BERGEN MUNICIPAL EMPLOYEE BENEFITS FUND
OPEN MEETING: JUNE 25, 2015
FRANKLIN LAKES, NEW JERSEY
12:00 P.M.

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

ROLL CALL OF 2015 EXECUTIVE COMMITTEE:

Chairperson		
Peter Van Winkle	Borough of Rutherford	Present
Secretary		
Victor Baginski	Borough of Wallington	Present
Executive Committee	**Members**	
Hugo Poli	Village of Ridgefield Park	Present
Richard Kunze	Borough of Oakland	Present
Gregory Hart	Borough of Franklin Lakes	Present
Donna Gambutti	Twp of S. Hackensack	Present
Michael Mariniello	Borough of Saddle River	Absent
Alternates		
Joseph Catenaro	Township of Fairfield	Present

APPOINTED OFFICIALS PRESENT:

Executive Director/ Administrator	**PERMA Risk Management Services**	Paul Laracy Emily Koval
Attorney	**Huntington Bailey, LLP**	Russ Huntington
Treasurer	**Joseph Iannaconi**	Joseph Iannaconi
Third Party Administrator	**Aetna**	Kim Ward Jason Silverstein
Dental Claims Administrator	**Delta Dental of NJ, Inc.**	Kim White
Auditor	**Lerch, Vinci & Higgins**	Elizabeth Schick
Actuary	**John Vataha**	
Independent Consultant	**LaMendola Associates**	Clark LaMendola
Benefits Consultant	**Conner Strong**	Brandon Lodics Jozsef Pfeiffer
RX Administrator	**Express Scripts**	Kenneth Rostkowski

OTHERS PRESENT:
Thomas Ucko, IMAC Insurance Agency
Dave Vozza, Vozza Agency

Tom Konikowski, Konikowski Agency
Frank Covelli, PIA

CORRESPONDENCE – None

APPROVAL OF MINUTES: April 23, 2015

MOTION TO APPROVE THE PRESENTED OPEN MINUTES OF APRIL 23, 2015:

MOTION:	Commissioner Hart
SECOND:	Commissioner Baginski
ROLL CALL VOTE:	**7** Ayes, 0 Nays

PRO FORMA REPORTS

- **Fast Track Financial Reports –** as of April 30, 2015
  - **Historical Income Statement**
  - **Cash Flow Tracking Reports**

Executive Director said the Financial Fast Track illustrated a $12.7 million surplus to date. The Fund is performing better than expected.

REGULATORY

AUDITOR AND ACTUARY YEAR-END REPORTS - A copy of the financial audit for the period ending December 31, 2014 was included with the agenda. Ms. Schick from Lerch, Vinci and Higgins was in attendance to review. Once approved, we will make a filing with the Departments of Insurance and Community Affairs to meet the June 30th deadline. Attached are Resolution 21-15 and the Affidavit of Certification to approve the December 31, 2014 audit. We request the approval via the following motion.

Ms. Schick said this audit was given best opinion under the appropriate Governmental Auditing practices. She reviewed the balance sheet which showed a Fund balance increase by over 2 million from 2013, some of which can be attributed to a dividend income from the MRHIF. She said there were no recommendations or comments. Commissioner Kunze congratulated the fund and professionals on the efforts made to maintain a clean audit.

Executive Director said the Fund accumulated more surplus than expected. Last year, the Fund used its rate stabilization. It is possible for the Fund to consider a dividend policy. Some members have more reserve than a possible very high year of claims.

STATEMENT OF ACTUARIAL OPINION - Included in the agenda was the review of actuarial assumptions and actuarial methods used in determining the reserves, by the Fund Actuary to be filed with the December 31, 2014 year –end financial reports to New Jersey Department of Banking and Insurance.

NEW MEMBERSHIP - The Fairfield Board of Education has approved membership and submitted and Indemnity and Trust agreement with the BMED effective July 1, 2015. Statistics of this new member are below:

Underwriting Factor	Fairfield Township BOE	Fund Average or Standard	Relativity
Current Carrier or Arrangement	Amerihealth Direct	Aetna	
Age Sex Factor	1.15	1.17	98.42%
Enrollment	73	802	9.10%
Trend Applied	11.0%	8%	137.50%
Risk Manager Fee Applied	NA		
Rate Effective Date			
From	7/1/2015		
To	6/30/2016		
Prior Fund Member?	No		
Current P&C JIF Member?	No		
Lines of Coverage to Fund			
Medical	Yes		
Dental	Yes		
Rx	Yes		
Anticipated Commissioner Involvement	To be determined		
Explanatory Notes or Contingencies	None		

Executive Director said the agency, IMAC, has brought in Fairfield and Fairfield BOE. In addition, we are also working with Montclair who is also interested in putting in an application. He thanked the broker for their marketing efforts.

