BERGEN MUNICIPAL EMPLOYEE BENEFITS FUND
OPEN MEETING: FEBRUARY 25, 2016
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 2016 EXECUTIVE COMMITTEE:

Chairperson		
Peter Van Winkle	Borough of Rutherford	Present
Secretary		
Victor Baginski	Borough of Wallington	Absent
Executive Committee	**Members**	
Hugo Poli	Village of Ridgefield Park	Absent
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	Present
Alternates		
Joseph Catenaro	Township of Fairfield	Absent

APPOINTED OFFICIALS PRESENT:

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

OTHERS PRESENT:
Carolyn Petrowski, Vozza Agency
Kim Ward, Aetna
Frank Covelli, PIA
Matt McArow, GJEM/Otterstedt
Deb Ginetto, Burton Agency

Dan Saragnese, Fairfield BOE
Bruce T Masopust, Borough of Lodi
Ben Kezmarsky, Borough of Westwood

CORRESPONDENCE – None

APPROVAL OF MINUTES: January 28, 2016

MOTION TO APPROVE THE PRESENTED OPEN MINUTES OF JANUARY 28, 2016

MOTION:	Commissioner Hart
SECOND:	Commissioner Kunze
ROLL CALL VOTE:	**5** Ayes, 0 Nays

EXECUTIVE DIRECTORS REPORT

FINANCES

PRO FORMA REPORTS

- **Fast Track Financial Reports –** as of December 31, 2015
  - **Historical Income Statement**
  - **Cash Flow Tracking Reports**

Executive Director said the financial fast track shows a surplus of 1.3 million for the 2015, even after paying a large dividend. He said 2015 was one of the best years financially in at least ten years.

REGULATORY

MRHIF MEETING - The Municipal Reinsurance Health Insurance Fund met on February 9 to reorganize for 2016. The new Coastal and SHIF commissioners were in attendance. The Committee reviewed the new reinsurance policies which are available for all Commissioners' review.

In addition, Express Scripts was present at the meeting to review the recent audit that found significant overcharges on generic drugs during the first quarter of the new contract. A year end audit is being conducted now and results will be available at the next meeting. Minutes from this meeting are included in Appendix II.

Executive Director said there was a discussion on the ESI audit that was presented at the previous SNJHIF meeting. He said if the contracted guarantees are not being met then they will reimburse the fund.

RISK MANAGER COMPENSATION - As discussed at the previous meeting, a resolution approving the Risk Managers and their compensation for the member town/school boards is included in the consent agenda. These producers are contracted through the Fund and must submit a contract or resolution that has been approved by each represented town.

In response to Commissioner Kunze, Executive Director said the rates vary by how long the member has been in the Fund.

OUT OF NETWORK CLAIM APPEALS - At the last meeting, the committee discussed amending the Risk Management Plan to assign out of network claim appeals to the small claims committee. The consent agenda includes revised resolution #8-16. Please refer to the underlined portion of Section 21 which includes language to address these appeals.

Executive Director said there is a revision to the Risk Management Plan regarding the Out of Network Fee Schedule and that is included in the consent agenda. Commissioner Gambutti volunteered to be an additional member on the small claims committee.

NEW MEMBERSHIP - Executive Director said that Edgewater will be joining the fund on 5/1/2016 with about 140 lives. In response to Board Advisor, Executive Director said this addition will get the Fund closer to 1100 medical lives.

BENEFITS OPERATIONS

EXPRESS SCRIPTS FORMULARY UPDATE – BRAND GLUMETZA CHANGE (ANTIDIABETIC) - This month, a generic medication for Glumetza is coming to the market. Normally, when a multi-source brand loses patent protection, substitution to the generic is automatic. In the situation with Glumetza, Valeant (its manufacturer) has entered into agreements with retailers to dispense their branded product as a generic at the contracted pharmacies. This action will circumvent normal generic substitution, client benefit plans and increase plan costs. Valeant increased drug prices throughout their products in 2014, and Glumetza saw an over 800% increase in price in 2015. As such, we recommend the exclusion of this multi-source branded product to ensure that normal generic substitution continues. This action maximizes your ability to control costs. This exclusion will ensures that the standard process of generic substitution will take place at the point of sale.

Benefits Consultant said the maker of Glumetza has negotiated with certain pharmacies to sell their branded drug as generic at brand price. He said the Fund is protected because of the pharmacy network and formulary.

DUPLICATE ID CARD REQUESTS - Effective immediately, the BMED no longer has the capability to request duplicate ID cards from the carrier systems. Going forward, the most efficient way for members to order additional ID cards is by calling the carrier directly or by registering online through the carrier's website. Most carriers also have mobile apps available where you can download their app to your mobile phone and you are able to view a copy of your ID card right from your phone.

Benefits Consultant said their enrollment department can no longer request duplicate ID cards. In response to Commissioner Kunze, Benefits Consultant said he can send out an email to all risk managers.

