Leary took roll call and determined that a quorum was present.

II. Review of Minutes - 7/18/95 Annual Meeting

(Open Session)

R. Smart suggested a clarification to the section addressing the drafting of application language concerning the open enrollment period.

M. Smyth asked that the sections dealing with 48 hour maternity be modified to note that, at the request of the Board, advice had been given during Open Session, and also to provide some additional details .

L. Moskowitz offered a motion that the Board adopt the 7/18/95 minutes, with appropriate modifications. M.L.B. Kaplan seconded the motion. The

Board voted unanimously in favor of adopting the minutes, as amended, with one abstention (R. Rondum)

(Executive Session)

M.L.B. Kaplan offered a motion that the Board adopt the 7/18/95 Executive Session minutes. L. Moskowitz seconded the motion. The Board voted unanimously in favor of adopting the minutes, with one abstention (R. Rondum).

III. Report of the Executive Director

Expense Report

K. O'Leary noted that the only "new" item on the report of 8/22/95 was the payment for the services of the bookkeeper. He reported that the bookkeeper was putting all the books in order, from day one.

L. Moskowitz observed that the charges for services from Deptcor appeared to be higher than in the past. K. O'Leary suggested that the publication of the 800 number in connection with newspaper articles following a couple of press conferences would have gotten the number to persons who had previously been unaware of the program. E. Shrem said it was good news that more people were calling to request information.

L. Moskowitz offered a motion to approve the payment of the expenses included on the 8/22/95 expense report. M.L.B. Kaplan seconded the motion. The Board voted unanimously in favor of approving the payment of the expenses.

Audits

K. O'Leary reported that the audit of reimbursable losses of BCBSNJ was ongoing.

M.L.B. Kaplan asked what was happening in light of HMO of New Jersey's recent ERISA position. In response to a request by counsel for HMONJ, K. O'Leary said he had requested an accounting, including accrued interest, from Ed Troy and Treasury. K. O'Leary stated that he did not think this step was necessary, but complied, at DAG Michael Goldman's recommendation. He assured M.L.B. Kaplan that accrued interest would be paid to BCBSNJ, in accordance with IHC rules.

Outreach

K. O'Leary reported that he had been in Portland on 8/8/95 at a conference of the National Academy of State Health Policy.

He said he continued to participate as a non-voting person on the NAIC task force working on individual health insurance reform. E. Shrem suggested that the model should allow people to move from state to state and get credit for pre-existing conditions. R. Rondum asked what type of entities attended the discussions. K. O'Leary said some consumer interest groups and carriers attend, but that mostly industry representatives could afford to attend NAIC meetings.

He commented that the State Health Notes newsletter included an excellent piece on NJ reform. A copy was included in Board packets.

Enrollment

K. O'Leary reported that while the enrollment reports were due 8/14/95, about 10 carriers had failed to file reports thus far. Staff was following up, and the press conference to announce enrollment would be in mid-September. C. Nicholas said it was tentatively scheduled for 9/21/95. L. Moskowitz asked that Health Access enrollment be broken out. K. O'Leary said the report would identify the number of Health Access enrollees, to the best of staff's ability, based on data available from Health Access.

IV. Report of TAC

Rate Filings

S. Kelly stated that TAC recommended that the Board consider the rate filings of 5 carriers as complete: MetLife; Oxford; Bankers Life and Casualty; Celtic and Prudential. L. Moskowitz asked if Celtic had the same rate problems with IHC rates as with SEH rates. B. Vehec said they did not.

L. Moskowitz offered a motion to adopt the rate filing recommendations made by TAC, and deem the filings to be complete. M.L.B. Kaplan seconded the motion. The Board voted unanimously in favor of adopting the rate filing recommendation.

Refund Plans

S. Kelly reported that the most recent refund plans submitted by MetLife Health Care Network, TMG and Travelers were acceptable, and recommended that the Board act to approve them. She noted that with these approvals, all 1993 refund plans would be approved, and these refunds would be released within 45 days. L. Moskowitz suggested it would be good press to announce the closing of 1993 refunds and asked that TAC calculate the total amount of refunds made.

K. O'Leary said TAC was working on amending the regulations to clarify the refund plan process and provide for a true-up.

M. Smyth said her office was reviewing what carriers should do with undeliverable refund amounts. M.L.B. Kaplan suggested that escheat laws would apply.

G. Young offered a motion to approve the refund plans, as recommended by TAC. R. Smart seconded the motion. The Board voted unanimously in favor of approving the refund plans submitted by TMG, Travelers and MetLife Healthcare Network.

