CENTRAL JERSEY HEALTH INSURANCE FUND
OPEN MINUTES
OCTOBER 28, 2015
BRIELLE BOROUGH MUNICIPAL BUILDING
1:30 PM

Meeting called to order by Chairman Thomas Nolan. The Open Public Meeting notice read into record.

PLEDGE OF ALLEGIANCE

MEETING OF EXECUTIVE COMMITTEE CALLED TO ORDER

CHAIRPERSON		
Thomas Nolan	Borough of Brielle	Present
SECRETARY		
William Rieker	Township of Lakewood	Present
EXECUTIVE	**COMMITTEE**	
Joseph Gilsenan	Township of Brick	Present
Diane Lapp	Township of Manchester	Absent
Adam Hubeny	Borough of Atlantic Highlands	Absent
Eugenia Poulos	Borough of Red Bank	Absent
Donato Nieman	Township of Montgomery	Present
ALTERNATES:		
Jane Marban (Gillespie)	Borough of Spring Lake	Absent

APPOINTED OFFICIALS PRESENT:

Executive Director/Administrator	PERMA Risk Management Services	**Paul Laracy** **Emily Koval**	Present Present
Program Manager	Conner Strong & Buckelew	**Brandon Lodics**	Present
Attorney	Berry, Sahradnik, Kotzas & Benson	**Jack Sahradnik**	Present
Treasurer		**Stephen Mayer**	Present
Network & Medical Claims Service	Qualcare Inc.	**Gary Epstein**	Absent
Network & Medical Claims Service	Aetna	**Kim Ward** **David Norton**	Present Absent
Dental Claims Service	Delta Dental	**Amy Lehrer**	Absent
Rx Administrator	Express Scripts	**Ken Rostkowski** **Kristie Weinert**	Present Absent
Auditor	Holman & Frenia	**Matt Holman**	Absent

OTHERS PRESENT:
Judy Sullivan, Bedminster Township

Suzanne Veitengruber, Shrewsbury Township
Dominic Cinelli, Brown and Brown
Charles Casagrande, Danskin Agency
Cindy Lisa, Danskin Agency
Kelly Bellu, Toms River MUA

CORRESPONDENCE: None

APPROVAL OF MINUTES: September 23, 2015 OPEN:

MOTION TO APPROVE OPEN MINUTES OF September 23, 2015:

MOTION:	Commissioner Nieman
SECOND:	Commissioner Gilsenan
VOTE:	Unanimous

PRO FORMA REPORTS

- **Fast Track Financial Report –** as of August 31, 2015
- **Cash Flow Report –** as of August 2015

Executive director reviewed the Financial Fast Track which showed a profitable month with 2.5 million net earnings. He said the Fund is performing well.

2016 BUDGET ADOPTION – Executive Director reviewed the budget stating there is a modest increase of 2.26%. A chart showing assessment's by member was included that illustrates a varying increasing by member. The swing in assessment is due to Lakewood's self insured retention and Manchester terminating its medical and prescription coverage, which lowered the Fund's exposure, but spread the risk to the other smaller members.

MOTION TO OPEN THE PUBLIC HEARING ON THE 2016 BUDGET

MOTION:	Commissioner Nieman
SECOND:	Commissioner Rieker
VOTE:	Unanimous

MOTION TO CLOSE THE PUBLIC HEARING

MOTION:	Commissioner Gilsenan
SECOND:	Commissioner Nieman
VOTE:	Unanimous

MOTION TO APPROVE THE 2016 BUDGET IN THE AMOUNT OF $39,824,460 AND CERTIFY ASSESSMENTS.

MOTION:	Commissioner Gilsenan

SECOND: Commissioner Nieman
Vote: Unanimous

Ms. Koval stated that the wellness committee met to discuss the wellness grant program. An application was sent to all members. She said the Program Manager's office has experienced wellness coordinators to assist in member programs. Commissioner Nieman said Montgomery participated in the program and participants are already requesting to participate again.

NEW BENEFITS ADMINISTRATION MANUAL - In our continuing efforts to improve Fund operations and communications, PERMA has created a new Benefits Administration Manual. The purpose of the manual is to provide additional guidance and assistance to the Benefit reps at each member group. The manual also explains policies and procedures that have been established and approved by the Fund's Commissioners.

PERMA mailed out the new manuals to everyone who currently has access to the system the week of October 12th. Electronic copies are available upon request. Any questions or requests for additional copies of the manual should be directed to the CJHIF Team. Their contact information is below.

MUNICIPALITY OPEN ENROLLMENT: CJHIF will be hosting Open Enrollment for January 1, 2016 elections: November 2nd- November 23rd.

