CENTRAL JERSEY HEALTH INSURANCE FUND
OPEN MINUTES
SEPTEMBER 23, 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	Present
Adam Hubeny	Borough of Atlantic Highlands	Absent
Eugenia Poulos	Borough of Red Bank	Present
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**	Absent
Network & Medical Claims Service	Qualcare Inc.	**Gary Epstein**	Absent
Network & Medical Claims Service	Aetna	**Kim Ward** **David Norton**	Absent Present
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:
Karen Lalla, Integrity Consulting

Dominic Cinelli, Brown and Brown
Charles Casagrande, Danskin Agency
*via conference call

CORRESPONDENCE: None

APPROVAL OF MINUTES: JULY 15, 2015 OPEN:

MOTION TO APPROVE OPEN MINUTES OF JULY 15, 2015:

MOTION:	Commissioner Poulos
SECOND:	Commissioner Rieker
VOTE:	Unanimous

EXECUTIVE DIRECTOR:

PRO FORMA REPORTS

- **Fast Track Financial Report –** as of July 31, 2015 *(page 7)*
- **Cash Flow Report –** as of July 2015 *(page 8)*

Executive Director reviewed the Financial Fast Track which illustrated a 14.5 million surplus, although a loss was seen in July but due to the release of a dividend. Financials continue to be stable.

INTRODUCTION OF 2016 BUDGET - The Central Jersey HIF 2016 budget materials were included. The Finance Committee met prior to the meeting and may have a recommendation for the Executive Committee.

Executive Director said the overall increase of 2.26% is very good as the Fund has been making earnings each month this year. Lakewood has its own retention, as of September 1 and Manchester is leaving at the end of the year, therefore members will be going up slightly more than average to accommodate. Lakewood and Manchester both had good experience, so the other member will have to make up for that loss of subsidy.

Executive Director said the biggest driver in the increase is prescription, while the medical is stable. Hepetitis C drugs and brand name drugs have increased by 14%, due to marketing and Affordable Care Act (ACA) that has increased the market. He said this budget includes lifting the grandfathering of Step Therapy, which provides a 5% savings. Executive Director said the Fund is in the process of reviewing an EGWP program for retirees which will provide more subsidies.

Executive Director further reviewed the proposed 2016 budget, as illustrated. He said Brick Township saw a larger increase because they are in the Fund for only prescription and its utilization is high. Since the Fund is decreasing, all professionals have proposed a flat rate for 2016. He said Aetna has been very coorperative and has dropped their medicare advantage costs and stayed flat on administrative fees. In addition, Executive Director said a dividend may be an option for next summer.

MOTION TO INTRODUCE THE CENTRAL JERSEY HEALTH INSURANCE FUND BUDGET FOR 2016 AND ADVERTISE A PUBLIC HEARING FOR OCTOBER 28, 2015 AT 1:30PM AT THE BRIELLE BOROUGH HALL TO ADOPT THE BUDGET.

MOTION:	Commissioner Nieman
SECOND:	Commissioner Rieker
VOTE:	6 Ayes, 0 Nays

ADMINISTRATION

PRO FORMA REPORTS

- **Regulatory Compliance Checklist –** as of September 12, 2014 *(page 10)*

MUNICIPAL REINSURANCE HEALTH INSURANCE FUND - The MRHIF met on September 9, 2014. Commissioner Hubeny's report was included. The overall increase is 9.46%. The assessment allocation is included in the report. RFQs for all positions were also reviewed and will be finalized during the budget adoption scheduled for December 9, 2015.

2016 RFQ RESPONSES - An RFQ for all Fund professionals was due on September 8, 2015. A summary of responses has been included. Only the incumbent professionals responded. Inadvertently, the Fund Attorney was not sent the RFQ, so we have extended the due date for that position to September 18 and will report on those responses at the meeting. Ms. Koval said only incumbent professionals responded and will be included in the reorganization resolution to approve these contracts.

QUALCARE UPDATE - A letter from Qualcare's president, Annette Catino, is included in the agenda describing the purchase of Qualcare to Cigna and Anthem.

BENEFITS OPERATIONS

CLAIM APPEALS – 1 for Executive Session

ONLINE ENROLLMENT SYSTEM - The Executive Committee voted and approved mandatory use of the online enrollment system by each member group. The majority of the member groups are using the system but there are still a few member groups that are not. Next month, we will be sending a letter to groups that are not using the system to remind them of the Fund's policy. The letter will include additional information regarding the system as well as training dates so the group can become complaint. If you need additional training on the online enrollment system, please reach out to Karen Kidd at kkidd@permainc.com of PERMA.

