CENTRAL JERSEY HEALTH INSURANCE FUND
OPEN MINUTES
MARCH 20, 2013
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

ROLL CALL OF 2013 EXECUTIVE COMMITTEE:

CHAIRPERSON		
Thomas Nolan	Borough of Brielle	Present
SECRETARY		
Adeline Schmidt	Township of Shrewsbury	Present
EXECUTIVE	**COMMITTEE**	
Richard Bethea	Borough of Ship Bottom	Present
Jerome Cevetello	Manasquan River RSA	Present
William Rieker	Township of Lakewood	Present
Joseph Gilsenan	Township of Brick	Present
Diane Lapp	Township of Manchester	Absent
ALTERNATES:		
Adam Hubeny	Atlantic Highlands Twp	Present
Jane 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	**Diane Peterson** **Joseph Linker**	Present Present
Attorney	Berry, Sahradnik, Kotzas & Benson	**Jack Sahradnik**	Present
Treasurer		**Stephen Mayer**	Present
Network & Medical Claims Service	Qualcare Inc.	**Sharon Seitzman** **Jerry Eisenberg** **Gary Epstein**	Absent Present Present
Network & Medical Claims Service	Aetna	**Kim Ward** **David Norton**	Present Present

Dental Claims Service	Delta Dental	**Jackie Wright**	Absent
Rx Administrator	Express Scripts	**Susan Wolf** **Katty Mercado**	Absent Absent
Auditor	Green, Holman, Frenia & Co.	**Rodney Haines**	Absent

OTHERS PRESENT:
Peter Gorbatuk, Englishtown
Donato Nieman, Montgomery Twp
Lori Cole, West Long Branch
Ted Wardell, Brown & Brown Metro
Joe DeIorio, Manasaquan
Cindy Lisa, Danskin
Charles Casagrande, Danskin
Dominic Cinelli, Brown and Brown
Colleen Lapp, Red Bank

CORRESPONDENCE: None

APPROVAL OF MINUTES: JANUARY 16, 2013 OPEN:

MOTION TO APPROVE OPEN MINUTES OF JANUARY 16, 2013:

MOTION:	Commissioner Gilsenan
SECOND:	Commissioner Schmidt
VOTE:	6 Ayes, 0 Nays, 1 Abstain (Abstain – Commissioner Cevetello)

EXECUTIVE DIRECTOR:

PRO FORMA REPORTS – The following reports were included in the agenda:

- **Fast Track Financial Report** – as of December 31, 2012
  as of January 2013 (distributed)
- **Cash Flow Report** – as of December 31, 2012
- **Budget Reconciliation** – as of March 2013
- **Regulatory Compliance Checklist** – as of March 13, 2013

Executive Director distributed the Financial Fast Track for January 31, 2013 which illustrated a loss of $300,000. He said there were a few high claimants that may have attributed to this loss.

SCHOOL BOARD MEMBER 7-1-2013 RATE RENEWALS - The fund actuary, John Vataha, is recommending medical rate increases for school members as follows

Spotswood BOE +18.16% Medical
+13.66% Rx

Seaside Heights BOE	+15.66% Medical
	+16.16% Rx

He is recommending that the same increase be applied to their Qualcare and Aetna plans.

MOTION TO ADOPT RESOLUTION #13-13 RATE INCREASE FOR SPOTSWOOD BOARD OF EDUCATION AS PRESENTED BY THE FUND ACTUARY FOR THE PERIOD 7/1/2013 – 6/30/2014

MOTION:	Commissioner Gilsenan
SECOND:	Commissioner Schmidt
VOTE:	7 Ayes, 0 Nays,

GASB 45 AUDIT - This year, PERMA will be administering the GASB 45 Audit actuarial services for all members with more than 200 employees. Red Bank, Manchester and Lakewood would be the only members that qualify in this Fund. We will reach out to these entities to start gathering information for their reports.