- PERMA will be bulk shipping Open Enrollment packets to individual entities for active employees
- Retirees and COBRA enrollees will receive the information directly at their residencies
- Medicare Advantage retirees will not be included in this open enrollment

A sample guide will be provided at the meeting.

Program Manager said that open enrollment begins next week, and thanked the commissioners for the quick turn around on the step therapy grandfather opt out response.

PRESCRIPTION UTILIZATION MANAGEMENT 2016 - All impacted CJHIF groups have been contacted by PERMA regarding an opting out of the removal of grandfathering on Step Therapy. Individual member impact reports were included for individual group review. We realize due to collective bargaining concerns the opt out request date may not be attainable, but want to address to concern regarding member communications.

Included in this agenda:

- Draft CJHIF Informational Flyer *(page 22)*
- Opt Out Form *(page 23)*

Step Therapy without Grandfathering (5% Impact on 2016 Rx Rates) - Step therapy is a program that requires members to utilize medications in a certain order based on price and clinical efficacy. The Fund implemented Step Therapy with grandfathering in 2013, which allowed members on a drug that required a step, to bypass the step as long as they remained on that medication continuously every 130 days. Removing grandfathering will require members to at least try the least costly/more

clinically effective medication before moving to the second tier drug. *Clinical exceptions are attainable for members that may not be able to take the preferred medication.*

Included in this agenda:

- Step Therapy FAQ *(page 24)*
- Member Notification Letter *(page 26)*

PLAN CHANGE OPTIONS- JANUARY 1, 2016 - If your entity is interested in adding new plan options for January 1, 2016 please notify PERMA no later than October 15, 2015. Due to ACA requirements and administrative concerns, PERMA will not permit plan changes/new plan additional later than this date.

LOW COST PRESCRIPTION PLAN

	Copays			
	Generic	**Formulary Brand**	**Non Formulary Brand**	
Retail	$ 5.00	$20.00	$40.00	**30 day supply per fill**
Mail Order	$10.00	$40.00	$ 80.00	**90 day suppler per fill**
Specialty	$100.00			

Considerations for Reducing Prescription Utilization and Premium			
Program	**Description**	**Intent/Purpose**	**Rx Premium Impact**
Exclusive Home Delivery	Maintenance medications would be required to be filled by Express Scripts Mail Order	Plan gets the advantage of Express Scripts low cost Mail Order medications, and eliminates dispensing fees.	-4%
Select Home Delivery *Active Choice*	Members would be required to fill maintenance medications through mail order, unless they make *active choice* (telephonic outreach to Express Scripts) advising they would like to continue filling at retail. Opt outs are required annually	Plan gets the advantage of Express Scripts low cost Mail Order medications, and eliminates dispensing fees.	-2%
Brand Replacement *Member Pay the Difference*	If members would like a brand medication, when a generic equivalent is available, they are required to pay the generic copay **plus** the difference in plan cost of the generic and brand.	Encourages the use of generic medications when available. And if a brand is chosen the plan is only charged the cost of the generic.	-4%

The above low cost prescription plan is meant to be suggestive and may not be the best fil for all municipalities in the CJHIF. Savings vary based on current plan designs. Plan may be modified from original version to better fit the needs of each entity.

If an entity is interested in implemented this or any low cost plans similar, a special open enrollment can be held for the sole purposes of employees electing to move in to this model plan.

PERMA will be working on a standard communication piece for this plan that outlines the caveats and explains the benefits in more detail.

ESTIMATED SAVINGS- 7% - 18% (based on current plan designs).
Savings estimate is illustrative only and is not a guarantee- individual entity implementation rates will require actuarial approval and certification

Program Manager said that other funds have requested a low cost plan option and if the Fund is interested they can work on this. The idea is a 3 tier plan with several built ins and an average of 10-15% in savings.

Cadillac Tax

The Cadillac Tax imposes a 40% non-deductible tax on the excess amount of the aggregate cost of "applicable employer–sponsored coverage" in a calendar year. Applicable employer–sponsored coverage is generally defined as the coverage under any group health plan made available to employees by an employer which is excludable from the employee's gross income or would be excludable from the employee's gross income under IRC section 106. The definition of "employees" includes former employees, retirees, surviving spouses and "other primary insureds" (an undefined term). The tax applies to all employers subject to excise tax provisions of the IRC which includes all private employers, regardless of size, and also includes tax exempt and governmental entities. The excess amount of the total cost of coverage, from which the tax is calculated, is the amount of applicable coverage which exceeds the annual statutory limits, which have been set at $10,200 for individual coverage and $27,500 for other-than-individual coverage for the 2018 tax year.