Reasonable & Customary (R&C)

S. Kelly reported that Time Insurance Company had submitted a request in 1993 to Jim Porter, the first Interim Administrator, to use an alternate fee profile. The issue first became known in connection with a response Time had provided to an Insurance Department inquiry, and that response was forwarded to the IHC Program staff. She

said K. O'Leary had located the original letters, and noted that neither TAC nor the Board previously reviewed the information submitted by Time. She noted, however, that the information provided in 1993 did not establish actuarial equivalency. The submission indicated the desire to use Medical Data Research (MDR) instead of 80th percentile PHCS. T. Smith commented that there had been complaints concerning the allowable charges.

L. Moskowitz was not only interested in the establishment of actuarial equivalency but also in the updating of whatever profile was used.

M.L.B. Kaplan suggested that since government programs were not using the PHCS profile, the Board may want to reexamine at the use of PHCS.

Staff was directed to write to Time to request documentation as to actuarial equivalency and updating of data.

[Break - 10:47 a.m. - 11:03 a.m.]

V. Discussion of Open Enrollment as Related to IHC and Health Access

L. Moskowitz opened the discussion by providing some background information. The IHC Program has designated the calendar month of October as the Open Enrollment Period. The Health Access Program has not yet designated the period, but may similarly elect to use the calendar month of October as the Open Enrollment Period. Regardless of when the Open Enrollment Period occurs, there must be a determination as to *who* would be eligible to enroll during the Open Enrollment Period.

During the August 16, 1995 SEH Board meeting, the SEH Board discussed a specific carrier's request to utilize an employer contribution requirement for group coverage of less than 10%. SEH regulations specify that there must be at least a 10% contribution unless a carrier files with the SEH Board and requests a lower percentage. The SEH Board voted to deny the carrier's request to use less than a 10% employer contribution requirement.

Joint Advisory Bulletin 95-01 stated that if there was no employer contribution, the plan would be considered an individual plan. Therefore, L. Moskowitz said that a portion of the marketplace would be forced, by definition, into the individual market if employee pay all health plans were provided. He noted that the intent of the SEH and IHC reform laws was to stimulate purchase under employer group plans, with the residual going to the individual market.

L. Moskowitz asked the IHC Board to consider what should be done with group plans that do not have employer funding. He suggested that, if group plans with less than 10% employer contribution cannot exist, there would be an influx of persons to both the Health Access Program and the IHC Program.

M.L.B. Kaplan summarized his concerns by stating that if an employer decided not to make the required contribution, and thus could not offer a group plan, employees could conceivably apply for and receive a subsidy from Health Access. So instead of the employer contributing to the cost of the employee's insurance, the state would contribute via a subsidy. He suggested that perhaps instead of stating that an

employer could not purchase or continue a group plan, that the employer could still offer a group plan, but it would not be a "qualified" plan.

L. Moskowitz commented that the recent trend has been for employers to contribute nothing toward the cost of dependent coverage.

G. Young suggested that the IHC and SEH Boards should jointly meet to discuss the consequences of the SEH Board's decision that a plan without a 10% contribution would not be group and any persons desiring coverage would be forced into the IHC market.

K. O'Leary said that the SEH Board had the authority to modify the SEH regulations as regards contribution and participation requirements.

R. Rondum asked for a clarification as to what would be so undesirable if persons were forced into the IHC market. L. Moskowitz offered the following points:

- A system would be set up in which the individual and group systems would be competing against one another. Pure community rating in the individual market would be compared to modified community rating as currently exists in the small employer market.
- The group mechanism is considered to be more sound than the individual mechanism due to the employer - employee relationship.

He stated that the SEH Board viewed the permissive 10% contribution requirement as desirable, and decided to make it mandatory.

E. Shrem said that there should be group insurance where there is an employer - employee relationship. L. Moskowitz added that there should also be a minimum level of participation.

L. Moskowitz observed that the impact on Health Access would ultimately be determined by Health Access since the Health Access Program determines who is eligible for a subsidy. *[Note: Under current Health Access Program regulations, if a person loses group coverage due to a layoff or company closing, that person may be eligible to apply. If a person loses group coverage because the employer ceases to offer it, there is a 12 month waiting period before the person would be eligible to apply for Health Access.]*

K. O'Leary noted that the 10% employer contribution requirement attached to all inforce small employer plans as of the first anniversary on or after 9/11/94. So, all small employer plans would be subject to the 10% employer contribution requirement by 9/10/95. He further stated that the SEH 10% employer contribution requirement would have no effect on the large group market. He did not see how the SEH Board's position would have any adverse effect on Access enrollment.

L. Moskowitz asked what would be an appropriate test to determine if a plan should be group or individual. He stated that who pays the premium should not be the sole test. K. O'Leary noted, however, that a premium contribution test was the only test provided in the law.