ADMINISTRATION

MUNICIPAL REINSURANCE HIF - The MRHIF met on February 6, 2013 for their annual reorganization meeting. Commissioner Schmidt's report is included in the agenda. A few of the local Funds have expressed interest in releasing an RFQ for Prescription TPA. The MRHIF Fund Attorney is reviewing the Express Scripts contract which is in its 2nd term of a 3 year contract to see if this is a possibility at this time. In the meantime, the Fund Lobbyist is beginning to look into the possibility of the MRHIF partaking in the Express Scripts contract through the State Health Benefits Plan.

2013 COMMITTEES - Below is the 2012 list of Committees. Fund Commissioners are encouraged to join a committee for 2013.

Finance and Contracts
Thomas Nolan, Chair
Addie Schmidt
Jerry Cevetello

Claims
Rich Bethea, Chair
Colleen Lapp
William Rieker

Wellness and Plan Design
Diane Lapp, Chair
Colleen Lapp
Joseph Gilsenan

IMPLEMENTATION OF MEDICARE ADVANTAGE PROGRAM - Aetna offers fully insured "Medicare Advantage" programs for Medicare retirees. Aetna has developed a custom plan for the HIFs that will allow us to certify "equal to or better" coverage for all Medicare retirees. These programs achieve savings compared to our existing program wherein our coverage is secondary to Medicare. Savings are derived from federal government subsidies, and from care management and wellness services that are customized toward elderly and disabled patients. We are recommending this program for all Funds. BMED has chosen to proceed and this matter will be on the agendas of all Funds this month. The savings to the Fund, or to the members with retirees, are $750,000 per year. We seek authorization to proceed with this program with a target implementation date of June 1, 2013. Mr. Joseph Linker presented the details to the Committee.

In response to Chairman Nolan, Mr. Linker said the program would be Fund wide and all members would be expected to participate in order to obtain the savings described. The Fund would certify Equal to or Better than letters to the members. He said he feels that the coverage would be greater and there would be little to none disruption of providers because the program accepts all medicare providers. The only disruption would be Aetna providers that do not accept Medicare, but the same disruption would occur for Medicare as it stands currently.

CHAPTER 78 REGULATION PROPOSAL - The MRHIF Lobbyist is setting up a meeting with the governor's office on this matter, the A4 surcharge, and the idea of an Rx consortium. The meeting is scheduled to take place in April. Commissioner Schmidt will be attending as an MRHIF and CJHIF representative. We will have an update on these matters at the May meeting, if not earlier.

2013 MEL & MR HIF EDUCATIONAL SEMINAR - The 3rd annual seminar is scheduled for Friday, April 12th, beginning at 9:00 AM at the National Conference Center, Holiday Inn, NJ Turnpike Exit 8, East Windsor, NJ. The seminar qualifies for an extensive list of Continuing Educational Credits including CFO/CMFO, Public Works, Clerks, Insurance Producers and Purchasing Agents. There is no fee for employees and insurance producers associated with MEL and MR HIF members as well as personnel who work for service companies that are engaged by MEL member JIFs and MR HIF member HIFs. Attached is the enrollment form.

NOTE: The afternoon session has been change from the original mailing to include a 75 minute class on Healthcare Reform.

FINANCIAL DISCLOSURE FORM - Enclosed is a copy of a notice received from the Division of Local Government Services concerning the implementation of an "on-line" process for local government officers (LGOs) to file their Financial Disclosure Statement forms commencing in 2013. We received an update from the division that the process is moving forward. They expect to issue a Local Finance Notice on March 22nd.

INCLEMENT WEATHER REPORT - A procedure has been instituted for Commissioners to confirm whether a meeting has been cancelled. The Executive Director will talk to the Chair to determine if a meeting should be cancelled. In the case of an early morning or evening meeting, PERMA will leave a message, which can be obtained by dialing the Fund's main number of (201) 881-7632 For meetings that occur during normal business hours, meeting status can also be obtained by dialing the Fund office.