The tax is calculated on a monthly basis, but is assessed on a calendar year basis. The value of applicable coverage must be calculated based on approved methods identified in the guide. Rules permit adjustments to the limits for retirees and high risk professions, as well as age and gender adjustments. Adjustments will also be made through 2018 and beyond for health cost inflation.

Each provider of coverage is responsible for paying its share of the tax. For all fully-insured coverages, the health insurer is the coverage provider. For self-insured coverages or other coverage, the employer/plan administrator is responsible for paying the tax. Keep in mind that while the coverage provider is responsible for paying the tax, employers sponsoring health plans are responsible for calculating the tax and determining the share of the tax attributable to each coverage provider. In general, penalties may be assessed on employers who miscalculate the tax or fail to correctly attribute the tax to the responsible party. The employer may be responsible for a penalty equal to 100% of the error plus interest. The IRS reserves the right to waive penalties for employers who can prove they were not aware of the mistake, provided the mistake is corrected within 30 days.

A recent article, "Union Plans Need to Look Ahead to Cadillac Tax Despite Lack of Guidance", was published in Bloomberg BNA discussing the importance of preparation for this looming tax and the consideration of adding contract language allowing reopening of negotiations in 2017 when more guidance is available. http://www.bna.com/union-plans-need-b17179923113/

Recordkeeping and Reporting

The Internal Revenue Service (IRS) released more detailed reporting information in the form of Questions and Answers (FAQs) in an effort to assist employers with IRS reporting (Form 1094-

C) and providing statements to its employees (Form 1095-C) regarding employer health coverage information under the Affordable Care Act (ACA). Employers must comply with these new reporting requirements beginning in 2016, reporting on calendar year 2015. The latest guidance consists of an updated Q&A document covering basic reporting requirements and a new Q&A document addressing more specific issues that may arise while completing Forms 1094 and 1095. The Q&As are clarifications to the existing rules. The final rulings remain unchanged. The revised Q&As can be found here, Questions and Answers on Reporting of Offers of Health Insurance Coverage by Employers (Section 6056), providing you the guidance needed in respect to the reporting of healthcare coverage

Finalized IRS Reporting Forms

Final 2016 ACA Reporting Requirements

The Internal Revenue Service (IRS) has released final forms and instructions for the information reporting provisions under the Patient Protection and Affordable Care Act (the "PPACA"). Compliance is mandatory for affected employers. Failure to file the required informational returns or filing incomplete or inaccurate forms could result in reporting penalties and penalties under the ACA's employer shared responsibility provisions. Employers should be prepared now to report for the first time in early 2016 for calendar year 2015. For more information on the final rules on this IRS information reporting for employers, please see the IRS ACA Reporting webpage.

The following final forms and instructions are now available for 2015 (minor changes were made to some of the forms and both sets of instructions):

The following final forms and instructions are now available for 2015 (minor changes were made to some of the forms and both sets of instructions):

- Form 1094-C (transmittal)
- Form 1095-C (employee statement)
- 2015 Instructions for 1094-C and 1095-C
- Form 1094-B (transmittal)
- Form 1095-B (employee statement)
- 2015 Instructions for 1094-B and 1095-B

The final instructions clarify various issues relating to how large employers prepare the Form 1095-C for full-time employees. Some helpful clarifications are provided, including:

- Instructions for obtaining an automatic 30-day extension to furnish forms to the IRS;
- Instructions for requesting an extension of time to furnish statements to employees;
- Instructions on correcting Forms 1094-C and 1095-C;
- Clarification that the IRS requires reporting for only one plan where employees are covered by more than one type of minimum essential coverage (such as a medical plan and an HRA);

- Clarification that COBRA offers for terminated employees are not reported as offers of coverage under any circumstances;
- Additional details on reporting cost of coverage for non-calendar year plans;
- Additional details on reporting coverage through multiemployer plans;
- Instructions on electronic filing and how to obtain a waiver from electronic filing; and
- Information on potential penalties and penalty relief.

Recently released IRS Notice 2015-68 also simplifies the rules for collecting Social Security Numbers (SSNs). When an employer sponsors a self-insured plan, the employer must report the SSN for each enrolled individual (including dependents). Pending additional guidance, reporting entities will not be subject to penalties for failing to report SSNs if they request them as follows: (1) make an initial solicitation at an individual's first enrollment or, if already enrolled on September 17, 2015, the next open enrollment season; (2) make a second solicitation within a reasonable time thereafter; and (3) make a third solicitation by December 31st of the year following the initial solicitation. In addition, plan sponsors do not have to solicit SSNs from individuals who have terminated coverage.