Representatives from the Health Access Program commented that they would seek guidance from both Boards. The question Health Access asks on the application was whether a person was eligible for employer - based group coverage. They would

allow persons who were eligible for individual coverage to apply for Health Access during the Open Enrollment period. They would not, however, allow persons who were eligible for employer - based group coverage to apply during the Open Enrollment period.

J. LeRoux commented that she participated in the August 16, 1995 SEH Board meeting and believed the SEH Board may not have been sensitive the whole issue.

Health Access would like clear distinctions between individual and group coverage so they might implement their regulations which differentiate between a person who is eligible for employer - based group coverage and a person who is eligible for individual coverage.

L. Moskowitz concluded the discussion by stating that "group was group," if it derived from an employer - employee relationship.

[Note: In order to begin a dialog of this issue, the IHC and SEH Boards will jointly meet. If possible, that meeting will occur 9/12/95, prior to the Hearing on policy form changes.]

VI. Report of the Policy Forms Committee

R. Smart said the proposed forms changes were published in the 8/21/95 New Jersey register. Written comments were being accepted until 9/20/95. She added that Board members were given a copy of the changes.

PPO Options

R. Smart referred to her 8/17/95 memo which had been faxed with the agenda, and was also included in the Board packets. While the issue initially came up because of a filing from one carrier, the discussion of PPO options should be broader than merely what one carrier had filed.

L. Yourman expressed concern that consumers would be confused with the introduction of additional options. She felt the 5 standard plans plus HMO were enough. M.L.B. Kaplan said that if a carrier marketed the PPO options correctly, the carrier should be given the opportunity to market PPO. G. Young stated it was the Board's challenge to regulate PPOs.

L. Moskowitz suggested that the Board could take the position that the Network benefits must be the benefits of A, B, C, D or E. E. DeRosa commented that such a structure would preclude a 100% Network benefit, and many of the PPO plans in the SEH market had utilized a 100% Network benefit. R. Vehec suggested that A - E could be designated as the Out-Network benefits. L. Moskowitz concluded that the IHC Board needs to construct a rational progression of benefits from 100% down to 60%, and that the SEH Board should do likewise.

G. Young asked TAC to look at the PPO benefit structure with an eye toward developing uniform controls.

HMO - POS

E. DeRosa summarized the work being done by the SEH Board as regards the development of an HMO - POS product. Drafts would be shared with the IHC Policy

Forms committee such that the products developed by both Boards would be as consistent as possible.

VII. Adoption of N.J.A.C. 11:20-3.1

K. O'Leary stated that a regulation regarding PPO differentials had been proposed in March 1995, and no comments were received. He reminded the Board that when the regulation had been brought to the Board for adoption following the comment period, the Board had not taken action to adopt the regulation, indicating that all PPO regulations should be adopted at once. This piece could wait until all pieces were ready to propose. K. O'Leary noted that the absence of this regulation had impeded the Board's ability to ask carriers to discontinue certain PPO plan designs, as, for example, a plan with a 50% out-network coinsurance.

L. Moskowitz offered a motion hat the Board adopt the amendment to N.J.A.C. 11:20-3.1. J. LeRoux seconded the motion. By roll call vote, the Board voted unanimously in favor of adopting the amendment to N.J.A.C. 11:20-3.1.

VIII. Report of the Marketing Committee

E. Shrem reviewed highlights of the handout provided to Board members, copy attached to the minutes. She noted the Committee would be meeting following the Board meeting, and that she would provide a summary of that meeting during the next Board meeting. She also noted that she had been in contact with M. Wiloughby of the SEH marketing committee to arrange discussions of possible joint marketing projects.

IX. Other

L. Yourman explained that the phone line she had been using for Board related matters was the same line her husband used for business, and her use was conflicting with his business use. She asked if Board funds could be used to activate another line which would be used solely for IHC business.

L. Moskowitz offered a motion that the Board authorize the activation of a "teen line", if available and applicable, if not, a regular telephone line, for L. Yourman, for the sole purpose of conducting Board business. M.L.B. Kaplan seconded the motion. The Board voted unanimously in favor of authorizing the activation of the appropriate line in L. Yourman's home, for the sole purpose of conducting Board business.

At 12:58 p.m., M.L.B. Kaplan offered a motion that the Board begin Executive Session.

Executive Session: 1:03 p.m. - 1:40 p.m.

M.L.B. Kaplan offered a motion that the IHC Board deny the request from the Equitable to re-open their calendar year 1993 Exhibit K for the purpose of correcting an error, since such action was time barred. L. Moskowitz seconded the motion. With one abstention (G. Young), the Board voted unanimously in favor of denying the Equitable request.

X. Close of Meeting

There being no further business to discuss, M.L.B. Kaplan offered a motion to adjourn the meeting. L. Moskowitz seconded the motion. The Board voted unanimously in favor of adjourning the meeting. The meeting was adjourned at 1:43 p.m.