MOTION TO OFFER MEMBERSHIP TO FAIRFIELD TOWNSHIP BOARD OF EDUCATION EFFECTIVE JULY 1, 2015

MOTION: Commissioner Kunze
SECOND: Commissioner Poli
ROLL CALL VOTE: **7** Ayes, 0 Nays

MUNICIPAL REINSURANCE HEALTH INSURANCE FUND - The MRHIF met on June 10, 2015. Chair Van Winkle'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.

PROFESSIONAL CONTRACTS – Ms. Koval said the BMED has always followed the alternate to the fair and open process of awarding contracts. All other local HIFs will be releasing RFQs this year and suggested that BMED do the same for due diligence. Chair Van Winkle agreed.

MOTION TO RELEASE AN RFQ FOR ALL PROFESSIONAL CONTRACT POSITIONS FOR A THREE YEAR TERM BEGINNING JANUARY 1, 2016

MOTION:	Commissioner Kunze
SECOND:	Commissioner Hart
ROLL CALL VOTE:	**7** Ayes, 0 Nays

BENEFITS OPERATIONS

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.

MEDICARE ADVANTAGE - All Medicare Advantage retirees were successfully transitioned to the new United Healthcare Medicare Advantage program. ID cards were mailed out and received prior to the June 1st effective date. In addition, UHC mailed informational welcome packets which included plan summaries and information on additional programs exclusive to UHC.

CONTACT INFORMATION - Please direct any eligibility, enrollment, billing or system related questions to our dedicated BMED Team. The team can be reached via email: bmedenrollments@permainc.com or by fax: 856-685-2257.

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

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 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/ (also attached).

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 Jozsef Pfeiffer at jpfeiffer@permainc.com. The expected turn around time to receive reports is 7-10 business days.

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.

Recommended Strategy

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 the FDA will be approving one brand at the end of July. The estimated cost per fill will be between $5,000-$7,000 per fill for these specialty drugs. The Fund is working with ESI on a plan of action. Mr. Rostkowski said the potential cost for these injectable could be $10,000-$12,000 per year, per person. He said only approximately 2% of high cholesterol patients should be prescribed this, but more than those who did it will receive a prescription. Express Scripts is suggesting a heavy pre-authorization process including a blood test, medical history and before approval. Program Manager said the issue with this particular drug is that high cholesterol is an epidemic within our membership. If a member did not respond well to statins, these drugs will replace this. For new diagnoses, patients would have to try the statins first.

Program Manager suggested that the Fund exclude for a few months and do further research since the Prior Authorization program is still very new. The Fund can meet as a committee to further develop a plan. He said this drug could increase the trend by 33% , whereas the PA program can reduce the trend to just an addition 3%, which will be more sustainable. In response to Board Advisor, Program Manager said he is recommending that the Fund exclude this class of drug for at least 2 months and if a prescription occurs, the member would have to go through the appeal process with an independent review organization. Board Advisor said the Fund should consider the impact on the membership and the bargaining units. Executive Director said the Fund should look at all options before making a recommendation, but does not believe that public entities can exclude all together in the long run.