Executive Director's Report and Attachments made part of the Minutes.

PROGRAM MANAGER: Program Manager thanked the board for the reappointment.

CONFIRMATION OF SUB-CONTRACT AGREEMENT - Conner Strong & Buckelew provides the local field service and marketing activities on behalf of the Fund.
In certain cases a member may request another appointed Broker to perform the field service in which case, after approval by the Fund's Executive Committee, the parties enter into a subcontract agreement with the appointed Broker. These sub-contractor agreements are currently with: Grinspec Consulting, a Division of Brown and Brown, Brown & Brown Metro, Inc. a Division of Brown and Brown and (2) The Danskin Agency. These agreements have been included in the Resolution #11-13 to be formally adopted at the meeting.

Grinspec Consulting:

1) Neptune City – Fee 3.06% of total assessment

Brown & Brown Metro:

1) Township of Hazlet – Fee $14.87 Per Employee enrolled under medical coverage per month
2) Borough of West Long Branch – Fee 2.2% of Total Assessment

Danskin Agency:

1) Borough of Englishtown – Fee 5.10% of Dental Assessment
2) Borough of Interlaken – Direct agreement with Borough
3) Borough of Allentown – Direct agreement with Borough
4) Borough of Keyport – Fee 2.5% of Dental Assessment

PERMA is a wholly-owned subsidiary of Conner Strong & Buckelew, which is disclosed each year to the Fund Commissioners.

MOTION TO ADOPT SUB-CONTRACTOR AGREEMENTS WITH GRINSPEC CONSULTING, BROWN & BROWN METRO AND DANSKIN AGENCY INCLUDING FEES DESCRIBED IN THE PROGRAM MANAGER'S REPORT.

MOTION:	Commissioner Bethea
SECOND:	Commissioner Lapp
VOTE:	8 Ayes, 0 Nays

ADMINISTRATIVE ISSUES

ENROLLMENTS - 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. Program Manager said that in the upcoming Fund Year, the program management team would like to include enrollment best practices updates to member enrollment representatives. Any suggested comments or questions to include in these monthly updates are welcomed.

STATUS OF JANUARY ID CARDS - All employees enrolled in Qualcare received new Medical ID cards. These new cards will reflect the preventive services under Health Care Reform, the addition of the PHCS network of providers outside the Qualcare Regional Network and any changes made during Open Enrollment.

All employees who made changes during Open Enrollment have received their new benefit elections.

PLAN DESIGN COMMITTEE - The Plan Design Committee met prior to the November meeting and presented their recommendations during that meeting. The minutes from this meeting are included in Appendix II.

SBC--Plan for Action

1. Carrier compilation of preliminary SBC- AETNA and Express Scripts has agreed to assist in this project. "Rough," SBCs for each group will be forwarded to the PM.
2. Upon receipt, the Program Manager will conduct a benefits audit for accuracy and compliance to bring SBC to finalization.
3. PERMA will be distributing the SBCs via the CJHIF eligibility & enrollment box and posting on the Benefits Express System.
4. Provide status update to Executive Committee (ongoing)

All changes will be instituted March 1.

Moving forward all group health plans will have to provide at least 60 days' advance notice of midyear material plan modifications that could affect the content of the most recently issued SBC. (CREATE CHANGE IN HIF PROCESS)

TAXES TO INCREASE COSTS IMMEDIATELY - Healthcare Reform includes four new taxes that are expected to have a definite and immediate impact on plan sponsors' costs.

- (2013) Patient-Centered Outcomes Research Fee (the "Comparative Effectiveness Fee")
- (2014) Transitional Reinsurance Program Contribution

- (2014) Health Insurer Fee
- (2018) High-Value Plan Tax (the "Cadillac Tax")

Early estimates have stated the anticipated increase will be around a 4% increase in premiums that employers see in order to account for these taxes and fees. Below is a brief description on each of these taxes.

