SOUTHERN NEW JERSEY REGIONAL EMPLOYEE BENEFITS FUND
OPEN MINUTES
JUNE 22, 2015
HADDONFIELD BOROUGH HALL
6:15 PM

Meeting of Executive Committee called to order by Michael Mevoli. Open Public Meetings notice read into record.

PLEDGE OF ALLEGIANCE AND MOMENT OF SILENCE

ROLL CALL OF 2015 EXECUTIVE COMMITTEE:

Michael Mevoli	Chairman	Borough of Brooklawn	Present
Mayor Joseph Wolk	Secretary	Borough of Mt. Ephraim	Present
Richard Michielli	Executive Committee	Borough of Magnolia	Present
Louis DiAngelo	Executive Committee	Borough of Bellmawr	Present
Terry Shannon	Executive Committee	Borough of Barrington	Present
Jack Lipsett	Executive Committee	Gloucester City	Present
Neal Rochford	Executive Committee	Borough of Haddonfield	Present
Joseph Collins	Executive Committee 1st Alternate	Delsea Regional BOE	Present
Gene Mercoli	Executive Committee 2ndAlternate	Cumberland Co. Vo Tech Ed	Present
Frank Domin	Executive Committee 3RD Alternate	Berlin Borough BOE	Present
Lisa Giovanelli	Executive Committee 4th Alternate	Rancocas Valley Regional	Absent

APPOINTED PROFESSIONALS PRESENT:

Executive Director/Adm.	PERMA Risk Management Services **Paul Laracy** **Emily Koval**
Program Manager	Conner Strong & Buckelew **Brandon Lodics** **Jeanne Frank**
Attorney	**J. Kenneth Harris, Esq.**
Medical TPA – Aetna	
Medical TPA – Amerihealth	

Dental TPA – Delta Dental

Prescription TPA – Express Scripts **Ken Rostkowski**

Treasurer **Kenneth Verrill**

Fund Coordinator (Coastal group) **Gerald Cowan**

PRESENT FUND COMMISSIONERS:
Robert Maybury, Mt. Holly MUA

ALSO PRESENT
John Cobb, J Cobb Insurance Group
Kim Porter, CHB Group
Michael Gaito, Conner Strong & Buckelew
Suzanne Wood, CBIZ Model
Karen Lall, Integrity
Ashley Stoffel, Integrity

Commissioner Rochford welcomed the Executive Committee and professionals to Haddonfield Borough.

APPROVAL OF MINUTES: **MAY 26, 2015 Open.** Ms. Koval said the May 26 meeting minutes were inadvertently excluded from the agenda but will be included in July for approval.

PRO FORMA REPORTS

- **Fast Track Financial Reports** – as of April 30, 2015
  - **Historical Income Statement**
  - **Consolidated Balance Sheet**
  - **Indices and Ratios Report**

Commissioner Wolk said the MRHIF approved a dividend, of which the Fund is receiving $1.7 million. This dividend can be considered in the Fund's dividend to the local membership.

FINANCES

AUDIT REPORT AND VALUATION REPORT AS OF DECEMBER 31, 2014 *(page 14)*

The Fund Audit is not yet complete because of delays in claims testing. We anticipate that the report will be ready for approval next month. We will request a 1 month extension from the State.

In addition to seeking approval of the audit, we were going to concurrently request approval of several steps that will prepare the financial structure of the Fund for the separation.

1. Close the 2013 fund year.
2. Separate the "Closed Year" account into three separate accounts:
    a. Southern Coastal Member Closed Year Account
    b. Schools Member Closed Year Account
    c. Municipal Member Closed Year Account
3. Transfer the balance of the Rate Stabilization Reserve for 2014 to the School Member Closed Year Account.

Once the 2014 fund year matures an additional few months, we will seek authorization to transfer its surplus to the respective closed year accounts.

Once the 2015 fund year budget is finalized, in December, we will also transfer the 2015 schools Rate Stabilization Reserve to the schools closed year account.

In all of these transactions, the discrete "ownership" of each entity's share of surplus by fund year is unchanged. These allocations however will create the basis for each subgroup to assure liquidity for its future operations and allow for separate surplus retention and dividend decisions.

Executive Director said the financial fast track illustrated a $6.2 million surplus this month. He said the MRHIF dividend and the reduction in IBNR contributed about 75% of that surplus. He said this additional funds gives plenty of options for a dividend in the next few months. The Audit is not prepared for this meeting as the testing has not been complete. PERMA will submit for an extension to the deadline.

Executive Director reviewed Resolution 17-15 which will move to close the 2013 Fund year, move surplus from 2014 to the closed year balance and include the rate stabilization

MOTION TO ADOPT RESOLUTION 17-15 CLOSING THE 2013 FUND YEAR, CREATING SEPARATE CLOSED YEAR ACCOUNTS BY PROSPECTIVE HIF, AND TRANSFERRING THE SCHOOL MEMBER 2014 RATE STABILIZATION RESERVE TO THE SCHOOLS CLOSED YEAR ACCOUNT.