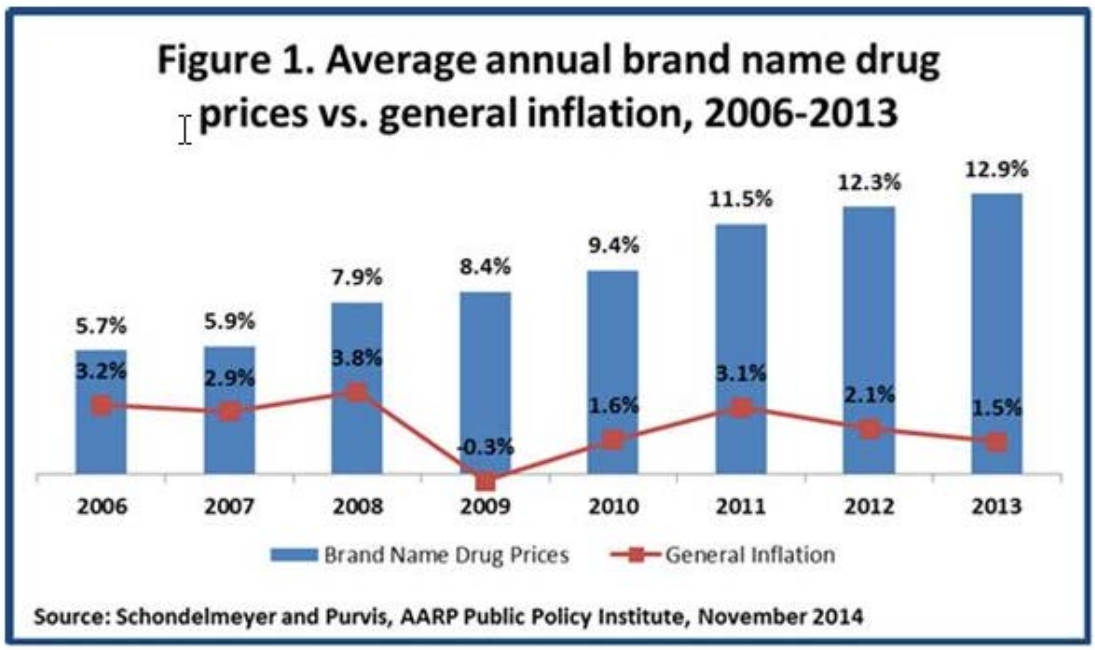
Commissioner Catenaro suggested that the Fund make a policy for all newly FDA approved specialty drugs, such a as a 90 day exclusion to allow for the Fund to make a plan, bring alternatives, look at the impact of the Fund. The professionals will research his further to develop a plan and bring back to the Committee at the next meeting. Board Advisor said a 60 day deferral is reasonable and prudent for the fund. Chair Van Winkle suggested that the Fund determine how many people are currently on statins.

In response to Commissioner Baginski, Mr. Rostkowski said he believes the State Health Benefits Plan will continue to cover this drug.

MOTION TO APPROVE 60 DAY NON COVERAGE PERIOD, ADDRESS ANY CLAIM APPEALS IN THAT PROCESS AND ALLOW PROFESSIONALS TO DEVELOP A PLAN FOR ALL PCKS9 DRUGS

MOTION:	Commissioner Baginski
SECOND:	Commissioner Hart
ROLL CALL VOTE:	**7** Ayes, 0 Nays

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.