Patient-Centered Outcomes Research Fee: This fee is being imposed in an effort to establish a fund for clinical outcomes effectiveness research. This fee will be $1 or $2 per covered life and is subject to increase in accordance with national healthcare expenditures. This fee is set to expire in 2019.

Transitional Reinsurance Contribution: This is established to fund reinsurance entities in order to finance the cost of high-risk individuals in the individual market. Over the course of three years (2014-2016) an aggregate fee of $25 billion will be collected.

Health Insurer Fee: As the name implies, this will be paid by insurers beginning in 2014 and is intended to offset a portion of the expense related to premium subsidies and tax credits. In 2014, there will be an industry fee of nearly $8 billion which is applicable to nearly all lines of coverage.

High-Value Plan Tax: Set to begin in 2018, this fee will be assessed on high-premium health plans. The thresholds that will serve as the determinants of "Cadillac" status are plans that have an annual cost of $10,200 for single coverage and $27,500 for family coverage. Any and all amounts in excess of these established amounts will be subject to a 40% excise tax.

Source: Conner Strong & Buckelew Legislative Update January 2013.

FEDERAL SIXTH CIRCUIT COURT RULING - Employer May Make "Reasonable Modifications" to Retiree Health Care Benefits

A recent federal court ruling offers clarity and potential for employers with retiree benefit plans that have been subject to collective bargaining. Recently the Sixth Circuit court has ruled that an employer was entitled to make "reasonable modifications" to its retiree health care benefits (Reese v. CNH America, LLC), reversing a district court's grant of summary judgment to the retirees. The district court originally found that the employer lacked the ability to modify any benefits except with the approval of the union that once represented the employees. The appeals court majority concluded that, whatever else vesting in the health care context means, it does not mean that beneficiaries receive a bundle of services fixed once and for all.

In their 1998 collective bargaining agreement (CBA), the parties imposed managed care on all retirees, which represented a reduction in the effective choices of coverage available. Pre-1998 retirees saw their coverage downgraded because they generally had to pay more for choosing an out-of-plan doctor. In view of the distinction between vesting of eligibility for a benefit and the scope of that commitment, and in view of the parties' 1998 CBA altering health care benefits, the

appeals court concluded that the employer could make reasonable changes to the health care plan covering eligible retirees.

The Sixth Circuit concluded that the retirees and the district court misread a prior ruling of the panel. In holding that the employer could reasonably alter the retirees' benefits, the appeals court recognized that the employer could alter them on its own, not as part of a new collective bargaining process. In answering the question "what does vesting mean in the health care setting?", the appeals court rejected the suggestion that the employer could make no changes to the health care benefits provided to retirees. Unlike pension obligations, health care benefits cannot readily be monetized at retirement, explained the court. Thus, vesting in the context of health care benefits provides an evolving, not a fixed, benefit.

In this instance, the appeals court observed that past changes to retiree health care benefits had not been collectively bargained, which comes as no surprise because "a union does not represent retired employees when it bargains for a new contract for its employees." Thus, the district court erred when it disregarded the appeals court's holding that the company may make reasonable modifications to the retirees' health care benefits.

In remanding the decision, the appeals court noted that to gauge whether the employer has proposed reasonable modifications to its health care benefits for retirees, the district court should consider whether the new plan provides benefits "reasonably commensurate" with the old plan, whether the changes are "reasonable in light of changes in health care," and whether the benefits are "roughly consistent with the kinds of benefits provided to current employees."

Any information provided by Conner Strong & Buckelew is for informational purposes only and does not constitute legal advice. If the topics addressed in these Updates have legal significance, you should review your options and your ultimate course of action with your legal counsel.

