

BERGEN MUNICIPAL EMPLOYEE BENEFITS FUND
OPEN MEETING: June 23, 2011
SADDLE RIVER BOROUGH HALL
12:00 P.M.

Meeting called to order by Chairman Charles Cuccia. The Open Public Meeting Notice was read into the record.

ROLL CALL OF 2011 EXECUTIVE COMMITTEE:

Chairperson		
Charles Cuccia	Borough of Saddle River	Present
Secretary		
Peter Van Winkle	Borough of Rutherford	Absent
Executive Committee	Members	
Linda LoPiccolo	Twp. of South Hackensack	Present
Robert Hoffman	Borough of Westwood	Present
Maureen Iarossi-Alwan	Borough of Montvale	Absent
Helene Fall	Borough of Park Ridge	Present
Hugo Poli	Village of Ridgefield Park	Present
Alternates		
Victor Baginski	Borough of Wallington	Present

APPOINTED OFFICIALS PRESENT:

Executive Director/ Administrator	PERMA Risk Management Services	Paul Laracy Loreine Ghani Despina Kontomanolis
Attorney	Huntington Bailey, LLP	Russell Huntington
Treasurer	Joseph Iannaconi	
Third Party Administrator	Aetna	Gary Lopez
Dental Claims Administrator	Delta Dental of NJ, Inc.	
Auditor	Lerch, Vinci & Higgins	Gary Vinci
Actuary	John Vataha	
Independent Consultant	LaMendola Associates	Clark LaMendola
Benefits Consultant	Conner Strong	Brandon Lodics
RX Administrator	Express Scripts	Katty Mercado

OTHERS PRESENT:

Frank Covelli, PIA
Robert Saul, Westwood
Tom Konikowski, RMC Wallington

Colleen Holdsworth, Parsells
Debra Ginetto, RMC

MOTION TO HANDLE CLAIMS APPEALS FIRST

MOTION: Commissioner Hoffman
SECOND: Commissioner Baginski
VOTE: Unanimous

MOTION TO GO INTO CLOSED SESSION

MOTION: Commissioner LoPiccolo
SECOND: Commissioner Baginski
VOTE: Unanimous

MOTION TO OPEN AND TO RATIFY DECISIONS MADE IN CLOSED SESSION:

MOTION: Commissioner Fall
SECOND: Commissioner Van Winkle
ROLL CALL VOTE: 4 Ayes, 0 Nays, 2 Abstain
(Commissioners Poli and Hoffman)

APPROVAL OF MINUTES: April 28, 2011 Open and Closed.

MOTION TO APPROVE THE OPEN AND CLOSED MINUTES OF APRIL 28, 2011

MOTION: Commissioner Fall
SECOND: Commissioner Baginski
VOTE: Unanimous

FINANCIAL REPORTS - The following reports were included in the agenda: Fast Track Financial Report as of May 31, 2011; the Cash Flow Tracking Report as of May 31 2001; the Budget\Billing Reconciliation, as of June 2011; and the Regulatory Compliance Checklist, as of May 31, 2011. There is a YTD surplus no significant trends that require analysis.

AUDIT REPORT AND VALUATION AS OF DECEMBER 31, 2010

Mr. Vinci presented the results of the 2010 Audit results. It was an unqualified audit. Mr. Vinci pointed out that the fund had reduced it's year over year deficit by \$400,000. In response to a question to a decline in net assets, Mr. Laracy explained it was due to an increase in United claims. Attorney Huntington pointed out that more claims is indicative of better claims management.

MRHIF LEGISLATIVE AGENDA – SENATE BILL 2718 -, MRHIF commissioners, Chairman Cuccia, representatives from our lobbying firm, and Perma had a series of meetings in the State House on the bill. We had 3 consecutive meetings with the staffs of the Senate Democrats and State Government Committee, the Senate Republican Office, and the chief of

staff for Treasury. Each of the groups we met with were attentive to our concerns and we left with the impression that our positions were recognized as reasonable and worthy of additional consideration. Chairman Cuccia address the results of all the lobbying and explained that the most critical aspects of the bill as it relates to health insurance funds were removed and applauded Mr. Laracy's efforts. Mr. Laracy thanked him and added that Perma is anticipating a separate bill's requirements and the Gateway BMED website will be a future model. There was a brief discussion about some website details. The website is about 90% complete.