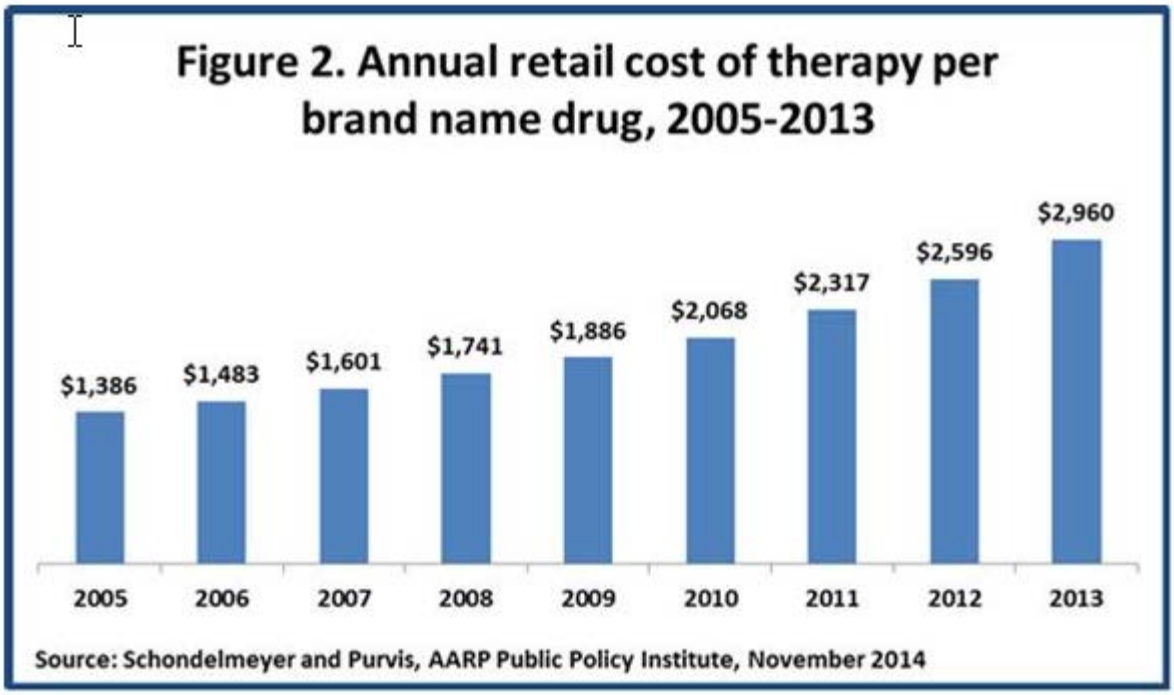


Figure 2 presents the retail price for widely used brand name drugs indicated for treating chronic conditions when the price is expressed as an average annual cost of therapy per drug. The average cost of therapy was nearly $3,000 per drug per year for brand name prescription drugs at the retail level 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.

FUND ATTORNEY – No report.

TREASURER - Fund Treasurer said his report was included in the agenda and the bills lists were included in the consent agenda.

RESOLUTION 22-15 MAY 2015 BILLS LIST

FUND YEAR	AMOUNT
2014	$6,500
2015	$270,797.59
TOTAL	**$ 277,297.59**

RESOLUTION 22-15 JUNE 2015 BILLS LIST

FUND YEAR	AMOUNT
2015	**$ 275,101.23**
TOTAL	**$ 275,101.23**

BOARD ADVISOR – No report

AETNA - THIRD PARTY ADMINISTRATOR – Ms. Ward said the platform migration in January caused a delay in claims, that caught up in march. April is performing as normal. She said the high dollar claim for $150,000 is from one patient who had heart surgery, which is impacting. She said Mr. Silverstein be attending meetings until she returns in October.

PHARMACY NETWORK (Express Scripts) – Mr. Rostkowski said the Fund is running at a 9% trend which is better than most public sector groups and HIFs.

DELTA DENTAL – None

CONSENT AGENDA:

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

Resolutions	Subject Matter
21-15	Acceptance of 2014 Year End Financial Statements
22-15	Authorization of May & June 2015 Bills List
23-15	Certification of Claim Payments/Imprest Transfers
24-15	Resolution for Executive Session - For specified purpose of Claims discussion

MOTION TO APPROVE THE CONSENT AGENDA, REMOVING 24-15

MOTION:	Commissioner Baginski
SECOND:	Commissioner Kunze
ROLL CALL VOTE:	**7** Ayes, 0 Nays

OLD BUSINESS: None.

NEW BUSINESS: Commissioner Gambutti said her husband receives a compound script and has been in a struggle to get it filled, even to this day. She said the Program Manager and broker have been helpful, but is struggling with the lack of a dedicated HIF express Scripts representative. She said she is trying to find a pharmacy that will fill the prescription that has not been an issue until now and was told the previous mail order pharmacy is in an exclusive contract. Program Manager reveiewed the steps his team has

taken to try and find a pharmacy that will continue to fill this compound. He said the issue is that the Fund excludes non-medically necessary, non-FDA approved compounds. Not all compounds are medically necessary,, so we have to review all that are prescribed. Compounding pharmacies charge per ingredient which can be very expensive. The override is set to avoid the PA. Mr. Rostkowski said an override was placed to allow a fill at the mail order pharmacy for at least 6 months. In response to Commissioner Gambuitti, compounds were included as the already approved prior authorization which changes periodically.As for the service, he said the new contract with ES included a dedicated line for the HIF.

PUBLIC COMMENT: Mr. Covelli said that audit was perfect. He suggested that a committee develop a long range plan to tackle the caddy tax and dividend plans which will be a long term benefit to the members. He volunteered to be on that committee.

In addition, as far as compound issue, Mr. Covelli said the total cost of this drug is under $350. The takeaway from this issue is the lack of customer service.

Executive Director reviewed the recent decision to not approve the PCSK9 drugs for 60 days with the Fund Attorney.

MOTION TO ADJOURN:

MOTION:	Commissioner Poli
SECOND:	Commissioner Hart
VOTE:	Unanimous

MEETING ADJOURNED: 1:15 pm

NEXT MEETING: September 24, 2015
Franklin Lakes Borough
12:00 P.M.

Emily Koval, Assisting Secretary
Date Prepared: August 11, 2015