CONTACT INFORMATION - All enrollment and billing questions should be directed to our dedicated enrollment team. The CJHIF enrollment team may be contacted via email at cjhifenrollments@permainc.com or by facsimile at 856-685-2258.

Broker Email Box - The broker email box is officially open for correspondence. We ask our broker partners to utilize this tool for service, advocacy or any like requests that may arise with their groups.

brokerservice@permainc.com

WELLNESS UPDATE - PERMA is currently in the process of scheduling a call with the CJHIF Wellness Committee.

2015 PPACA UPDATES - In our constant effort to keep you informed of the ongoing progression of PPACA, the following communications regarding 2015 PPACA updates are included in the attachment section of this report:

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/

In response to Commissioner Poulos, Program Manager said members can include lower cost plans to try and bring the member's cost to or below the threshold of this tax. Commissioner Poulos said she would like to see more lower cost options because the few that are being offered at Red Bank are not seeing any enrollment.

Recordkeeping and Reporting - he 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

To assist with ACA required recordkeeping and reporting requirements (1094/95 B &C), PERMA can run census and data reports out of the Benefits Express system that can be utilized to generate the necessary reports.

If you'd like a standard report, please have your Risk Managers reach out to Jeanne Frank at jfrank@permainc.com. The expected turn around time to receive reports is 7-10 business days.

Draft Instructions and Revised Draft 2015 Forms for IRS Reporting Requirements
On August 7, the Internal Revenue Service (IRS) released draft instructions and revised draft 1095-B and 1095-C forms to be used for Affordable Care Act (ACA) Minimum Essential Coverage (MEC) and Large Employer reporting in 2016. The IRS has posted the 2015 draft instructions and forms at IRS.gov/draftforms as information only, and will post final versions at a later date.

The revised 2015 draft forms are generally unchanged from the versions released on June 19, 2015. However, the IRS made several changes to the 2014 final instructions, including:

> **"B" form instructions for applicable large employers** – The draft instructions for forms 1094-B and 1095-B now allow applicable large employers (ALEs) the option to use the "B" forms to report coverage of individuals who are not considered full-time employees for any month during the calendar year.
>
> **"C" form instructions for applicable large employers** – The draft instructions for forms 1094-C and 1095-C require that ALEs continue to report all employees enrolled in self-insured coverage on the "C" forms – as part of MEC reporting.

30-day extension for IRS filing – An automatic extension is granted if Form 8809 is submitted to the IRS on or before the filing due date.

30-day extension for providing forms to individuals – An extension may be granted by submitting a letter to the IRS on or before the due date for providing forms to individuals.

Details on how to file corrected forms – The draft instructions include details on filing corrected paper returns. Information on electronic filing corrections can be found on IRS Publication 5125.

Hand delivery – Both sets of reporting may be hand delivered to individuals.

Reporting supplemental coverage – The definition of a "plan sponsor" has been clarified for the purpose of reporting supplemental coverage by the same reporting entity as the health plan sponsor.

Reporting coverage offered under multiemployer plans – Simplified reporting now available for reporting offers of coverage for employers with multiemployer arrangements that qualify for relief.
Reporting on COBRA participants – Clarifications on how to report COBRA participants.

Draft Instructions and Forms
Instructions for Forms 1094-C and 1095-C
Form 1094-C – Transmittal/"cover sheet" for Large Employer and self-insured MEC reporting (applicable large employers)
Form 1095-C – Report to individuals and the IRS information on coverage offered and self-insured MEC (applicable large employers)
Instructions for Forms 1094-B and 1095-B
Form 1094-B – Transmittal/"cover sheet" for MEC reporting (insurance carriers and self-insured small group employers)
Form 1095-B – Report to individuals and the IRS information on MEC (insurance carriers and self-insured small group employers)
We will keep you informed when final instructions and forms are made available.

Program Manager said a census report can be provided to members. There is a local company, Primepoint, that is providing filing services.

EXPRESS SCRIPTS – Cholesterol/PCSK9 Medications Strategy Update - Express Scripts has delayed the requirement of Select Home Delivery (SHD) of their clinical review program. At the last meeting the CJHIF elected to opt out of the SHD program for a fee of $0.20 PMPM. The Fund will not be assessed this amount.

The requirement has been delayed until 2017, at which time the Fund can revaluate the SHD program and its impact on employees and their dependents.

EXPRESS SCRIPTS – Drug Quantity Management (DQM) - Drug Quantity Management (DQM) is a program that was incorporated into your prescription-drug benefit in 2011 that's designed ***to make the use of prescription drugs safer and more affordable.*** It provides you with medications you need for your good health and the health of your family, while making sure you receive them in the amount — or quantity — considered safe. Program Manager said the impact of this program is not very large. Ambian is the most notable drug that seems to be flagged in this program. One more fill will be allowed before the guidelines are set.