Moved:	Commissioner D'Angelo
Second:	Commissioner Wolk
Vote:	7 Ayes, 0 Nays

In response to Commissioner Shannon, Executive Director said the Fund may decide on a dividend in the next few months after the audit confirms the reserve accounts. A finance committee will be scheduled prior to the next meeting.

ADMINISTRATION

NEW FUND FILINGS - The Coastal Fund has submitted its first filing with the State and we are awaiting a response. The Schools Health Insurance Fund is expected to file by the end of the month.

MUNICIPAL REINSURANCE HEALTH INSURANCE FUND - The MRHIF met on June 10, 2015. Commissioner Wolk's report is included in the agenda. Holman and Frenia presented a clean Annual Audit ending December 31, 2014 and the report was unanimously approved by the committee.

In addition, the Executive Committee approved a dividend in the amount of $3,340,070. Allocation of these funds by local member is included in the MRHIF report. When the Funds transferred their retiree coverage to the fully insured Medicare Advantage plans, many prescription-only plans were left under the self insured Fund plans. Munich Re did not extend coverage for members without medical under the Fund The MRHIF Program Manager is researching other options, but in the meantime, $408,111 of the approved dividend will be retained for prescription claims over the MRHIF level.

A claim audit schedule was also approved. ESI's first quarter contract compliance and United Healthcare claims will be audited this year.

BENEFITS OPERATIONS

PRO FORMA REPORTS

- **Claim Appeals** – none

MANDATORY USAGE OF THE ONLINE ENROLLMENT SYSTEM - Usage of the online enrollment system is in full progress. The PERMA Enrollment Department continues to offer assistance to HR representatives as they acclimate themselves with the system. Please reach out to our Enrollment Team if you are in need of training.

CONTACT INFORMATION - Please direct any eligibility, enrollment, billing or system related questions to our dedicated SNREBF Team. The team can be reached via email: southernnj_enrollments@permainc.com or by fax: 856-685-2249.

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 similar requests that may arise with their groups.

brokerservice@permainc.com

WELLNESS UPDATE

SCHOOL BOARDS - A conference call is being organized among the chosen school boards to initiate the Wellness Coaches Pilot Program. Grant monies from 2014 budget will be available until December 31st,
2015. Additional monies will be allocated July 1st, 2015 for the new budget year.

MUNICIPALITIES - We would like to get the committee back together to discuss the wellness program moving forward. A PERMA representative will be reaching out to the members of the municipality wellness committee to discuss dates, times and location for an upcoming meeting. If you are interested in joining the Municipality Wellness Committee, please reach out to Emily Koval.

PERMA met with Bravo Wellness, a technology driven wellness vendor with the capability to conduct large scale incentive driven programs which may be a good fit for municipalities. We are awaiting pricing from Bravo and look forward to discussing this option in greater detail with the committee. In response to Commissioner Shannon, Program Manager said the Committee may discuss levels of incentives and what employees will need to do to meet these levels.

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 (page 20):

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 guidance; the 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 it 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 timely (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/

Program Manager said that union negotiations over the next few years should include to some language to allow the contract to be reopened if a certain amount of the plans meet the threshold. PERMA has a tool that projects where each town will be at the threshold between 2018-2022.

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 remained 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.

In response to Commissioner D'Angelo, Program Manager said the employers will need to check off that coverage was offered.

Update on Family Out of Pocket Limits & Deductibles for 2016 - The Departments of Health and Human Services (HHS), Labor (DOL) and Treasury have issued FAQs clarifying the treatment of out-of-pocket (OOP) cost-sharing limits for family coverage required as part of the Affordable Care Act (ACA). Under the guidance, an "embedded" individual OOP is required for family coverage. In other words, the in-network individual OOP maximum will apply to each individual enrolled in family coverage. Therefore, the annual OOP maximum under ACA for self-only coverage applies regardless of whether the individual has self-only or family coverage. These rules will apply for plan years beginning on or after January 1, 2016. This clarification is significant and will affect many employer health plans.

Example: In 2016, a group health plan has an aggregate annual family limitation on in-network cost sharing of $13,000 (note that a plan is permitted to set an annual limitation below the maximum). The self-only maximum annual limitation in $6,000 applied to each covered family member. Assume family of four (Mom, Dad, Son and Daughter) enrolls in family coverage. Mom incurs claims associated with $10,000 in cost sharing, and Dad, Son and Daughter each incur claims associated with $3,000 in cost sharing. For Mom, the plan is required to bear the difference between the $10,000 in cost sharing and the maximum annual limitation for Mom

($6,000), or $4,000 paid by plan. With respect to cost sharing incurred by Dad, Son and Daughter, the aggregate $15,000 ($6,000 + $3,000 + $3,000 + $3,000) in cost sharing that would otherwise be incurred by the four family members together is limited to $13,000 (the annual aggregate limitation under the plan), and the plan must bear the difference between the $15,000 and the $13,000 annual limitation, or $2,000.