STEP THERAPY – REVISIT - Step therapy is a program that requires members to utilize medications in a certain order based on price and clinical efficacy. The Fund implemented Step Therapy with grandfathering in 2013, which allowed members on a drug that required a step, to bypass the step as long as they remained on that medication continuously every 130 days. Removing

grandfathering will require members to at least try the least costly/more clinically effective medication before moving to the second tier drug. *Clinical exceptions are attainable for members that may not be able to take the preferred medication.*

Executive Director said the removal of grandfathering was built into the budget but then tabled due to the out of network situation. He said it can still be implemented for any interested entity. Proposal would be to hold off and revisit next year unless an individual entity is interested. Executive Director said disruption reports were provided to the Risk managers. He said we can work with ESI to get a more in depth disruption report.

FEE SCHEDULE APPEALS - As discussed at the previous meeting, we are seeing an increase in appeals over out of network fee schedules. In addition to appeals, members have been seeking exceptions to continue to cover out of network physicians at higher rates of payment. PERMA is proposing BMED implement a "Fee Schedule Appeal" Process in which appeals based solely on out of network reimbursement rates be presented to a selected group of BMED commissioners. Once the committee is established, all appeals and payment exceptions will be presented blind of identifying information and either approved or denied by majority vote.

Benefits Consultant said several appeals have come in the last few weeks mostly from providers regarding out of network fee schedules. In response to Commissioner Van Winkle, Executive Director said the small claims limit is $1000 or $2500 in a rolling 12 month cycle. In response to Commissioner Covelli, Fund Attorney said the dollar amount can be reviewed if it becomes an issue. Benefits Consultants said most of the appeals have been in excess of the claims limit.

Board Advisor said the limits are no longer reasonable and should be increased. There are OON claims coming in at $75,000. Fund Attorney said small claims can not review claims that large, anything that large would be reviewed by the executive committee. Board Advisor suggests raising the small claim limits to $2,000 and $5,000. Executive Director said the Risk Management Plan includes this change.

Recordkeeping and Reporting – IRS Grants Automatic Extension

The Internal Revenue Service has announced that it has decided to delay the 1094 and 1095 forms filing deadlines for employers, insurers and others health plan coverage providers after it determined that filers need "additional time to adapt and implement systems to gather, analyze and report this information." The delay provides an "automatic" 60-day extension for furnishing Forms 1095-C and 1095-B to employees and an "automatic" 3 month extension for filing these forms with the IRS. **The new due date for furnishing the 2015 Form 1095-C to employees is extended from January 31, 2016 to March 31, 2016. And the new due date for employers furnishing the 2015 Form 1094-C to the IRS is extended from February 28, 2016 to May 31, 2016 (if filing electronically the new due date is extended from March 31, 2016 to June 30, 2016).**

Employers are advised to consult with their tax, HRIS/payroll, and legal advisors for assistance with specific issues/complexities regarding form preparation, appropriate eligibility and hours tracking rules, and the actual implementation of the data gathering, tracking, and reporting rules.

All entities with medical coverage in the Fund are self-insured and therefore required to file and distribute these forms; even those employers with less than 50 employees.

Entities with less than 50 employees will need to complete the 1094 and 1095 B forms.

Entities with more than 50 employees will need to complete the 1094 and 1095 C forms.

ACA and 1095 Forms Generally / Individual Tax Filing Issues – Most Commonly Asked Questions:

1. ***What are the new health coverage forms required by the Affordable Care Act?***
The Affordable Care Act (ACA) is a law designed, in part, to extend access to affordable health care coverage to more Americans. As required by the ACA, you must receive 1095 forms reporting on certain offers of health coverage and actual health coverage received in the prior year (note that other benefits such as dental plans, life insurance, or disability benefits are not reported on 1095 forms). The 1095 forms are filed by the marketplace (Form 1095-A), other insurers or providers (Form 1095-B), and certain large employers (Form 1095-C). One copy is sent to the Internal Revenue Service (IRS) and one copy is sent to you. A 1095 form is a little bit like a W-2 form. A W-2 form reports your annual earnings. The 1095 forms will show that you and your family members either did or did not have an offer of health coverage and/or actual health coverage during each month of the past year. Because of the ACA, every person who is not otherwise exempt must obtain health insurance or pay a penalty to the IRS.

2. ***How many forms will I get and when should I receive the form(s)?***
Depending on the circumstances, some people may receive multiple forms and some people may receive no forms. You may receive multiple forms if you had coverage from more than one coverage provider, if you worked for more than one employer during 2015, or if you enrolled for coverage in the marketplace for a portion of the year and received coverage from another source for part of 2015. If you are due a form, you should receive it by March 31, 2016. (Starting in 2017, you should receive it each year by January 31, just like your W-2.)