The IRS is encouraging employers and tax professionals to take a close look at its new webpage titled "Affordable Care Act Information Center for Applicable Large Employers (ALEs)." The webpage can be used to determine ALE status and as a means to finding additional resources on these complicated rules. According to the webpage, two provisions of ACA that apply only to ALEs are now in effect—the employer shared responsibility provision, and the employer information reporting provision for offers of minimum essential coverage. Self-insured ALEs, i.e., employers who sponsor self-insured group health plans, have additional provider information reporting requirements.

Employers are advised to consult with their tax, HRIS/payroll, and legal advisors for assistance with specific issues/complexities regarding form preparation, appropriate eligibility and hours tracking rules, and the actual implementation of the data gathering, tracking, and reporting rules. Final versions of the 1094-C and 1095-C have been included for your reference.

Program manager said that the Cadillac tax reports were distributed.

ACA change to Small Group Market Definition

Background: Under the ACA, health insurance offered in the small group market must meet strict underwriting requirements and cover all essential health benefits; conditions that do not apply in the large group market. A controversial aspect of the ACA called for the establishment of a new, federal definition of "small employer" as those with 2-100 eligible employees effective as of January 1, 2016. Prior to January 1, 2016 states had the flexibility to maintain the definition of a small employer to those with up to 50 employees and most states continued to do so. Under the ACA rules beginning January 1, 2016, every state was required to expand the definition of the small group market to include employers with up to 100 employees. The ACA's expanded definition would have forced non-grandfathered insured plans of employers with 51-100 employees into the ACA community rating standards and would have required them to cover all essential health benefits. With expansion, these 51-100 groups would have faced less favorable rate structures, narrow networks and restricted access to out-of-network services.

The change: Concerns about steep price increases and loss of benefit design flexibility from many businesses with 51–100 employees who would be re-classified as a "small group"

prompted a push for the repeal of this requirement. The PACE Act now repeals the mandatory expansion of the small group market to employers with up to 100 employees and reverts to the prior definition of up to 50 employees.

State rules can vary: States maintain flexibility to define the small market as up to 100 employees. While the federal definition is now set at 2-50 as a result of the change to the ACA, federal law still allows states to develop their own definition of what constitutes a small group. For example, a state could still establish their own local requirements that a small group could be defined as 2-50, 2-75, 2-100 or any denomination they choose. A few states, like New York for example, have already enacted laws or issued regulatory guidance changing their small group definition to the 1-100 employee definition in 2016. Most states will likely be reverting back to 50 lives for community rating, however, these states will need to enact legislation prior to considering a change.

Potential implications for employers and plan sponsors: While this law is very significant for smaller companies, it also has possible indirect implications for larger companies. If the political parties and the President can reach bi-partisan compromise on changes to the ACA on this issue, there is hope they can do the same on other aspects of the law that are unfavorable to employers and sponsors; things like the "30 hour rule", the complex "reporting rules," and the wildly unpopular "Cadillac tax." We are monitoring all of these developments closely and will share updates as they become available.

TREASURER: Mr. Mayer reviewed the October bills list. Mr. Mayer said the MRHIF and CJHIF will be following the direction of the MRHIF and the MEL investment plan which will require moving banks from Wells Fargo. He will update the committee with the decision of the MEL and MRHIF.

Bills lists:

September 2015 – Resolution 21-15

FUND YEAR 2015	$304,000.13
TOTAL ALL FUND YEARS	$304,000.13

September 2015 – Dividend Resolution

CLOSED YEAR	**$18,058.61**
TOTAL ALL FUND YEARS	**$18,058.61**

MOTION TO APPROVE PAYMENT OF THE OCTOBER 2015 BILLS LIST, CLOSED YEAR DIVIDEND, AND APPROVE BALANCE OF TREASURER REPORT AND CERTIFICATION OF CLAIMS

MOTION: Commissioner Rieker
SECOND: Commissioner Gilsenan
VOTE: 4 Ayes, 0 Nays

ATTORNEY: No Report

QUALCARE: Report was distributed

AETNA: Ms. Ward reviewed the claim activity report through August 2015. The total amount of claims paid is $936,586.

DELTA DENTAL: No report

NEW BUSINESS: None

OLD BUSINESS: None.

PUBLIC COMMENT: None

MOTION TO ADJOURN MEETING:

MOTION:	Commissioner Gilsenan
SECOND:	Commissioner Rieker
VOTE:	Unanimous

MEETING ADJOURNED: 1:15 PM