**MINUTES OF THE MEETING OF THE**
**NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM BOARD**
**AT THE OFFICES OF THE**
**NEW JERSEY DEPARTMENT OF BANKING AND INSURANCE**
**TRENTON, NEW JERSEY**
**February 17, 1999**

**Members present:** Tim English (Guardian); Charlotte Furman (Anthem Health & Life); Larry Glover, Chair; Jane Majcher (DOBI); Bryan Markowitz; Mary McClure (The Prudential); Michael Torrese (Horizon BCBSNJ); Dutch Vanderhoof (arrived at 10:10 a.m.); Eric Wilmer (Celtic); Bonnie Wiseman (DOHSS).

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

## I. Call to Order

L. Glover called the meeting to order at 9:45 a.m. W. Sanders announced that notice of the meeting had been published in three newspapers and posted at the Department of Banking and Insurance ("DOBI") and the Office of the Secretary of State in accordance with the Open Public Meetings Act. A quorum was present.

## II. Public Comments

L. Glover asked if any person attending the meeting wished to offer any comments. No comments were offered.

## III. Board Member Election

J. Petto asked if any member carriers present at the meeting wished to cast ballots. She then tallied the ballots. She announced that Bryan Markowitz received the greatest number of votes for the seat for a representative of a small employer. She reported that an equal number of votes were cast for AmeriHealth and Oxford to fill the seat for an HMO. W. Sanders announced that the Board would seek advice from the Attorney General's office concerning how to proceed and that he would contact the carriers concerning next steps.

The Board agreed to keep the election open during the remainder of the meeting in the event a member carrier should arrive to cast a vote.

## IV. Staff Report

*Legislative Activity*
W. Sanders reported that the Board packets include an updated report on legislative activity. He noted A.2631, in particular, which would require carriers to provide written

notice of termination directly to employees covered under employer-sponsored group plans in the event the employer terminates the plan.

B. Markowitz said that Senator Cardinale introduced a bill to create a guarantee fund for HMOs. He said the fund would be funded by assessments to HMOs that would require a 3% increase in premium for the first year and 2% in subsequent years. He noted that the bill, as drafted, would be retroactive to January 1998 so as to include HIP and American Preferred Providers (APP). He said this was an administration-driven bill. M. McClure commented that an increase in premiums in the small employer market, in particular, would be harmful to the continued viability of the market. E. Wilmer recalled that HMOs strenuously argued to be kept out of the existing guarantee association that currently applies to indemnity carriers. He said that HMOs argued that they were solvent and did not require protection.

*Status of HIP*
W. Sanders said that Board materials included copies of press releases concerning HIP. He reported that all plans would be terminated on March 31, 1999. M. McClure said that carriers have questions concerning the implementation of the open enrollment period. W. Sanders offered that carriers could send questions to staff and that staff would direct them to persons who would be able to provide responses.

*Outreach*
W. Sanders reported that he spoke at a seminar on individual health insurance reforms, sponsored by Alpha Center, in Washington, DC.

W. Sanders noted that he was able to note the availability of the Buyer's Guide when he was interviewed on CBS radio for New York and a TV interview on NJN.

*NJ KidCare*
W. Sanders reported that the ad hoc committee to consider how to implement KidCare in the employer sponsored market met on February 3, 1999. He noted that in addition to Board members, who volunteered for the committee, he invited former Board member Melanie Willoughby, and Charlotte Aylor from United States Life to participate on the committee.

*High Deductible Plan Design*
E. DeRosa reported that the deductible and out of pocket amounts for high deductible plans that could be used in conjunction with the Medical Savings Account (MSA) are subject to adjustment, each year, for inflation. She said she received Revenue Procedure 98-61 that sets forth the inflation-adjusted amounts for tax year 1999. She explained that the Procedure was not clear as to how plans with the 1998 level amounts would be brought into compliance with the 1999 amounts. After numerous phone calls, she reported that she spoke with a representative of the IRS and received guidance. She said that the plans issued with the 1998 amounts were expected to be guaranteed renewable. However, if the policyholder wishes to retain the favorable tax advantages associated

with an MSA, the policyholder must voluntarily amend the plan to include the new amounts for the 1999 tax year.

E. DeRosa reminded the Board that it did not create standard plan text to address the high deductible plans. She said the Board did, however, release a Bulletin and a sample rider to give carriers guidance concerning how to amend the standard plan such that it would be a high deductible plan. She said the riders, which are riders of decreasing value, are filed with the Department of Banking and Insurance. She said she intended to release a new Bulletin to advise carriers of the inflation-adjusted amounts and provide sample text for a revised rider.