3. ***What do I do with the form(s)?***
You should keep your forms with your tax records. You don't actually need the form(s) in order to file your taxes, but when you do file, you'll have to tell the IRS (by checking a box on your tax return) whether or not you had health insurance for each month of 2015. Since you don't actually need the form(s) to file your taxes, you don't have to wait to receive it if you already know what months you did or didn't have health insurance in 2015. When you do get the form, keep it with your other 2015 tax information in case you should need it in the future to help prove you had health insurance. In the meantime, if your accountant or tax preparer requests proof of coverage, the government suggests these forms of documentation as proof of insurance coverage: insurance cards, explanation of benefits, statement(s) from insurers, W-2 or payroll statement(s) reflecting health insurance deductions, record(s) of advance payments of the premium tax credit, and other statements indicating an individual or family member had coverage.

4. ***Where can I go for more information?***
You can go to the governmental websites and find more detailed information on the forms and the ACA requirements. See the IRS Questions and Answers about Health Care Information Forms for Individuals (Forms 1095-A, 1095-B, and 1095-C) at https://www.irs.gov/Affordable-

Care-Act/Questions-and-Answers-about-Health-Care-Information-Forms-for-Individuals. See also the Department of Health and Human Services website at https://www.healthcare.gov/fees/ for detailed information on how the penalty is calculated. Ask your tax preparer or advisor if you have specific questions while filing your personal tax return. Everyone's family structure and income situation is different, and coverage providers and employers are not able to give you personal income tax advice. For further assistance you can always call the IRS helpline at **800-829-1040**.

FUND ATTORNEY – Fund Attorney said he will need a brief closed session.

TREASURER – Fund Treasurer reviewed the bills list and supplemental bills list that was not included in the agenda.

RESOLUTION 14-16 FEBRUARY2016 BILLS LIST

FUND YEAR	AMOUNT
2015	$762.31
2016	$319,464.35
TOTAL	**$320,226.66**

BOARD ADVISOR – Board Advisor said the minutes from the Wellness Committee Meeting are included in the agenda. He said the committee has formal sessions set up with Hackensack University Medical Center as well as Valley Hospital to build a relationship with the Fund. He said the materials received from Valley are impressive. He said he has received some information from Aetna on what they can provide for the membership. In addition, he said he is working with Mr. Covelli on Tuberculosis screenings for a particular member.

AETNA - THIRD PARTY ADMINISTRATOR – Ms. Ward said the financials for 2015 finished strong, below 2014. She said Aetna rolled out the Liberty plan which is similar to the Horizon Omnia plan. She said they want to offer a similar narrow network plan for the Fund. In response to Board Advisor, Ms. Ward said this could be an additional plan option for members to opt into. In response to Mr. Covelli, Ms. Ward explained the three tier plan design. Commissioner Marinello said members may be not be enrolling in fear that their preferred hospital could be in a Tier 2, which would increase their out of pocket. Ms. Ward agreed stating that the premium savings must be significant enough to cause change.

PHARMACY NETWORK (Express Scripts) – Mr. Ruebenacker addressed the ESI audit and the concern regarding generic claims. He said one of the biggest factors was Nexium not going generic as early as expected in 2015. He said from a contractual perspective the Fund is protected with a discount guarantee, and any guarantees that are missed are trued up at the end of the contract year. He said ESI ran a report starring 5/1/15 and compared it to the same 9 month time frame starting 5/1/2014. He said membership increased by 33% but there was only a 6.5% rise in plan costs pepm. The average trend across the book of business is 21%.

DELTA DENTAL – Ms. White network utilization is at 91.4%. She said the PPO network offers the best discount.

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

Resolutions	Subject Matter
Resolution 8-16:	Revised 2016 Risk Management Plan
Resolution 13-16:	Risk Manager Compensation
Resolution 14-16:	Authorization of February 2016 Bills List
Resolution 15-16:	Certification of Claim Payments/Imprest Transfers
Resolution 16-16:	Resolution for Executive session-for specified purpose of claims discussion

MOTION TO APPROVE THE CONSENT AGENDA, AS DISCUSSED:

MOTION:	Commissioner Hart
SECOND:	Commissioner Kunze
ROLL CALL VOTE:	**5** Ayes, 0 Nays

OLD BUSINESS: None

NEW BUSINESS: None

PUBLIC COMMENT: Commissioner Covelli thanked the Benefits Consultants for help this month on some difficult claim handling.

MOTION TO ALLOW EXECUTIVE DIRECTOR AND FUND ATTORNEY TO ACT WITH WHAT WAS DISCUSSED IN CLOSED SESSION :

MOTION:	Commissioner Hart
SECOND:	Commissioner Kunze
ROLL CALL VOTE:	**5** Ayes, 0 Nays

MOTION TO ADJOURN:

MOTION:	Commissioner Mariniello
SECOND:	Commissioner Gambutti
VOTE:	Unanimous

MEETING ADJOURNED: 2:00 pm
NEXT MEETING: April 28, 2016
Franklin Lakes Borough
12:00 P.M.

Emily Koval, Assisting Secretary
Date Prepared: March 11, 2016