PERMA will continue to make the necessary updates to plan out of pockets and deductibles to individual plans to assure groups remain compliant. Majority (if not all), medical plans in the HIF have deductibles that operate in this way.

EXPRESS SCRIPTS – CHOLESTEROL / PCSK9 MEDICATIONS STRATEGY UPDATE - Starting in July, 2015, a new class of statins to treat high LDL cholesterol is being introduced to the market. Termed PCSK9 medications, these specialty medications are designed to specifically treat those who are resistant to higher dose statins, intolerant to statins, or have a diagnosis of familial hypercholesterolemia. Based on the currently estimated cost, prevalence, and clinical prescribing guidelines, these drugs have the potential to increase your current overall drug costs by 30-40%. In combination with projected annual drug trend, plans are now facing potential 50% increases in annual drug costs. In light of this unprecedented cost impact to plan sponsors, PERMA is recommending a strategy that will allow the Funds to calculate the potential cost impact and make a fully informed decision for this class of drugs prior to offering member coverage.

Based on clinical trials and current medical benchmarks, it is estimated that between 8%-24% of current statin users will qualify for these new specialty medications. The annual cost of the new statins are currently estimated to be anywhere from $7,000 to $12,000 per utilizing member. In contrast, the current annual cost of a generic statin is approximately $600 per utilizing member. Also, the $7,000 to $12,000 is a reoccurring cost as the patient will still have to take the new medications indefinitely.

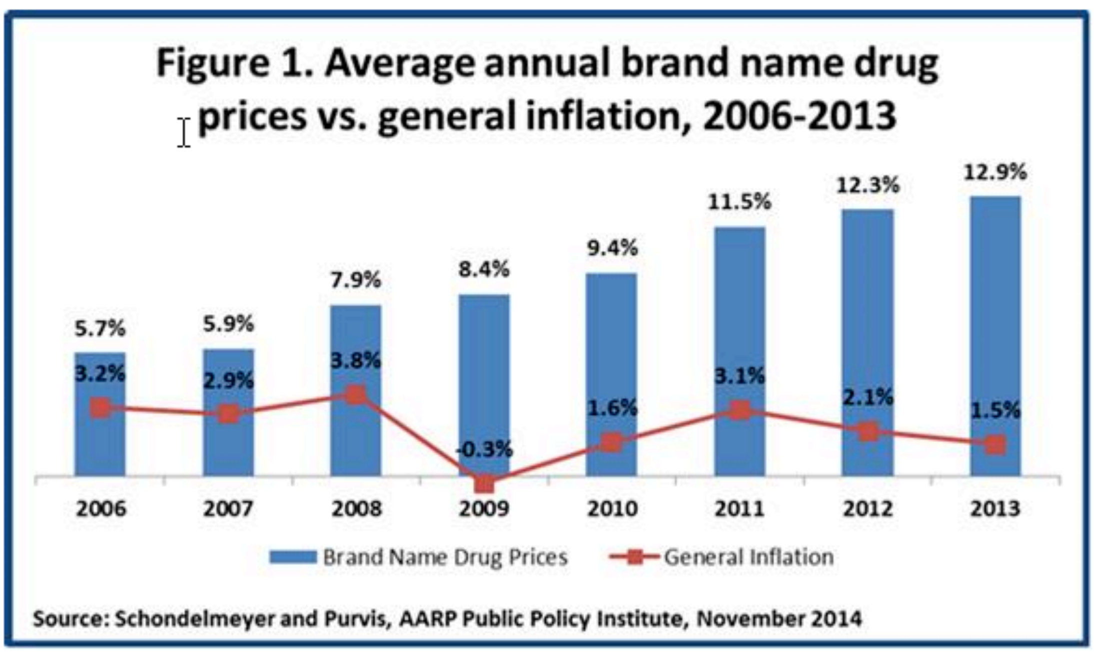
<u>Recommended Strategy</u>

PERMA has requested specific reporting from Express Scripts that will estimate the potential cost impact to the SNJREBF. Because of the broad variances (over 200%) for both cost and prevalence, we recommend that our clients exclude these medications from coverage for the first six months following their release in July & August. This will allow the Fund to wait for real world prescribing that will determine the (1) number of current statin users to whom doctors will prescribe these medications, (2) the actual average annual cost per member, and (3) the clinical protocols under which these medications are being prescribed. The total annual cost impact can then be calculated and an informed decision made to continue excluding these medications or to begin coverage for your members. We also anticipate the current clinical guidelines changing as drug companies "sponsor" research studies that broaden the criteria for prescribing these drugs.