## V. Minutes

*December 16, 1998*

**D. Vanderhoof offered a motion to approve the minutes of the Open Session of the December 16, 1998 Board meeting. C. Furman seconded the motion. The Board voted unanimously in favor of the motion.**

*January 20, 1999*

**C. Furman offered a motion to approve the minutes of the Open Session of the January 20, 1999 Board meeting. D. Vanderhoof seconded the motion. The Board voted in favor of the motion with B. Markowitz abstaining.**

## VI. Report of Staff (Continued)

***Expense Report (see attached)***

W. Sanders explained that the Board received a bill for services rendered by Hughes & McLaughlin after the expense Report was prepared. He said that the Board's contract with this accounting firm to prepare program books was subject to a $6,000 cap. He said that the bill exceeds that cap and that he and P. Lechner would seek further information from the firm concerning the extraordinary circumstances that the firm believes necessitated exceeding the cap on charges for the bookkeeping service. He recommended that the Board pay $5500 pending resolution of the full payment to be made.

**M. McClure offered a motion to approve the payment of the expenses specified on the February 17, 1999 expense sheet, amended to include payment of $5500 to Hughes & McLaughlin. J. Majcher seconded the motion. The Board voted unanimously in favor of approving the motion.**

W. Sanders said the Institute for Health Solutions and HCFA were sponsoring a meeting in Arlington Virginia. He said that either he or E. DeRosa might attend. He said expenses to be reimbursed by the Board would be limited to the cost of train travel.

*Exhibit CC Reporting*

E. DeRosa explained that Exhibit CC is the report that member carriers file each March 1 to report net earned premium (NEP) from small employer plans for the prior year. She said the issue was the manner in which carriers should treat refunds in the calculation of the NEP. She said that two carriers, when filing the exhibit in March, estimated the amount of refund they would be required to pay, and reduced their NEP by that amount. E. DeRosa noted that carriers do not file loss ratio reports and any necessary refund plan until August, and that refunds, if due, are not paid until after the loss ratio report and refund plan have been approved by the Department of Banking and Insurance. She said the refund amount the carrier may estimate in March might not be the same as the amount the carrier would actually be required to pay. She said she discussed possible solutions with both Neil Vance and Bob Vehec. She said B. Vehec advised her that the Department favored an approach whereby a carrier could reduce the NEP for a specific year by refunds actually paid in that year. For the 1998 Exhibit CC, carriers would therefore reduce 1998 NEP by the refund mount PAID in 1998. She said that while the refund amount PAID in 1998 would be for premium collected in 1997, the number would be a verifiable number. She said she asked B. Vehec if there would be any problems for carriers in using a refund paid during the year. She said he viewed the Exhibit CC report as a report providing data for the Board to use in the administration of the SEH Program and that data entered on this report should not affect any other statutory reports a carrier must file.

After some discussion the Board agreed that it would be best to have all carriers reporting NEP on the same basis. Therefore, the Board agreed that a Bulletin should be released to explain how to reduce the NEP for 1998 by refunds paid in 1998. The Board asked to review the Bulletin. W. Sanders said that since carriers must file the Exhibit CC by March 1, it was essential to release the bulletin as quickly as possible. He asked Board members to provide comments, if any, no later than February 19, 1999. He noted that the Board could make the necessary changes in the regulations prior to the filings for 1999.

*4Q98 Enrollment Reports*

J. Petto said that 4Q98 enrollment reports were due February 16, 1999. She said she had all but 5 or 6 of the SEH reports and would have a summary report for the next Board meeting.

*Temporary Services*

W. Sanders reported that a temporary employee from the agency used by the Department came in for one day. He said the arrangement was not as helpful as he had hoped, and has canceled the requests for future temporary employees through that agency.

## VII. Report of the Legal Committee

E. DeRosa explained that prior to HIPAA, the definition of "prior coverage" that carriers used to determine pre-existing conditions portability specifically excluded coverage from outside the United States. She said the definition of "creditable coverage" in HIPAA does not specifically state that coverage from outside the United States is excluded, so the forms do not expressly exclude coverage issued outside the United States. She reported

that a carrier contacted her and asked that the definition of "creditable coverage" be re-evaluated, as the carrier believed it could be read to exclude coverage issued outside the United States. She said the Legal Committee considered the definitions of the terms to which the "creditable coverage" definition refers and believed a legal argument could be made to support excluding coverage issued outside the United States from the scope of "creditable coverage." She further said that the Committee noted that any decision as to how to interpret the definition would be a policy, not a legal decision. The feeling of the Committee concerning a policy decision was that the definition should not include coverage issued outside the United States.

T. English explained that the preamble to the proposed HIPAA regulations seeks input as to whether government programs outside the United States should be considered "creditable coverage." He acknowledged that the question did not address private insurance programs a person may purchase to supplement the government program.