The program follows guidelines developed by the U.S. Food & Drug Administration (FDA). These guidelines recommend the maximum quantities considered safe for prescribing certain medications. Together with Express Scripts — the company that manages your prescription-drug benefit — your plan develops your Drug Quantity Management program based on FDA guidelines and other medical information.

The program includes ***prescription drugs that could have safety issues for you*** if the quantity is larger than the guidelines recommend. For instance, it includes prescription drugs that aren't easily measured out, like nose sprays or inhalers. ***Prescription drugs that come in several strengths*** are also included. Again, if you can take fewer doses at a higher strength, you save because you pay fewer copayments — and your plan can save, too.

This program does not deny access to the medication members need, but rather the quantities that follow the plan's guidelines for safe, and economical use.

Here's what occurs at the pharmacy when a prescription drug is included in your Drug Quantity Management program:

1. When you hand in your prescription, your pharmacist sees a note on the computer system indicating that your medication isn't covered for the amount prescribed. This could mean:

You've asked for a refill too soon; that is, you should still have medication left from your last supply. Just ask your pharmacist when it will be time to get a refill.

OR your doctor wrote you a prescription for a quantity larger than our plan covers.

2. If the quantity on your prescription is too large, here's what you can do:

Have your pharmacist fill your prescription as it's written, for the amount that our plan covers. You pay the appropriate copayment. But you may need to get this prescription filled more often — for instance, twice a month instead of once a month — which means you pay more often.

OR ask your pharmacist to call your doctor. They can discuss changing your prescription to a higher strength, when one is available. In most cases, if your doctor approves this change you have fewer copayments because you receive your medication just once a month.

OR ask your pharmacist to contact your doctor about getting a "prior authorization." That is, your doctor can call Express Scripts to request that you receive the original amount and strength he/she prescribed. During this call, your doctor and an Express Scripts representative may discuss how your

medical problem requires medication in larger quantities than your plan usually covers. They may consider safety issues about the amount of medication you're going to receive. And the Express Scripts representative will check your plan's guidelines to see if your medication can be covered for a larger quantity. Express Scripts' Prior Authorization phone lines are open 24 hours a day, seven days a week, so a determination can be made right away.

A Frequently Asked Questions (FAQ) provided by Express Scripts is included this is report for your review and distribution should you feel necessary.

TREASURER: Chair Nolan reviewed the August and September bills lists.

Bills lists:

August 2015 – Confirmation of Payment

FUND YEAR 2015	**$379,347.96**
TOTAL ALL FUND YEARS	**$379,347.96**

September 2015 – Resolution 19-15

FUND YEAR 2015	**$**341,835.91
TOTAL ALL FUND YEARS	$341,835.91

MOTION TO APPROVE PAYMENT OF THE SEPTEMBER 2015 BILLS LIST AND APPROVE BALANCE OF TREASURER REPORT AND CERTIFICATION OF CLAIMS

MOTION:	Commissioner Lapp
SECOND:	Commissioner Gilsenan
VOTE:	6 Ayes, 0 Nays

ATTORNEY: No Report

QUALCARE: Executive Director reviewed the Qualcare report included in the agenda.

AETNA: Mr. Norton reviewed the claim payment report and high dollar claim report through July, which were slightly higher than prior months, but in line. He said he expects this kind of fluctuation.

EXPRESS SCRIPTS: Mr. Rostkowski said he will provide more comprehensive reports for future agendas. Overall pharmacy is up due to inflation and usage. Generic use in this Fund is increasing and compound exclusion has helped. There is one Hep C and one MS drug that picked up some higher claims.

DELTA DENTAL: No report

NEW BUSINESS: None

OLD BUSINESS: None.

PUBLIC COMMENT: None

MOTION TO ENTER EXECUTIVE SESSION:

MOTION:	Commissioner Lapp
SECOND:	Commissioner Gilsenan
VOTE:	Unanimous

MOTION TO APPROVE PAYMENT OF CLAIM #06-15-04 AT 80% OF FAIR AS PER THE RECOMMENDATION OF THE PROGRAM MANAGER, WITH NOTIFICATION TO THE INSURED THAT THIS IS A ONE TIME EXCEPTION.

MOTION:	Commissioner Lapp
SECOND:	Commissioner Gilsenan
VOTE:	Unanimous

MOTION TO ADJOURN MEETING:

MOTION:	Commissioner Lapp
SECOND:	Commissioner Gilsenan
VOTE:	Unanimous

MEETING ADJOURNED: 2:00 PM