We are suggesting the delay in covering these medications until January 1, 2017 (18 months) so that the market, pricing and clinical protocols may become clearer. In light of market's recent experience with the Hepatitis C medications that hit the market in early 2014 and the unpredicted spike in inappropriate Compound medications that also rocked the pharmacy world last year we feel a delay is appropriate at this time. In both instances (Hep C and Compounds), the cost issues were devastating and it was hard to turn back the clock. A delayed approach in covering these new medications allows the markets to settle and also allows for price adjustments to take place. Again, in the interim all current medications used to treat high LDL cholesterol remain in place as they have been. Self funded clients can shorten the delay and begin to cover the medications sooner if they so choose.

Program Manager said that automatically denying the drug will cause members to put appeals into the Fund regularly, which can be burdensome. Very recently, Express Scripts introduced a strict prior authorization process with these injectable. The member will need to try the statins. If that does nto work, the clinical medical necessity prior authorization process will require blood tests and medical chart review. He said this utilization management process is projected to increase trend by 3% instead of 35% if nothing is done. Mr. Rustkowski agreed that the clinical review is very detailed and robust that will require clinicians and nurse reviews.

TRENDS IN RETAIL PRICES OF BRAND NAME PRESCRIPTION DRUGS FOR OLDER AMERICANS - According to a new report by the AARP Public Policy Institute, the annual percentage change in retail prices for brand name prescription drugs has consistently increased substantially faster than general inflation in recent years. Retail prices for the 227 brand name drug products most widely used by older Americans rose 12.9% in 2013 (Figure 1). The average **annual retail price increase in 2013 for these brand name prescription drug products was more than eight times higher than the rate of general inflation (12.9% vs. 1.5%).**



The annual retail price change for brand name drug products reported in Figure 1 averages annual point-to-point price changes for each month in a 12-month period (referred to as a rolling average change), smoothing over the entire year the annual change in brand name drug price that occurs for a single month (referred to as an annual point-to-point change).

Key Takeaways

- The retail price of brand name drug products has steadily increased over time since 2006;
- Brand name drug price increases at the retail level have been substantially higher than the rate of general inflationThe gap between the rate of brand name drug price change and the rate of change in general inflation has substantially widened over the period from 2006 to 2013. This gap has ranged from a less than two-fold difference in 2006 to a nearly nine-fold difference in 2013. The cost of brand name drug therapy reached nearly $3,000 per drug per year in 2013.

Figure 2 presents the retail price for widely used brand name drugs indicated for treating chronic conditions when the price is expressed as an average annual cost of therapy per drug. The average cost of therapy was nearly $3,000 per drug per year for brand name prescription drugs at the retail level in 2013. This average annual cost ($2,960) is more than double the average annual cost ($1,386) for a brand name drug in 2006, the year Medicare implemented Part D. Almost two-thirds of older Americans take three or more prescription drugs in a given year. If they used brand name drugs to treat their chronic conditions, they would have experienced an average annual retail cost of drug therapy of $8,880 for three drugs in 2013.

Executive Committee requested a payroll stuffer that will highlight the savings for employees.

TREASURER'S REPORT – Fund Treasurer reviewed bills lists for June Resolutions 18-15.

Resolution 18-15: Payment of June 2015 Bills

Fund Year 2014	**$15,884.74**

Fund Year 2015	**$2,098,565.05**
TOTAL 2011	**$2,114,449.79**

MOTION TO APPROVE RESOLUTION 18-15 JUNE BILLS LISTS FOR THE SOUTHERN NEW JERSEY REGIONAL EMPLOYEE BENEFITS FUND BILLS LIST.

Motion: Commissioner D'Angelo
Second: Commissioner Michielli
Vote: 7 Ayes, 0 Nays

MOTION TO APPROVE THE CASH RECONCILIATION REPORT AND CASH TRANSACTION REPORT.

Motion: Commissioner Wolk
Second: Commissioner Michielli
Vote: Unanimous

AETNA: Executive Director reviewed the April claim and high claimant reports.

AMERIHEALTH – Executive Director reviewed the April claim and high claimant reports

DENTAL ADMINISTRATOR: No Report

PRESCRIPTION ADMINISTRATOR: No further report

FUND ATTORNEY: No report

OLD BUSINESS: none

NEW BUSINESS: None

PUBLIC COMMENT: none

MOTION TO ADJOURN:

Moved: Commissioner Michielli
Second: Commissioner D'Angelo
Vote: Unanimous

MEETING ADJOURNED: 7:46 PM

NEXT MEETING: July 27, 2015

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Emily Koval , Assisting Secretary

for

JOSEPH WOLK, SECRETARY