EMPLOYERS EXPECTED TO CONTINUE OFFERING BENEFITS; PLAN OFFERINGS TO CHANGE - According to a recent survey completed, employers of all sizes polled around the country have cited that employee benefits are still an integral part of their effort to attract and retain competent employees. This is not to say that employers will not be toning down their coverage levels in anticipation of the Cadillac Tax that will take effect in 2018. Rather, it is indicative that employers increasingly are recognizing the need for increased cost control measures that will stem rising costs. Additionally, there has been a steady increase in CDHP enrollment over the past few years and researchers at Aon Hewitt have stated it is now the second most common plan design offered by U.S. employers. So, while employers will not be dropping coverage anytime soon it is important that employees anticipate a substantial change in plan design strategies.

Source: Kathryn Mayer, "Reform isn't impacting employer-sponsored coverage." *Benefits Newswire* December 2012.

PAY-FOR-DELAY CASE WILL BE A HUGE CASE TO WATCH FOR IN 2013 - For years the Federal Trade Commission (FTC) has tried to stop "pay-for-delay" agreements between brand and generic drug manufacturers. These arrangements essentially result in brand manufacturers making payments to generic rivals to keep their competing products of the market for a certain number of years. Both drug manufacturers win as this arrangement is more lucrative

than litigating their case or settling on alternative terms. The FTC has brought numerous cases against these drug manufacturers in the past but the courts have not upheld any of their cases. The FTC estimates that these deals result in generics reaching the market 17 months later than normal and cost consumers approximately $3.5 billion per year. The removal of these pacts would obviously be welcome news for plan sponsors as the ability to move patients to a less expensive treatment will yield cost savings. Finally, the FTC has appealed all the way to the Supreme Court and it is expected that they will make a ruling in June.

Source: "SCOTUS Review of Pay-for-Delay Case Could Be Big Boon for Plan Sponsors." *Drug Benefit News* 13, No. 24 (2012): 1,7.

MONTHLY REPORTING

CLIENT ACTIVITY REPORTS - Client Activity Reports illustrate service specific communication from the participants. Global Issues are reported separately to the Executive Committee via the Program Manager Report.

COMPLAINT REPORT as of January 15, 2012 - No written complaints were received during December.

CLAIM APPEALS - There were three claim appeals that need to be determined at this meeting

PLAN DOCUMENTS - A status report for Plan Documents was included.

TREASURER: Fund Treasurer was absent; Executive Director read the report that was included in the agenda.

Bills lists:

February 2013 – Confirmation of Payment

FUND YEAR 2013	**$343,676.04**
TOTAL ALL FUND YEARS	**$343,676.04**

March 2013 – Resolution 14-13

FUND YEAR 2011	**$111.90**
FUND YEAR 2012	**$341,586.33**
FUND YEAR 2013	**$24,335.00**
TOTAL ALL FUND YEARS	**$366,033.23**

MOTION TO APPROVE FEBRUARY 2013 BILLS LIST AND ADOPT RESOLUTION 14-13 TO PAY MARCH 2013 BILLS LIST.

MOTION:	Commissioner Schmidt
SECOND:	Commissioner Bethea
VOTE:	8 Ayes, 0 Nays

MOTION TO APPROVE BALANCE OF TREASURER'S REPORTS, AS SUBMITTED

MOTION:	Commissioner Schmidt
SECOND:	Commissioner Bethea
VOTE:	8 Ayes, 0 Nays

ATTORNEY:

No report

QUALCARE: Mr. Epstein reviewed the claim payment report which totaled a little over $3 million and the high dollar report which totaled $24,609 for 2013. He said that Qualcare will be sending EOBs via email instead being mailed unless the member opts out.

AETNA: Ms. Ward reviewed the December and January reports. She said December's pepm averaged $1245, while January was a bit lower at $1059. She also introduced the Aetna app that can be downloaded on smart phones and tablets.

EXPRESS SCRIPTS:

No report

DELTA DENTAL:

none

NEW BUSINESS:

None

OLD BUSINESS:

None.

PUBLIC COMMENT:

None

MOTION TO ADJOURN MEETING:

MOTION:	Commissioner Cevetello
SECOND:	Commissioner Schmidt
VOTE:	Unanimous

MEETING ADJOURNED: 2:35 PM