LOGO AND MARKETING COMMITTEE – Marketing efforts continue towards membership in the Gateway BMED fund. Oakland still continues to be a prospect.

SMALL CLAIMS COMMITTEE – Attorney Huntington presented a proposal to establish a Small Claims Committee to handle claim appeals under an agreed upon limit. The consensus of the group was that small claims were defined as under \$1000 to a limit of \$2500 per claimant/ per year. The committee will consist of Commissioners LoPiccolo, Poli and Van Winkle.

Executive Director's Report Made Part of the Minutes.

TREASURER - The Treasurers' Report was included in the agenda. Chairman Cuccia reviewed the bills

MAY 2011 BILLS LIST

FUND YEAR	AMOUNT
2011	\$117568.13
TOTAL	\$239,826.92

RESOLUTION 25-11 JUNE BILLS LIST

FUND YEAR	AMOUNT
2010	\$10,000
2011	\$117,705.32
TOTAL	\$237,672.46

APRIL CERTIFICATION OF CLAIMS\IMPREST TRANSFERS



FUND YEAR	AMOUNT
2011	\$4,658,732.63
2010	\$1,362,468.59
2009	(\$1777.05)
TOTAL	\$6,019,424.17

Treasurer's Report Made Part of the Minutes

BOARD ADVISOR: No Report

AETNA - THIRD PARTY ADMINISTRATOR - Mr. Lopez distributed the Monthly Claim Activity Report. He said the March and April claims equaled \$1,948,666. He added that the spikes are due to high claims and if you take those out of the equation, the claim per employee would be around \$1000 which is inline with the current trend. In addition, Mr. Lopez distributed handouts showing Aetna's customer service tracking and the financial impact of emergency or catastrophic claims.

TPA's Report Made Part of the Minutes

BENEFITS CONSULTANT: Conner Strong presented by Brandon Lodics

- Administrative Issues
- Conner Strong and Buckelew
- Plan Document- Medicare Language
- Benefits Express Update
- Small Claims Committee
- For Your Information
 - Health Care Reform
 - Bylaws Regarding Appeal Process
 - OnLIFE Report
 - Client Activity Report
- Monthly Reporting
 - Complaints
- Claim Appeal- Closed Session

ADMINISTRATIVE ISSUES

There are no administrative updates.

CONNER STRONG & BUCKELEW

We are pleased to announce that we will now officially be referred to as Conner Strong & Buckelew. This change is to recognize the accomplishments of our company's chairman, Joseph Buckelew, who was the founder of our predecessor company over 50 years ago.

PLAN DOCUMENT- MEDICARE LANGUAGE

Proposed Language:

Eligibility Requirements for Retired Employees and Other Medicare Eligible Persons.

This Plan requires that Covered Persons who are eligible for Medicare because of retirement or disability and Medicare would become a Primary Payor must be enrolled under the a Medicare program for Part A / Medicare Hospital Insurance and Part B / Medicare Medical Insurance in order to be a participant under this Plan. This Plan cannot pay for benefits, which should be paid by Medicare. Medicare eligibility may be based on individual, spousal or former spousal eligibility, regardless of premium requirement,

Participants are required to enroll in Medicare Part A & Part B by the first day of the Calendar Month following thirty days of the qualifying event if eligible for enrollment during the Medicare Special Enrollment period, or during the next available Medicare Open Enrollment period (January 1st through March 31st of each year to be effective by the following July 1st) following the qualifying event.

A Retired Employee must follow the same rules for enrollment in the Plan as Full-Time Active Employees. It is the participant's responsibility to notify the Plan of any changes. If family members cease to be eligible, claims will not be paid. The actual change in coverage will not take place until the participant has formally requested the change in writing. A participant may change plans during open enrollment or during a rate change period.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) added a new prescription drug program to Medicare (Medicare Part D). Under the provisions, Covered Persons who are eligible for Medicare will receive an annual disclosure notice stating whether their current prescription coverage under the Plan is considered to be creditable coverage under Medicare. As defined in regulation at 42 CRF 423.56(a), drug coverage is creditable if the actuarial value of the coverage equals or exceeds the actuarial value of standard Medicare prescription drug coverage.

Current Language:

Eligibility Requirements for Retired Employees and Other Medicare Eligible Persons.