The Board discussed the Certificate of Creditable Coverage that carriers must issue when a person terminates coverage. The Board noted that persons coming from other countries would not have such a certificate. E. DeRosa noted that there are other methods a carrier could use to verify the nature of the coverage issued outside the United States.

Board members were asked to take the issue back to their companies and be prepared to discuss the issue during the March meeting.

**VIII. Report of the Policy Forms Committee**

E. DeRosa explained that one carrier, Anthem, filed a series of riders that updated riders that were previously found complete. Pursuant to a Board resolution, she reported that she reviewed the riders and communicated completeness and substantial compliance to the carrier.

E. DeRosa reported that the Committee met to discuss an optional benefit rider filing from Prudential. She described the rider as a prescription drug card option rider, with a generic/brand copayment structure of $10/$20. She said the Committee recommended that the Board find the filing complete and in substantial compliance.

**D. Vanderhoof offered a motion to accept the recommendation of the Committee and find the Prudential rider filing complete and in substantial compliance. B. Markowitz seconded the motion. The Board voted in favor of the motion, with M. McClure abstaining.**

E. DeRosa reminded the Board that it had not acted on an AmeriHealth request during the January Board meeting. She explained that AmeriHealth had elected to cover prescription drugs under the standard HMO plan subject to a $15 copayment. The carrier wished to discontinue offering the $15 copayment for new business and begin to offer coverage for prescription drugs subject to a 50% coinsurance requirement. E. DeRosa explained that both are valid options under the standard HMO plan. She said that while

there is a withdrawal regulation in place to govern market withdrawal from the SEH market, there is no regulation governing plan option withdrawal. She noted that the IHC program addressed this same issue several years earlier when one carrier requested to stop issuing new business with the $15 copayment and begin to issue HMO plans that covered prescription drugs subject to 50% coinsurance. She said that since at that time there was no withdrawal mechanism at all for IHC coverage, the IHC Board determined that the carrier could discontinue new sales with the $15 prescription drug copayment, but must renew the inforce plans that had $15 copayment for prescription drugs. She added that the medical cost under the HMO plan whether issued covering prescription drugs subject to a $15 copayment of 50% coinsurance, was required to be the same. She suggested that as long as AmeriHealth was willing to continue to renew inforce HMO plans that had been issued with a $15 copayment for prescription drugs, and would begin to sell the HMO plan covering prescription drugs subject to 50% coinsurance, AmeriHealth would comply with the guaranteed renewability features of the SEH law, and satisfy the obligation to offer the standard HMO plan. D. Vanderhoof noted that AmeriHealth could price the plan with the $15 copayment such that it would effectively withdraw the plan.

After some discussion, the Board agreed that AmeriHealth should be allowed to discontinue selling new HMO plans that cover prescription drugs subject to a $15 copayment so long as they renewed inforce plans.

E. DeRosa reminded the Board that AmeriHealth filed an optional benefit rider that could only be used if the Board were to allow the carrier to begin to sell the HMO plan with prescription drugs coverage subject to a 50% coinsurance requirement. She said the rider filing had been revised, as the Committee suggested, prior to the January Board meeting. She said that since the Board had not taken any action on the rider filing, the carrier could have deemed the filing complete on the 45$^{th}$ day after submitting it. In order that the Board's files as well as those of the carrier may be complete, she asked the Board to vote to find the rider filing complete. She explained that the rider provided a prescription drug benefit.

**C. Furman offered a motion to find the AmeriHealth optional benefit rider filing complete and in substantial compliance. J. Majcher seconded the motion. The Board voted unanimously in favor of the motion**

W. Sanders said the Board needed to enter Executive Session to discuss ongoing enforcement matters as well as seek advice concerning the election. He asked for a motion to enter Executive Session.

## IX. Executive Session

**D. Vanderhoof offered a motion to begin Executive Session. J. Majcher seconded the motion. The Board voted unanimously in favor of beginning Executive Session.**

*[Break 11:15 a.m. – 11:30 a.m.]*

*[Executive session: 11:30 a.m. – 12:07 p.m.]*
*[B. Markowitz left the meeting.]*

## X. Final Business and Close of Meeting

**J. Majcher offered a motion to hold a run-off election between AmeriHealth HMO and Oxford HMO. There would be a new ballot, with only those carrier names included, where no write-in votes would permitted, and only votes received prior to the meeting would be counted. M. McClure seconded the motion. The Board voted in favor of the motion, with D. Vanderhoof abstaining.**

**B. Wiseman offered a motion to adjourn the Board meeting. J. Majcher seconded the motion. The Board voted unanimously in favor of adjourning the meeting. The meeting adjourned at 12:10 p.m.**

Attachment: Expense Report