This Plan requires that Covered Persons who are eligible for Medicare (Retirees, disabled persons), based on individual, spousal or former spousal eligibility, regardless of premium requirement, must be enrolled under the a Medicare program for Part A / Medicare Hospital Insurance and Part B / Medicare Medical Insurance in order to be a participant under this Plan. This Plan cannot pay for benefits, which should be paid by Medicare.

Participants are required to enroll in Medicare Part A & Part B by the first day of the Calendar Month following thirty days of the qualifying event if eligible for enrollment during the Medicare Special Enrollment period, or during the next available Medicare Open Enrollment period (January 1st through March 31st of each year to be effective by the following July 1st) following the qualifying event.

A Retired Employee must follow the same rules for enrollment in the Plan as Full-Time Active Employees. It is the Retired Employee's responsibility to notify the Plan of any changes. If family members cease to be eligible, claims will not be paid. The actual change in coverage will not take place until the Retired Employee has formally requested the change in writing. A Retired Employee may change plans during open enrollment or during a rate change period.

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BENEFITS EXPRESS UPDATE

Bills are continuing to be successfully run and sent to each group. The benefits audit of the plans on the portal has been completed. We are working with Benefits Express to have the necessary adjustments made.

Upon completion of the plan audit, the system will be rolled out to the Risk Managers and Benefits Coordinators and a training schedule will be made available.

SMALLS CLAIMS COMMITTEE

We have reviewed the policy and sent our suggestions to the Fund Attorney.

FOR YOUR INFORMATION

Health Care Reform

It is worthwhile to note that effective April 15, the U.S. Senate repealed the free-choice voucher provision that was enacted as a part of Health Care Reform. This provision, which was slated to become effective in 2014, would have forced employers to offer vouchers to certain employees whose cost of coverage fell within the 8-9.8 percent range of their household income. These vouchers would have enabled employees to purchase their coverage through the state-based insurance exchanges and many experts had argued that these vouchers would result in adverse selection. In any event, this requirement will no longer be effective. However, it is important to note that in 2014 employers will still be required to pay a penalty for not offering coverage or for offering coverage which has been deemed unreasonable in terms of cost.

The Department of labor has recently stated that the rules concerning internal appeals and external review processes will go into effect as of July 1, 2011. This change will impose an additional requirement on the carriers, such as providing additional information in the event of an adverse benefit determination. On all future letters of denial that are sent to members, the carriers will now be expected to include the date of service, provider, claim amount, the reason for the denial, and a description of the methodology the carrier used when coming to the benefit determination. Carriers will also be required to provide all of this information on the Explanation of Benefits (EOBs) that they send out to members along with the denial code for the service rendered.

OnLife Health Reports

Attached are various reports regarding the status of the wellness program with the Gateway-BMED. Every month, Onlife Health will release these statistics to keep the Fund informed of participation, employee engagement, and the results obtained from biometric screening measures.

MONTHLY REPORTING

There were no written complaints received by:

- ⊗ Conner Strong
- ⊗ Delta Dental
- ⊗ Aetna.
- ⊗ Express Scripts

CLAIM APPEALS

There are THREE claim appeals to be reported in closed session; TWO to be voted on.

Benefits Consultant Report Made Part of the Minutes

PRESCRIPTION PROVIDER – EXPRESS SCRIPTS- No Report

CONSENT AGENDA:

The following Resolutions listed on the Consent Agenda will be enacted in one motion.

Resolutions	Subject Matter
22-11	Acceptance of Financial Audit as of December 31, 2010
23-11	Small Claims Administration
24-11	Certification of Claim Payments/Imprest Transfers
25-11	Authorization of June 2011 Bills List

MOTION TO APPROVE THE CONSENT AGENDA, AS DISCUSSED:

MOTION:	Commissioner Hoffman
SECOND:	Commissioner LoPiccolo
ROLL CALL VOTE:	6 Ayes, 0 Nays

OLD BUSINESS:

None.

NEW BUSINESS:

None

PUBLIC COMMENT:

None.

MOTION TO ADJOURN:

MOTION:	Commissioner LoPiccolo
SECOND:	Commissioner Baginski
VOTE:	Unanimous

MEETING ADJOURNED: 2:00pm

NEXT MEETING: August 25, 2011

Saddle River Borough Hall
12:00 P.M.

Loreine Ghani, Assisting Secretary
Date Prepared: July 11, 2011